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Experiences of Individuals With Opioid Use Disorder in Medication Assisted Treatment Programs

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Walden University 2022

Abstract

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Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

Opioid use accounts for many deaths each day in the United States. Although research has shown that retention in medication assisted treatment (MAT) programs increases quality of life for those individuals with opioid use disorder (OUD) and decreases premature death, there has been limited research on the perspectives of individuals with OUD in MAT programs and why they remained in or left the programs. The purpose of this qualitative phenomenological study, guided by Merleau-Ponty's theory of perception, was to explore the lived experiences of those with OUD treated in a MAT program. An algorithm type interview was conducted to ask about the lived experiences of individuals with OUD who have been treated in a MAT program and have chosen to stay, leave, or reenter. In-depth semistructured interviews with 11 purposively selected participants provided rich data of how OUD and treatment are lived through and understood. Transcribed interview data were interpreted using Saldana's open coding using in vivo codes resulting in pattern recognition that led to three themes. The themes were: rhythm of recovery, shattered reflections, and transcending the program. The themes reflected that a personal connection was needed for retention in a MAT program. The potential for relapse occurred even while patients were on MAT medications, and failure to stay in one program did not preclude entry into another MAT program. Future studies should explore the patient perspectives on the reasons some participants are "not ready" for recovery from OUD. Results of this study may promote positive social change as MAT program providers understand the OUD patients' perspectives on retention or leaving a MAT program for OUD.

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Dedication

To God who came through with miracles in my day-to-day life and bless me with the end of seeing this through to completion.

To the participants who became my partners in this research and unselfishly chose to give of themselves to allow others to benefit from their lived experiences. Thank you for your words and reflections and for teaching me...

To my patients who have made my life richer and who opened my eyes to all the possibilities in life.

To Nurses everywhere “stay the course”. The public may never know the extent of our responsibilities, but we do! Protect and Serve but never fail to nurture those coming behind.

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Chapter 1: Introduction to the Study

Opioids are the most abused drugs in the world (Chen et al., 2020) and cause two thirds of overdose deaths. Twenty-three percent of individuals exposed to opioids will develop opioid use disorder (OUD); Sofuoglu et al., 2019), and of the 2.5 million persons with OUD needing treatment in the United States, almost 4 out of 5 individuals do not receive any form of treatment (Madras et al., 2020). *Opioid use disorder* is defined as the misuse of prescribed or illicit opioids over a 12-month period disrupting two or more health or functional criteria (Connery, 2015). The American Hospital Association (2020) cited 50,042 opioid overdose deaths occurred in 2019, an increase of 4.6% from the 2018 statistics. A person born in 2017 has higher odds of dying from an opioid overdose than from a car crash (National Safety Council, 2019). In addition, there is a 20-fold greater chance of early death of individuals who have OUD from overdosing, infectious diseases, trauma, and suicide (National Academies of Sciences, Engineering, and Medicine, 2019). There are increased risks to health with prolonged opioid use throughout the life span (Schulte & Hser, 2017).

Medication assisted treatment (MAT) programs are the first line treatment for patients with OUD (Sofuoglu et al., 2019), providing opportunity for social repair. Yet, patients with OUD engaged in a MAT program are estimated at only one third of those needing treatment receiving one of the medications approved by the Food and Drug Administration (FDA; Williams et al., 2019). MAT programs provide clinical interventions with the use of federally approved medications and counseling for individuals with OUD (Substance Abuse and Mental Health Services Administration

[SAMHSA], 2019). Overall retention in MAT programs remains low with estimates at 50%–80% who start treatment with buprenorphine stop within several weeks or months (Williams et al., 2020). Retaining patients or getting them to start treatment remain barriers to care (Williams et al., 2019). Interventions provided by MAT programs are associated with a reduction of opioid use, decreased infectious diseases, and lowered opioid overdose deaths (Williams et al., 2020). Yet, there is a high attrition rate of individuals within MAT programs leading to worsening health outcomes (SAMHSA, 2019). There are wide variations in statistical reports of dropout rates within MAT programs, but most studies pointed to a consistent lack of retention within weeks to months of initiating treatment (Smyth et al., 2010; Williams et al., 2019, 2020). Many individuals who present to MAT programs have a history of treatment failures (Allen & Olson, 2015; Smyth et al., 2010). This lack of engagement may be in part caused by insufficient knowledge of individuals with OUD and their perceptions of why they choose to opt to stay in or leave a MAT program. Social implications of continued opioid use suggest ongoing dysfunction in the individual, families, communities, and society associated with multiple factors including premature morbidity and mortality rates (Bech et al., 2019; Hser et al., 2016). This study contributed to social change by knowledge gained of the patient's perspectives of their lived experiences with OUD and why they chose to opt out or stay in a MAT program.

This chapter addresses the history of opioid use, listed known factors affecting people with OUD, and introduced the premise of the MAT program. This chapter further addresses the ongoing confusion and complexity surrounding addiction and how this may

have affected treatment program retention or attrition. The research question is posed, aligning the question with the theoretical framework, nature of the study, definitions, assumptions, and study limitations. Conclusions of the chapter show how the study's significance of understanding patients' perspectives of opioid use within a MAT program may lead to positive social change.

Background

Opioids are one of the most powerful drugs used for pain relief but also one of the most addictive (Volkow et al., 2019). Opioid use is not new. Neolithic (8000–10,000 years ago) remains have been found with opium (opioids are extracted from the opium poppy plant) in bone samplings (Inglis, 2019). Opium was depicted in pottery and found in sacred ritual sites in early human history (Guerra-Coce, 2015) later holding medicinal value by early Greeks (Harrison et al., 2012). From the Renaissance era to present day, opioids have touched human lives causing euphoria, reduction of pain, addiction, and death (Inglis, 2019).

Opioid use is a global problem (Degenhardt et al., 2019), and opioid drugs are widely abused (Chen et al., 2020). In 2017, the U.S. president declared a national crisis due to the death rates caused by opioid use (U.S. Department of Health and Human Services, 2017). MAT programs are a response to OUD and the societal crisis opioids have caused. In 2000, the Drug Addiction Treatment Act (DATA 2000) was passed, allowing specially trained physicians to treat opioid addiction in an outpatient setting with scheduled medications for the first time in 100 years (Loftwall & Walsh, 2014; SAMHSA, 2020). In 2016, the Comprehensive Addiction and Recovery Act (CARA)

was passed, giving midlevel providers (nurse practitioners and physicians assistants) political support and training to provide for OUD in an outpatient setting (SAMHSA, 2020). MAT programs are one of the results of legislation and represent funding and increased access for OUD (Hernandez-Delgado, n.d.).

Although research has begun to show efficacy of the MAT programs, studies also indicate retention in MAT programs is an area where more work is needed (Bentzley et al., 2015; Bhatraju et al., 2017; McElrath, 2018). Connections between retention in MAT programs and improved quality of life by better social engagement, reduction of infectious diseases, reduced criminality, decreased opioid use, and a reduction of deaths resulted in the scientific research (Bech et al., 2019, Hser et al., 2016; The Council of Economic Advisors, 2017). Attrition rates were consistent in many research findings at 40%–60% (Lappan et al., 2019; Mendola & Gibson, 2016) with Williams et al. (2019) citing up to 80% of those initiating treatment failing to remain in the program and complete their care. This data indicated the need for this study to understand the patients' perspectives of why this phenomenon of attrition or retention occurs in MAT programs of those individuals with OUD.

While the overall causes of mortality rates in the United States do not list OUD as a cause of lost longevity, the decline in life expectancy may have been partly attributed to drug overdose rates (American Academy of Family Physicians, 2020; Muenning et al., 2018; Woolf & Schoomaker, 2019). Hedegaard et al. (2020) published graphs of overdose rates showing the drug contribution to mortality in the United States. In a Vital Statistics report, Hedegaard et al. (2019) noted nine of the drugs involved in overdoses in

2017 were the same reported in a 2011–2016 report. Six of the nine drugs were opioids. Of the 67,000 drug overdose deaths in the United States in 2018, nearly 70% involved an opioid (Centers for Disease Control and Prevention [CDC], 2020). This represented a 4.1% decline in overdose deaths in 2018 from 2017 in 14 states plus Washington, DC. However, the rate of deaths by synthetic opioids other than methadone increased by 10% (Hedegaard et al., 2020). Patients surviving a near fatal opioid overdose will be at a 24% higher risk to have another overdose within the next year (Olfson et al., 2018).

MAT programs provide successful evidence-based treatment options for those individuals with OUD, addressing both the physiological and psychological aspects of addiction (Hyatt & Lobmaier, 2020). MAT programs assist in opioid abstinence with FDA-approved medications by covering opioid receptors in the brain either by attachment (methadone, buprenorphine) or by blockade (naltrexone). Although relapse from MAT programs is an expected occurrence and not the exception (Hser et al., 2016; Wiese & Wilson-Poe, 2018; Yang et al., 2015), the alternative to having no option to care has worsening outcomes. Understanding the patient's perspectives of their OUD within a MAT program is the gap in the literature. Prior to MAT programs, counseling and detoxification (abstinence) programs without medications were not working, with frequent relapse occurrences and poor long-term effectiveness (Stotts et al., 2009). Despite the evidence-based research supporting the successful results of MAT programs, scholars note that less than half of those needing MAT services are in treatment (Bentzley et al., 2015; Klein & Seppala, 2019) and those individuals who do engage with a MAT program are at risk of discontinuing their treatment prematurely.

External barriers of understanding substance use disorder (OUD is included in this category) are conflicting scientific views of what OUD is and how to treat this disorder (Heyman, 2013; Lewis, 2017; Volkow & Boyle, 2018), insufficient numbers of MAT programs, a lack of waivered providers, and inconsistent federal and state regulations of MAT programs (Loomis et al., 2020). Waivered providers are those medical personnel (e.g., physicians, nurse practitioners, and physician assistants) who have addiction treatment education and training, become certified, and are allowed to prescribe methadone (methadone clinics only) or buprenorphine (primary care or addiction clinics). Depending on the area in the United States, there may be inadequate insurance coverage for those with substance use disorders (Williams et al., 2020).

Research of internal barriers of engagement suggest patients may deny they need treatment, have dissatisfaction with program requirements and length of treatment (Bentzley et al., 2015), and be determined by the drug type and way of using the opioid (intravenous versus nasal inhalation) drugs (Chen et al., 2020; Hedegaard et al., 2020). No known studies previously have been published from the phenomenological lens that provided the patients' perspectives about why they do or do not complete MAT programs after individuals with OUD begin treatment.

Problem Statement

The problem addressed in this study was that the perspectives of patients who experienced OUD, were treated in MAT programs, and chose to stay in, opted out of, or reentered treatment were unknown even though MAT programs had been shown to improve outcomes for those who are retained in the program (Bech et al., 2019, Hser et

al., 2016). There may be multiple factors leading to program failure by participants but there is no consensus on why drop out or retention occurs (Williams et al., 2020). Historically, in a paternalistic medical health care model, which is what the United States has, learning patients' perspectives of their disorder has not been considered a high priority in treatment interventions, potentially affecting outcomes (Anderson & McCleary, 2015). This may be more of a barrier in substance use as structural and self-stigma of the OUD patients are seen more in substance use disorders than in any other illness (Livingston et al., 2012). Sharma et al. (2017) conducted a systemic review showing there has been little patient engagement in the medical environment in the past 15 years after evidence showed patient engagement could change attitudes and the culture of health care with improved outcomes. Additionally, Haesebaert et al. (2018) stated that patients only had a passive role in their healthcare decisions. Thus, it may not be known how patients with OUD perceive their experiences and make meaning within their lived experiences as successful outcomes with program engagement or treatment attrition may be based on clinical and not personal experience with the MAT programs.

This study bridged the gap in scientific knowledge by exploring the lived experiences of those participants with OUD who were treated in a MAT program and stayed in, opted out of, or reentered services.

Purpose

The purpose of this qualitative phenomenological study was to explore the lived experiences of individuals with OUD who were treated in a MAT program. This later expanded into individuals with OUD treated in a MAT program who chose to stay in, opt

out of, or reenter treatment. The phenomenological approach can offer insight into the complex lived experience (Creswell & Creswell, 2018) of OUD and how individuals perceived their treatment for OUD within the MAT program. This allows the researcher to experience and interpret the phenomenon without having lived through the experience (Davidsen, 2013). There may be shared patterns that can be isolated leading to attrition or retention by viewing and acknowledging how opioid addiction may be part of the individuals' phenomenological makeup (Quintana et al., 2006; Vahdat et al., 2014).

Research Question

The research question for this qualitative phenomenological study was: What are the lived experiences of individuals with OUD in a MAT program? This question later expanded to include individuals with OUD who had been treated in a MAT program and chose to stay, to opt out of, or who reentered treatment.

Theoretical Foundation

Phenomenology is founded on the belief of multiple realities (Merleau-Ponty, 1945/2012; Patton, 2015). Lived experiences are examined and coded into themes as patterns emerge and are interpreted (Saldana, 2016). The three major fields of phenomenology are transcendental, existential, and hermeneutic.

Husserl, considered the modern father of phenomenology, believed in transcendental phenomenology, and will be discussed due to his influence on Merleau-Ponty. Transcendental phenomenology was believed by Husserl (1936/1970, p. 128) to get to the basic "thing itself" by including the perceiver's background, beliefs, and anticipations that were unique to the perceiver. Reduction and interpretation of the data

allowed for transcending above the influences and biases of the researcher back to a "naïve view" of the phenomenon (Husserl, 1936/1970, p. 143; Merleau-Ponty, 1945/2012, p. lxxi). Transcendental phenomenology seeks to find the meaning of lived experience or what actually is by those experiencing the phenomenon by bracketing the biases and beliefs of the researcher and describing what was learned (Husserl, 1936/1970; Patton, 2015).

Hermeneutic phenomenology, defined by Heidegger, is the study of human experiences and interpretation of texts specifically not bracketing the researcher from the interpretation but encompassing the researcher into the findings (Laverty, 2003). To achieve understanding, the researcher interprets the text going from parts of the experience back to the whole experience repeatedly until the creation of sensible meaning with no inner conflicts are reached (Laverty, 2003). Heidegger believed humans lived in a situated position and could not be separated from their worldly experience (Laverty, 2003).

Existentialism phenomenology through Merleau-Ponty follows Husserlian philosophy but broke from transcendental phenomenology to incorporate the embodied human. Merleau-Ponty sought to acknowledge the embodied human as a subjective and objective way of living in the world. The body, according to Merleau-Ponty (1945/2012, xxxiv) is not merely a "passive" object which could only react when triggered to do so but also has a unique ability to position itself to understand; the body is a perceiving as well as a sensing object. I used the existentialism theory specifically through Merleau-Ponty's belief on embodiment as the lens to guide my study. Embodiment was defined in

this study as experiences being shaped by the individual's meaning of the body and mind situated in the world of addiction and treatment and what actions accompanied this knowledge.

Although Husserl believed in suspending or bracketing the researcher's beliefs to avoid contamination of the data, Merleau-Ponty partially supported this view by offering the ability to reduce the data but stated, "The situation of the patient whom I question appears to me within my own situation" (Merleau-Ponty, 1945/2012, p. 353). Merleau-Ponty (1945/2012) believed the perception of the world occurred through the experience of the individual's body and these two processes were intertwined in a way which could not be separated. He stated, "the union of the body and soul is not arbitrary… not a subject and an object" (p. 91). The body may remember addiction in a unique way, a perceptual horizon that remains unreflected until the perception allows the meaning to be known to the patient (Merleau-Ponty, 1947/1964). These emerging findings would then be interpreted by the researcher. More detail on phenomenology and the assumptions will be presented in Chapter 2.

Nature of the Study

I conducted a qualitative phenomenological existential approach by in-depth interviews of purposive samples of participants. This allowed me to examine the lived experiences of individuals with OUD, their experiences in MAT, and whether they opted in, chose to leave, or reentered treatment. The in-depth interviews (See Appendix A) of individuals with OUD permitted access to the participants' unique knowledge of the event of retention or attrition within the MAT program. The inductive approach to

expand on existing knowledge of why the phenomenon happens allowed the researcher to gain "focused insight into the individuals' lived experiences" (Ravitch & Carl, 2016, p. 146). The qualitative approach examined the "why" the attrition or retention rates occurred, giving a rich depth of understanding of the phenomenon. My technique of noting my biases and thoughts on the participants, their environment, and their drug use were written as field notes, analytic memos, and journaling. I acknowledged my role of nurse practitioner as well as a beginning researcher. This helped show my inherent biases about opioid use, those with opioid use, and the medical community that I could not completely recognize until reflective thinking was done. Data were gathered, and transcripts were rewritten verbatim. The information was then read and reread, and comparison of my initial thoughts to later thoughts was accomplished as I played back the taped interviews while revisiting the notes until I became immersed in the information and determined which in vivo codes were pertinent. After the initial first coding, I planned to use the emotional coding system allowing insight into the individual's experiences, reasoning, how they made choices, and how risk may have affected which decisions they made (Saldana, 2016).

The phenomenology or study of essences (Merleau-Ponty, 1945/2012) approach was used along with the existentialism or the conscious individual who interprets the world in which they reside (Barral, 1969) and gives meaning to their lived experiences. The phenomenon of individuals with OUD treated in a MAT program who choose to stay in, exit out, or reenter treatment has not been extensively researched. Since the purpose of examining the phenomenon of individuals with OUD treated in a MAT program was to

explore whether there are emerging patterns within this specific group, quantitative studies would have offered consistency and relationships between variables but would not have shown "why" individuals chose to stay in, leave, or reenter the program. To do this there had to be some interpretation of what emerged in the subjective contextual data.

Nursing theorists may have been able to identify the abnormal of what emerges in a health care situation, but they do so from a nursing perspective. Therefore, nursing theorists were not chosen for this study. From Nightingale (1860) to Leininger (2005), the nursing role shows how environmental, cultural, and lack of knowledge and power influences the health and understanding of the patient but always from the nursing perspective. Even Abdellah (Tipton, 2011), a nursing theorist, who in 1960 shifted nursing perspectives from disease-centered care to patient-centered care returns to what can be achieved by the nurse working with the patient. Because there is little known of the phenomenon of an individual with OUD and choosing to stay in or opt out of a MAT program, it was necessary to choose a theorist who believed in multiple realities of the human experience without assuming an outcome or having science imposing "categories upon the phenomenal universe that only make sense within a scientific universe." (Merleau-Ponty, 1945/2012, p. 11). Once information became available on specific reasons why individuals with OUD opt in or leave a MAT program, nursing theorists could offer future studies and interventions to aid in retention within MAT programs of individuals with OUD.

The research tradition of phenomenology was not used to change but to identify what was in the lived experiences, which could be shared and could affect individuals in

a universal way. This existential phenomenological approach allowed for gaining access to general knowledge by those individuals living through the experience of having OUD, making choices of retention, opting out of, or leaving and treatment in a MAT program. The phenomenological lens increased scientific knowledge of those who have expert knowledge of the phenomenon being researched– the participants (Larsen et al., 2019). This meant seeking out those with expertise of individuals with OUD in MAT programs in places where the MAT programs and participants with OUD were located. The social implications of learning more about why participants left the MAT program may extend past OUD and into other chronic disorders.

Definitions

The following key words and terms included concepts from my research problem:

Addiction: The inability to give up on a substance or activity (Rosenthal & Faris, 2019).

Attrition: Dropping out, stopping of treatment (Meier et al., 2006)

Barriers: Obstacles preventing care (Madras et al., 2020).

Medication assisted treatment program: Medical services using medications with counseling interventions to aid people with OUD toward recovery (FDA, 2019).

Opioid use disorder: Maladaptive use of prescribed or illicit opioids resulting in 12 or more months with two or more health or functional criteria not requiring tolerance or dependence of the substance (Connery, 2015).

Opioids: Substances derived from the opium poppy plant or synthetically made including heroin, fentanyl, hydrocodone, oxycodone, codeine, tramadol, or morphine

causing pleasure, sedation, and the reduction of pain. The opioids are associated with physiological tolerance, physical and psychological dependence, and addiction (Pathan & Williams, 2012).

Recovery: Prevention, response, and continuation (Elder & Elder, 2019); a process where individuals change to improve their quality of life through self-direction to reach their potential (SAMHSA, 2012).

Relapse: Returning to drug use after a period of sobriety (American Addiction Centers, 2020).

Retention: Ongoing participation (Hagedom, 2006).

Substance use disorder: Formally known as addiction, substance use disorder is a mild to severe compulsive use of mind-altering drug taking with chronic relapsing. OUD falls within this definition (American Psychiatric Association, 2013).

Waiver: Certified in addiction treatment – able to prescribe buprenorphine in an outpatient setting within a MAT program (Brunisholz et al., 2019).

Assumptions

The assumptions in a qualitative research project are the aspects of the study that are believed but cannot be demonstrated to be true (Simon, 2011). The assumptions gave this research guidance by describing the researcher as the instrument in this qualitative study and the way the data was gathered through the interview process. In this study, an assumption was all participants would tell their lived experiences as they understood them with truthful in-depth answers to the questions asked (see Rubin & Rubin, 2012). There were no expectations of having only one reality in this phenomenological study as

each subjective account had the promise of "multiple realities" (Patton, 2015; Rubin & Rubin, 2012, p. 14). It is believed in a phenomenological study there are essences to experiences that are shared between individuals living through similar phenomena (Patton, 2015). It was assumed opioid use will not suddenly resolve itself either nationally or globally. With opioids as the mainstay for treatment of short- and long-term pain control, access to the drug will continue to be easy.

The assumptions were necessary in the context of this study because through the lived experience of the individuals with OUD who have experienced treatment in a MAT program, I attempted to answer the research question. Without those individuals with OUD and their truth, this study would not have been possible. If OUD were clearly understood in the realm of one reality, it would not be a problem today. Therefore, multiple truths of addiction were expected but could not be assured.

Scope and Delimitations

Delimitations defined the boundaries of this study (Simon, 2011). This limited the scope and determined the research questions. The theoretical lens that I looked through determined the wording of the research question. Writing clear guidelines emphasized who and what the study would and would not cover (Simon, 2011). As I attempted to address what meaning the individuals with OUD had, who had attended a MAT program and made their decision to stay in, leave, or reenter a MAT program, it was necessary that I selected participants who had experienced this phenomenon.

The initial participants in this study were to be three to 10 persons (Creswell & Creswell, 2018) diagnosed with OUD within the past 10 years who engaged in a MAT

program within the past 5 years and had chosen to stay in, opt out of, or reenter a MAT program. Participants were between the ages of 18 and 58 years old and lived in the Midwest region of the United States. Polysubstance users were included as most participants with OUD also have other addictions (Cicero et al., 2020) but the participants' drug of choice was an opioid. Pregnancy would not have been an exclusion as these individuals may be more complex but were not viewed as a vulnerable population (American College of Obstetricians and Gynecologists, 2015). Individuals had OUD but no major known physical or mental health disorders. Mild forms of anxiety and depression were not seen as reasons to exclude as many adults live full productive lives with these disorders. Participants with severe disorders such as psychosis were excluded. Past and present patients of mine were excluded due to the potential power inequality risk to the participants (Creswell & Creswell, 2018).

A quantitative approach to the study was not chosen as it was the depth and not the breadth of the phenomenon of individuals with OUD who opt to stay in, to leave, or reenter the MAT program that I was studying. I examined the "why" of the individuals through in-depth interviews. It was with purposeful sampling with open-ended questions (Creswell & Creswell, 2018) set in an algorithm type adaptive interview process that I was able to address the research question through reduction and interpretation. It was not a matter of how many individuals making their decision to stay, leave, or reenter the program but why and how the individuals made the choices they did that I sought to answer. The pattern through the examinations of their lived experiences and context of what was happening at the time of the individual's decision increased my knowledge of

the phenomenon of individuals with OUD within a MAT program. This research was confined to the Midwest region of the United States and had a small sample size. This would not be generalizable to the general population, but the information gained could be transferred to other groups with the same characteristics.

I chose the qualitative approach to this study for multiple reasons. Since there is little known about the phenomenon of individuals with OUD and their decision to stay in, opt out of, or reenter a MAT program, it was appropriate to begin with the individuals' lived experiences and interpreting how the individuals made sense of their choices (Sofaer, 1999). Although quantitative approaches can take text and numerically make a logical argument, I needed to bring the subjective experience to a better understanding. To do this, I needed to get deeper below the studied individual's surface conscious beliefs, "beneath the pure subject," or I would not be able to answer the research question I asked (Merleau-Ponty, 1945/2012, p. xxxiv). As the researcher, I inserted myself into the data by the questions I asked and the interpretation of the data I gathered. As my nursing history is in critical care, following an algorithm type design was a natural progression to the question format. In a quantitative study this would be a violation, in the qualitative study this was seen as valuable. The acceptance of multiple realities fit my own ontological belief of a socially constructed lived world and the scientific world which may or may not exist.

The phenomenological approach gave depth to the complexity of the issue by allowing me to examine the subjective meanings of participants with OUD who have been in a MAT program (Qutoshi, 2018). The research study was an inductive approach

and therefore the individual factors of why the individuals with OUD had retained or dropped out of MAT programs emerged as data was gathered and interpreted. Acknowledging my thoughts and assumptions through reflexivity of how my experiences as a provider of MAT services, a nurse practitioner, a mother, and a woman affected my beliefs of opioid use, recovery, and how these were viewed was necessary to limit my biases (Rudestam & Newton, 2015). I agreed with Merleau-Ponty; I would never be able to separate myself entirely from the information gained. This was only partially accomplished through field notes, analytic memos, journaling, and observation notes during the complete research process. This reflexivity showed how the interpretation of data was influenced by my origins and my own subjectivity (Creswell & Creswell, 2018). The phenomenology approach I utilized had no expectations of proving theory, of changing existing programs, or of proving one reality exists versus another.

Limitations

Limitation were potential weaknesses of this study and were out of my control (Simon, 2011). There were several limitations to this study. Seeking out those with OUD was difficult and there was a high rate of attrition in this study, as there is in the actual MAT programs. The study took place in a region of the Midwest in the United States and so would not be reflective of the entire general population. However, this was an accepted process in a qualitative study and with transparency of the research with rich description of the findings of the individuals within their environment, transferability could be assumed to like populations (Rudestam & Newton, 2015).

The purposive sampling may have created biases by only having individuals with OUD involved in a treatment program. This study did not include participants who had stopped opioid use on their own or who had engaged in other non-MAT program treatments. The sampling bias in this study were individuals who had many of the same OUD and treatment traits. Because treatment centers are normally found in urban areas, the information obtained may not be representative of rural areas. Another limitation was the probability of individuals knowing each other due to the high rate of treatment failures and frequent clinic switching, diminishing the confidentiality of the study. This was seen in two of the participants who were obtained by the technique of snowballing where one participant recruited other individuals into the research. The third participant had been a past co-worker of mine and offered to participate when she knew what the research was about. Transparency of data did not include more than masking patient identification to avoid patient identification by situation.

The small sample size was expected in a qualitative study but was offset by having rich data collection until data saturation occurred (Ravitch & Carl, 2016). Time was a limitation for this study (Simon, 2011) but the contributions of this study allowed for a more comprehensive understanding of those individuals with OUD and their engagement in a MAT program.

Challenges to the study were in obtaining participants with OUD willing to take part in a study due to the subject matter. The attrition rate may have proven to be a difficult subject for those with frequent dropout rates. The participants may have avoided the truth, expanding, or deflecting their lived experiences (Rubin & Rubin, 2012). Opioid

use continues to be a stigmatized health care issue (Wakeman & Rich, 2018) and participants may have mistrust of the scientific world (Fisher et al., 2008). However, Rubin and Rubin (2012) stated that people are not likely to lie if they are not forced to talk. Taking the opportunity to see what lies behind any matter which seemed untruthful may have been an opportunity to delve more deeply into the subject matter.

The data analysis revealed unexpected information challenging my beliefs in what concepts are discovered, coded, and themed related to the perspectives of the participants and their OUD treatment. This was a positive happenstance. Reporting and identifying concepts correctly led to increased general knowledge providing new or contradicting information.

Significance

This study helped to fill the gap by furthering understanding patients with OUD perspectives, their participation in a treatment program, and why they chose to stay in, opt out, or reenter a MAT program. With a better understanding of these issues, forming interventions on a broad base knowledge of those living through the experience may help conform treatments to be patient centered. A patient's belief of treatment success may not be what the clinical expectations are (Farre & Rapley, 2017), creating a wider chasm between intervention and successful treatment. Slowing or stopping drug use increases the health of the individual, families, communities, and ultimately society (Painter, 2017). Preventative measures could target those populations who may in the future misuse opioids, whereas early identification could target those already with this disorder. This research inquiry has shown that little has been written about patients' perspectives on

their own opioid use while in a MAT program, and the meaning those with OUD and their participation of staying in, dropping out of, or retaining MAT services. Social change may result if the findings of this study show that patients sharing their experiences of participating with health planning teams can improve retention in MAT programs and slow or stop opioid use.

Summary

The purpose of this qualitative phenomenological study was to explore the lived experiences of individuals with OUD in the Midwest region of the United States who had participated in or had exited a MAT program. By understanding why patients with OUD may choose to retain, drop out, or reenter services, there is the expectation this increased knowledge could affect care of those with OUD by understanding why MAT treatment options were or were not effective. The phenomenological approach allowed me to examine the lives of the participants living through the phenomenon (Ravitch & Carl, 2016) and helped to identify and seek out patterns among those with OUD who are in treatment programs to support health and wellness. The social significance of this study could be multifaceted by filling in the gap of understanding why participants elect to stay in, drop out, or reenter treatment, identifying factors enabling participants to recover from opioid use, and a reduction of morbidity and mortality rates. The study results added to existing knowledge and could create more individualized treatment options by examining the patients' perspectives. It could also create an environment where primary prevention could be aided by helping to determine social patterns with individuals with OUD. This could cause societal change by allowing patients to enter into their care as the drivers of

change and may cause a decrease in needless opioid deaths through the reduction of opioid use with more effective treatment.

In Chapter 2, I provide an extensive review of the literature to further show how the current and historical studies cumulated in illuminating the gap in knowledge, how the theoretical foundation supported and directed this study, and how concepts which pertain to this study were defined.

Chapter 2: Literature Review

Opioid use is an ongoing problem with tens of thousands of deaths a year in the United States (Wilson et al., 2020). MAT programs were designed to reduce mortality by improving the treatment of and outcomes for OUD. MAT programs incorporate counseling and medications to assist patients with OUD. Yet, poor retention in MAT programs threatens the benefit that MAT programs can offer for individuals with OUD (Williams et al., 2020). The purpose of this phenomenological study was to explore the lived experiences of participation of individuals with OUD and their decision to stay in, opt out, or reenter a MAT program. This research was needed as opioids are the most widely abused drug globally (Chen et al., 2020) and opioids are involved in two thirds of all drug related deaths in the United States (Shaw et al., 2020). However, MAT treatment programs, which are effective in reducing morbidity and mortality (Mumba et al., 2018), are often not completed by the individuals who need them the most and who may have histories of multiple treatment failures. Therefore, understanding patient perspectives on lived experiences and their participation within their OUD and treatments could show how to improve retention in programs designed to reduce the devastation of OUD effects.

Through this study's original contribution to scientific knowledge, I gained an understanding of the lived experiences of MAT participants with OUD who chose to stay in, opt out of, or reenter a MAT program. The results of my study helped bridge the gap of knowledge deficits between the world of retention and attrition with OUD participants in MAT programs by gathering and interpreting data on what occurs within their lived experiences. The social contribution of this study allows the patients' voices to influence

the understanding of individual OUD addiction pathways having commonalities and the "universal" human voice to be interpreted (Merleau-Ponty, 1947/1964, p. 10). This research increased knowledge of individuals with OUD retention and attrition, potentially increasing awareness of other chronic illnesses and retention of treatments helping to identify the "treatment burden" (Sav, 2015, p. 313), further contributing to social change (Sav, 2015).

Literature Search Strategy

Databases used for the literature search included CINAHL Plus with Full Text, PsychInfo, PubMed, ProQuest Central, and Science Direct. The initial search terms consisted of *treatment of opioid use*, *addiction*, *MAT programs*, *patient perspectives*, and *statistics of opioid use* both globally and within the United States. Since OUD is considered a subset mental health disorder and is frequently co-occurring with substance use disorders, including OUD, mental health within substance use disorders was also reviewed. The search then expanded into patients' perspectives of services within a healthcare setting. *Stigma of treatment* and *stigma of addiction* were terms added to the search. This expanded search allowed a broad base of understanding of addiction and addiction treatment as it is conceptualized today. Using this strategy, I started to narrow the search to specific articles focusing on those that targeted participants with OUD and their perspectives within a MAT program. This became increasingly difficult due to the limited articles found surrounding the focused topic. After doing a systematic review of literature with patient-centered outcomes, Sola et al. (2019) indicated there was a paucity of research on perspectives of participants with OUD. To combat this deficit, the search

then included other chronic health conditions and patient adherence with diabetes, hypertension, and obesity. Viewing addiction and chronic conditions from other research disciplines allowed for additional forms of addictions to be examined. These included food, gambling, and nicotine.

Expansion of key terms was then used as the process of critical analysis of the literature revealed there was no one concrete or theoretical definition of addiction accepted by the scientific community (Beran, 2019), and therefore of OUD.

Theoretical Foundation

The theoretical framework guiding this study was Merleau-Ponty's (1945/2012) phenomenology of perception. This theoretical lens, rooted in philosophy and psychology, was suited to addressing the complex issue of OUD from the patient's perspective within a MAT program. Addiction has been viewed both as the physical and the mental source of continued opioid use (Volkow & Boyle, 2018). Merleau-Ponty believed that humans gained understanding of their world through concrete lived experiences by their perceptual bodies (embodiment), which could not be separated from their human abstract experiences (consciousness). The qualitative view through Merleau-Ponty's lens of embodiment allows for meaning to be explored of the individual with OUD in their habitual mode, including withdrawal symptoms from opioids along with the mental triggers to continue opioid use. These factors may influence continued attendance in a MAT program. The phenomenological outlook allowed for interpreting the individual meanings made of the phenomenon by sensations of their bodies in their individualized opioid use as well as mental acceptance and barriers to continued care.

This research was beneficial to see how individuals subjectively made and interpreted meaning to identify whether there was a pattern of retention or attrition in MAT programs. Merleau-Ponty (1945/2012, p. 11) believed, "science only succeeds in constructing a semblance of subjectivity," so studying what was considered subjectivity from the individuals' perspective increased knowledge of the phenomenon of participants with OUD in MAT programs. Merleau-Ponty, influenced by Husserl, believed the mind was inseparable from the body, which broke from the traditional dualism theory. Access to how the body perceives addiction may bring a different perspective of participants with OUD who attend treatment.

Literature Review Related to Key Variables and/or Concepts

MAT programs have been shown to reduce morbidity and mortality when established in primary care (Lagisetty et al., 2017) yet there has been poor retention by participants with OUD (Williams et al., 2020). There was little consensus on the definition of addiction (Beran, 2019; de Wit et al., 2018; Satel & Lilienfield, 2013) and therefore confusion about how to treat it exists. The literature pointed to the significant number of unstandardized treatments within MAT programs treating patients with OUD (Baxter et al., 2015; Lagisetty et al., 2017). Farre and Rapley (2017, p. 5) identified the need for a more "realistic connection between the biopsychosocial vision and clinical reality" when addressing strategies providing integration of care. This could potentially contribute to the attrition rates if there was little understanding the patients' perspectives within their opioid addiction and how they make meaning of their OUD experiences with programs who vary in care.

There have been differing opinions and broad guidelines to treat those participants with OUD (Peele, 2016; Sanger et al., 2018). Patient preferences have not been likely to be included in care management (Frank, 2018) and may lead to factors constituting treatment failure. Many people with an addiction stop drug use on their own in their 30s without any treatment. For those who continue to misuse drugs, severe consequences are associated with their ongoing drug use (National Institute on Drug Abuse [NIDA], 2021). The key concepts used in this literature review included addiction confusion, view of addiction, models of addiction, and threshold models creating barriers to care. Opioids are defined within the premise of MAT programs. Complexity of the patients with OUD was addressed along with complexity of addiction. Patient perspectives were reviewed lastly with suggestions of further research needed for more defined patient input into treatment of OUD.

Addiction Confusion

Conflicting opinions of addiction have led to confusion in the scientific community with the basic understanding of the concept of addiction not established (Copoeru, 2018; Heather & Segal, 2017; Peele, 2016). Addiction has been a poorly defined concept and not well understood (Barata et al., 2019; Kuroikoski & Uusitalo, 2018; Satel & Lilienfeld, 2014), yet according to Wakeman (2019) science remains the best option to understand and resolve public health crises. Addiction is a public health crisis (OUD falls under addiction). Sola et al. (2019) suggested the lack of patient input in assessing patient wellbeing was primarily measured through clinical outcomes. Strada et al. (2017) cited limited suitability to measure quality of life instruments for opioid

dependence as a factor that hinders patient outcomes measurements. This indicates there was no acceptable way to measure the phenomenon of attrition or retention in a MAT program of individuals with OUD. The complexity of the OUD patient within a MAT treatment program justifies phenomenologically driven research in areas of patient perspectives of their own OUD and treatment.

Views of Addiction

In the early history of medicinal treatments, opioids were known to be an accepted curative transitioning to the 1860s Industrial Age when chronic opioid use was determined to be a societal problem (Center for Substance Abuse Treatment, SAMHSA, 2005). Addiction to opioids affected output of the workers through absenteeism and poor health. Recently some scientists revised the lack of morality model of addiction to a chronic relapsing brain disease model (Volkow et al., 2016). Recently multiple researchers took a more combined lens of addiction, acknowledging the neurological changes but allowing other factors such as choice and moral responsibility within the lived experience to be considered (Buchman et al., 2010; Copoeru, 2018; Heather & Segal, 2017; Peele, 2016; Satel & Lilienfeld, 2013).

Addiction, which includes OUD, is complex and was considered an unstable phenomenon (Torronen & Tigerstedt, 2018). Volkow et al. (2016) stated that addiction is a chronic brain relapsing disease, whereas others saw addiction as an illness of choice (Peele, 2016), or a mental disorder with neurobiological changes (Schütz et al., 2018). Treatment of patients was based on variety of programs and clinical best practices without patient input of what was considered important outcomes (Haesebaert et al.,

2018). In a grounded study by Mitchell et al. (2011), from the patients' perspective, failing to abide by treatment rules and not completing treatment did not mean treatment failure. Patients with OUD have the same low rates of compliance as others with different chronic diseases (Mitchell et al., 2011; Wakeman, 2019) and yet the OUD disorder is seen as a socially stigmatized and criminalized problem.

In this study, the view of addiction shaped the research not as a moral failure or a chronic brain disease, but as an embodied lived experience of individual participants within their environmental context (Buchman et al., 2010) and how OUD may result from risk factors presented (Barata et al., 2019). The phenomenological approach of OUD addiction for this study was what each person with OUD understood it to be and how this affected their retention or attrition in a MAT program. Bright and Franklin (2018) stated that existing frameworks concentrate on clinical and economic outcomes not incorporating the patient into the equation, missing important outcomes when patients are not partners in their health care decisions. Existing frameworks or models of addiction are plentiful. The next section outlined what makes up a framework or model and why they are needed in research.

Scientific Models

Gilbert (2004) defined a scientific model as a route between scientific theory and the lived world. Models provide a loose structure aligned with the assumptions to build theory, confirm theory, or break down existing theory. Patterns through the research can then be seen or allow for prediction under different epistemological lens. Scientific models examine phenomena, events, and systems yet scientific inquiry may exclude

sociology, psychology, and anthropology approaches (Ruane, 1989), all components of addiction. The dichotomy between biological science and psychology may ignore the mind-body aspect (Ruane, 1989) of OUD. The same studied phenomenon can be examined under multiple lens in different fields. Addiction is seen as a biological matter by some as well as a psychological one by others. This allowed for fluidity of the structure while holding true to its underlying structural foundation in this research study. The model cannot be an exact replica of the phenomena but can show the complexity of the abstract by highlighting the connections of concepts (Gilbert, 2004). A model remains open to change as knowledge increases, which will be needed as there was little research in the area of retention or attrition from the patient perspectives who have OUD. The theory of perception by Merleau-Ponty (1947/1964) showed the body as a perceiving subject. The individual understands the world through the ability of their body's experiences and how this translates into specific meaning into our consciousness. Understanding the participants' perspectives and how the individuals make meaning of their OUD and their decision to stay in, opt out, or reenter a MAT program was needed.

Models of Addiction

Addiction as a Brain Disease

In the brain disease model of addiction, physical brain changes had been seen in addiction studies (Volkow & Boyle, 2018). As scientific advancement became prevalent in the 1990s with brain scans and imaging of addiction, the new norm of thinking addiction as a brain disease was formed. Imaging showed the use of opioids contributes to risky behavior by affecting the impulse center of the brain leading to further health

problems such as hepatitis C, human immunodeficiency virus (HIV), and death (Ling et al., 2014). Continued opioid use leads to ineffective management of life activities, e.g., giving up personal time to acquire the drug, use the drug, and recover from the drug effects (American Society of Addiction Medicine, 2015, p. 13).

Comparatively, there was a large amount of scientific evidence showing the brain changes in pathological gambling addiction that was similarly seen in substance use disorder (Joutsa et al., 2011). Brain changes (plasticity) are normal and seen with any learning (Satel & Lilienfeld, 2014). Brain changes have not explained why most opioid users stopped using drugs in their 30s with little or no treatment (Field et al., 2020; Heyman, 2013; Peele, 2016; Wakeman, 2019), whereas up to 40%–60% of those considered chronic OUD patients in MAT programs failed to achieve recovery (Lappan et al., 2019).

This highlighted a discrepancy within the disease model. For example, individuals with Alzheimer's disease, a chronic brain disease, cannot "will" themselves better, stop taking a medication to be cured, or even take a medication to gain a disease-free state (Satel & Lilienfield, 2014). Cigarette smokers can quit "cold turkey" (on their own). Soldiers once addicted to heroin in Vietnam ceased taking the drug when they had to have a clean urine sample, free of illicit drugs, in order to be transferred back to American soil with few relapsing to drug use (Satel & Lilienfield, 2014). Yet, treatment interventions are being suggested to offset the opioid crisis without fully understanding what individual OUD addiction is and why in some individuals it may be a lifelong struggle with frequent relapses (Kosten, & George, 2002, Marchand et al., 2015).

Addiction of Choice/Abstinence Model

Peele (2016) preferred no treatment for addiction and felt this was as good or better than having a substitution opioid (methadone, buprenorphine) or blocker (naltrexone). Peele believed having addiction that was seen as "a chronic brain disease" instead of a disorder of choice negated free will to stop using the drug. Self-help or 12-step programs are placed in this category as group members in this model may have a conflict with individuals taking MAT medications to avoid illicit drug use (Klein & Seppala, 2019). Laudet (2008) reported a positive cost–benefit relationship but acknowledged high attrition rates with little scientific research of high evidence ratings for the self-help groups.

Addiction of Learned Behavior

Lewis (2017) was more inclined to place addiction into a learned process model. Strong motivation for drug use was seen as addiction reinforces not only the desire to use but also increases other negative emotions as well. This creates a time gap where those with drug use disorders are stuck in the present unable to see a way to their future life. Additionally, Heinz et al. (2019) tied drug cravings to certain stimulus and showed how Pavlovian cues with environmental backgrounds were associated with drug use. These research findings indicate the ability to change the narrative of choosing to do a drug by recognizing stimulus promoting drug use.

There may be misconceptions of addictions within the OUD community itself hindering effective models of treatment. Participants in Cooper' study (2013) while admitting to addiction from over the counter (OTC) medications like opioids (codeine, an

opioid, was sold OTC in the United Kingdom), depicted themselves as addicted but different from those who took illicit opioids such as heroin. In Bentzley's et al. study (2015), they found that participants who had lack of engagement and perceived low risk of opioid relapse had less interest in engaging in treatment with shorter treatment duration. In both latter cases, there did appear to be an individual perspective of self-reflection which does not hold OUD to be as serious of a problem as it is.

Addiction of Differing Thresholds

There have been models of addiction examined with varying theories as a brain disease to a disorder of choice (Bevan, 2019; Heather & Segel, 2017; Volkow et al., 2016). McElrath (2018) stated there may be models of differing thresholds contributing to the negative characterizations of having addiction. There may a high threshold of structural and program barriers (e.g., long wait times to enter a program, inadequate number of facilities to treat addictions, regional barriers—urban accessibility versus poor rural availability of clinics, strict program criteria). There may also be low tolerance such as regulatory policies (e.g., special waiver training for those administering MAT services, methadone clinics being mainly in urban areas, daily dosing of medication) as well as limited provider acceptance of MAT services (McElrath, 2018).

Opioids

Opioids are a scheduled (regulated) classification of drugs and are used in clinical practice for the treatment of pain symptoms (NIDA, 2020; Pathan & Williams, 2012). Opioids work in human beings because they resemble the naturally occurring endorphins and enkephalins substances found in the human body (Stoeber, 2018). These

neurochemicals allow dopamine releases promoting feelings of reward for continuing activities of life sustaining and pleasure events. Opioids attach to the same receptor cells in the central nervous system, and throughout the periphery as the naturally occurring neurochemicals blocking pain signals (NIDA, 2020; Pathan & Williams, 2012). With more opioid use, there is increased reinforcement to like the drug more resulting in dependence and addiction (Volkow & Boyle, 2018) regardless of the negative consequences.

Heroin, one of the most widely abused illicit drugs of OUD (Dinis-Olivera, 2019), may stimulate different opioid receptors sites than natural opioids do making understanding addiction only in the beginning stage (Stoeber et a., 2017). The evidence now pointed to patients taking prescription opioids are 40 times more likely to abuse heroin (Becker, 2018). In the United States, prescription misuse of opioid products had increased over threefold since 1990 (Ling et al., 2011), and although the prescribing of opioids has declined from 2012–2018, prescription rates remain high in the United States (CDC, 2020). Death rates from illicit synthetic opioids, like heroin, have increased by 4.6% since 2018 (CDC, 2020).

The Premise of MAT Programs

MAT programs consist of counseling and three medication options approved by the FDA to assist patients with OUD. Medications of MAT are buprenorphine, methadone, and naltrexone. Two of the MAT medications, methadone, and buprenorphine are considered the “gold standard” of care for OUD treatment (Connery, 2015; Mund & Stith, 2018). MAT programs were started as no single intervention was

appropriate for everyone and opioid overdose deaths were on the rise. There were increasing diverse needs of the individual being treated (NIDA, 2020), and those considered high risk could potentially benefit from medication-based treatment (Lagabeer et al., 2020). Detoxification approaches were not always working (NIDA, 2020). Research began to show patients with OUD remaining in treatment had better outcomes and increased chances of abstinence if retained in MAT programs (Dunlop et al., 2017; Feelmyer et al., 2013; Mumba et al., 2018; Timko et al., 2016).

However, there was a lack of standardized care in MAT programs (Hyat & Lobmaier, 2020; Lagisetty et al., 2017) and inconsistent clinical research to evaluate outcomes in MAT treatment (Sanger et al., 2018). In a systematic review in assessing what works in primary care models for MAT programs, Lagisetty et al. (2017) noted there was only a few studies asking about patient perspectives.

Complexity of Patients with OUD and Need for Their Perspectives

It was estimated 8%–9% of adults in their early 20's in the United States had a drug use disorder in 2017 (Richie & Roser, 2016). Overdose deaths from drug use have affected the mortality rate in the United States (Hedegaard et al., 2020). OUD and mental health conditions are frequently co-occurring (Jones & McCance, 2019) making the patients harder to medically treat. OUD also may make the patients less able to fully comprehend and react appropriately to choices and situations on whether to use opioids or not. Individual factors as well as collective patterns affecting retention may be identified when research is conducted by in-depth interviews of participants with OUD. There may be patient denial in needing treatment as their opioid use may not be

considered a problem even when faced with negative consequences of continued use (e.g., loss of family and friends, obtaining infectious diseases such as hepatitis or human immunodeficient virus through risky behaviors, employment, imprisonment, or loss of housing) (Moeller et al., 2020). Studying outlier cases, as well as similar cases, added to the unique knowledge of factors (Ravitch & Carl, 2016) affecting patients' retention in MAT programs.

Patient Perspectives of OUD and Treatment

As stated earlier, there are limited studies of patients with OUD and their retention or attrition within a MAT program (Palmer et al., 2009). There are calls for research to involve participants with OUD into studies examining their perspectives (Bentzley et al., 2015; Ivers et al., 2018; Kane et al., 2020; Lappan et al., 2019). The National Academies of Sciences, Engineering, and Medicine; Health and The Medicine Division Board on Health Sciences Policy (2018) in a public forum cited several barriers to MAT programs by those participants with OUD. Individuals wanted greater understanding and awareness of their OUD, recognition of the barriers to care they face in seeking treatment such as stigma, long wait times, strict entry requirements for MAT programs, and significant physical and mental health issues.

An understanding of what each person was experiencing in their OUD treatment and how their experiences affected their decision to continue care, opt out of, or reenter treatment may promote development of strategies to support retention and reduce attrition rates. This need to understand the complexity supports the choice of why phenomenology was the right research methodology for this study. It was necessary to examine the

subjective experiences of MAT patients to explore their understanding of lived experiences. Synthesizing experiences and interpreting any emergent patterns increased understanding of how choices are made to stay in, opt out of, or reenter treatment programs. By my purposefully selecting participants with the lived experiences of having OUD experiencing a MAT program and illuminating potential universal patterns of meaning, I increased my chance of answering the research question.

In 2018, Sanger et al., in their introduction outlined a proposed systemic review of the need for identifying patient-important outcomes in MAT programs. Sanger et al. felt individuals with OUD are often excluded from the process of determining these outcomes and inclusion was needed to determine what patients felt were successful treatment indicators. Their review was the first systematic review relating patient important outcomes and the limitation was the paucity in patient important outcomes reported.

Nonadherence to treatment interrupts the benefits gained by individuals with OUD in treatment, and addiction was already known for frequent relapse of those with OUD (Loftwall & Walsh, 2014). Placing patients within the decision making of their OUD treatment showed a commitment to improved health outcomes (Vahdat et al., 2014). Therefore, knowing patients' thoughts of their own opioid use, how they make meaning of their decision to stay, opt out of, or reenter a MAT program, and how their environment and other life events may influence their decision seems to be a common sense ask of research.

Summary

The definition of addiction in the scientific environment was unclear, and treatment was based on diagnosing individuals in many instances without patients' perspectives of their own disorder or input for treatment. The "why" of individual with OUD choosing to stay in, opt out of, or reenter a MAT program was lacking in the literature. Though MAT programs are effective in helping to slow or stop illicit opioid use, retaining patients longer in a treatment program, and decreasing opioid deaths, there remained high dropout rates in MAT programs which was not understood. Addiction definition, which includes OUD, has been described as inadequate and vague (Bevan, 2019) yet treatment of patients with OUD persists. There was an ongoing conflict of the definition of OUD as a chronic brain disease versus disorders of choice or behavioral dysfunction (Heather & Segal, 2016). There was no one causal factor which has been associated with retention or attrition by patients with OUD in a MAT program, but all studies show a lost retention rate of participants in MAT programs. Relapse in addiction remains high, retention in OUD MAT programs remain low, and may be more pronounced in those using specific drugs such as heroin or fentanyl. Yet, those with substance use disorder have a lower perceived need for treatment and physical deficits in behavioral associations shown by brain scans show these same individuals to have less capacity to change (Moeller et al., 2020).

Knowing how and why these individuals make the decision to leave or stay in a MAT program and address their OUD was needed. Known external barriers to MAT programs include not enough MAT programs with poor access especially in rural areas,

not enough providers who are waivered, and stigmatization both of opioid drug use as well as opioid treatment. Patients' perspectives are needed to have the patient involved in their care allowing for respect and equitable treatment by asking for the significance or meaning of their lived experience (Thorarinsdottir et al., 2017).

In Chapter 3, I explain how the qualitative phenomenological approach was the best direction to approach this complex phenomenon. The rationale will explain how interviewing individuals most strongly associated with OUD within a MAT program needed to be done to increase understanding, how the participant selection was obtained, and how the researcher was the instrument in this qualitative research study. The limitations, and feasibility of the study will be examined. Ethical considerations will be discussed and introduction to the flyer for participation, informed consent, and the interview guide will be given.

Chapter 3: Research Method

The phenomenological approach was chosen for my study because of the need to explore the angles to this phenomenon which may have been looked at before from a different perspective. There were no expectations of having one truth to allow for emerging thoughts to form answers to the question of why individuals with OUD in a MAT program chose to stay in, opt out of, or reenter the program.

The purpose of this qualitative phenomenological research was to study the lived experiences of individuals with OUD who were currently in, had opted out, or who had reentered a MAT program. MAT programs had been shown to be effective in those participants with OUD who retain services (Bech et al., 2019; Hser et al., 2016; The Counsel of Economic Advisors, 2017). However, the attrition rate in MAT programs remained high with no understanding of why this occurred (Williams et al., 2020). Opioid misuse had become a public health catastrophe in the United States multiplying health and societal problems (Stuart et al., 2018). This study addressed the gap in the literature regarding individuals with OUD and their choices to either stay in, opt out of, or reenter a MAT program. In this chapter, I explain why I chose the qualitative phenomenological research design and rationale for this study, review the role of the researcher in this qualitative research, review researcher-designed instruments used, and explain how the components of recruitment, participation, data collection, and data analysis were anticipated. The chapter concludes with a discussion of issues of trustworthiness, ethical considerations, feasibility, and appropriateness of the study.

Research Design and Rationale

I used a qualitative phenomenological approach to examine the lived experiences of participants with OUD and their retention or attrition within a MAT program. The research question for this qualitative phenomenological study was: What are the lived experiences of participants with OUD who were treated in a MAT program? This later expanded to include the specifics of staying in, opting out of, or reentering a MAT program. To answer this research question, I needed to research the subjective lived experiences of those individuals who have experienced OUD and have been treated in one or more MAT programs either currently or in the past.

The phenomenological approach was chosen to understand the "complexity" (Patton, 2015, p. 51) of the unknown, allowing inductive themes to emerge (Creswell & Creswell, 2018; Patton, 2015). Addiction and treatment are complex issues and there was an insufficient understanding of these subjects (de Wit et al., 2018; Schütz et al., 2018). An inductive approach was used to expand knowledge of this phenomenon. De Lima et al. (2018) used Merleau-Ponty's phenomenology lens to gain understanding of the perception of drug users about family while in a psychosocial rehabilitation. Thomas (2018, p. 373) stated that Merleau-Ponty and the combined phenomenology with the existentialism lens creates a space where patients have a "potential for growth" as they continue in life. Kemp (2009) used Merleau-Ponty's thoughts of embodiment as the foundation of the existence of humans, which must be understood in context. Moya (2014) used Merleau-Ponty's ideas to explain habits and embodiment in mental health disorders (OUD is considered a mental disorder) where there was a divide between the

habitual body and the actual body. The "community of meaning" stems from individuals having the same experience even if the experiences are slightly different to have patterns within (Moya, 2014, p.2). A descriptive phenomenological approach was used to learn what the individual's meaning was using heroin and methamphetamine and their subsequent arrests and why this phenomenon changed their lives (Bardon, 2018). Kane et al. (2020) expressed the lack of patients with OUD perspectives in treatment and the need for patients' perspectives.

Overall, the phenomenological lens supported the flexibility of this type of data collection through in-depth interviews (see Appendix A), reduction of data into themes, and bracketing the researcher's thoughts as much as possible to avoid bias and preconceived ideas (Creswell & Creswell, 2018; Patton, 2015). Data interpretation stayed close to the participants' voices; interpreting how the individual makes meaning of what was lived through and how they perceived the phenomenon (Patton, 2015). The phenomenological route of inquiry may still be considered not scientific enough. Empirical scientific models demand measurement of the phenomenon to gain insight into a proposed reality. Ruane (1989) found that researchers in psychology, sociology, economics, and anthropology considered scientific models irrelevant due to the dichotomy between biological and psychiatric science.

Addiction may be view through both the physical and mental lens. Recognizing multiple realities from many perspectives allows new focuses of why retention or attrition may be seen in participants with OUD in a MAT program. Increasing knowledge through understanding participants' perspectives helped to explore whether there were behavioral

patterns leading to retention or attrition. By my asking questions as the researcher without assuming an answer or being influenced by predetermined theory, there may be undiscovered areas about participants with OUD emerging which highlight patterns of retention or attrition within a MAT program. Due to the complex nature of this study, the complexity of addiction, and the many factors influencing the participants, phenomenology was the best fit to support what was not known about the phenomenon of patients' perspectives and their participation in the decision of retention or attrition within a MAT program.

Multiple factors are associated with opioid use. Disease burden of chronic pain (Jones et al., 2017), genetics, lower socioeconomic status, criminal records, being single, and being unemployed (Kadam et al., 2017). There was an 85% increase in opioid deaths between 1999 and 2016 in the Midwestern United States when manufacturing plants abruptly shut down compared to when manufacturing plants who did not close (Venkataramani et al., 2020). Poor pain management programs with increasingly liberal prescribing of opioids contributed to the U.S. increase in OUD death rates (NIDA, 2021). There were three defined periods of increases in opioid consumption and deaths in the United States beginning in 1999 with prescription opioids, continuing in 2010 with heroin, and currently with synthetic opioids such as fentanyl (Wakeman, 2019). This occurred among all classes of people but particularly in the more physically challenging jobs affecting the working class (Shaw et al., 2018). The transitioning of prescription medications to street heroin and fentanyl due to cheaper cost and availability has caused more deaths (NIDA, 2021). In Heyman's report even those with a genetic propensity to

use, most individuals with addiction quit on their own, and the reasons of stopping drug use were moral reasons not recovery correlates (2013).

From 2017 to 2018, there were 47,000 opioid deaths in the United States (Wilson et al., 2020). Research had shown MAT programs can reduce incidents of premature deaths by preventing opioid overdoses (Baxter et al., 2015; McElrath, 2018; Stotts et al., 2009). If patients do not stay in treatment, they do not receive the full benefits of the MAT program. Yet, rates of a high patient dropout from MAT programs continued (Williams et al., 2020). The problem of individuals with OUD staying in, opting out of, or reentering a MAT program was complicated by the lack of research examining participants' insight into their opioid use and the underlying meaning of their own experiences (Haesebaert et al., 2018; Sharma et al., 2017). There are variations of dropout rates but statistics in most of literature read indicated that 40%–80% of individuals being treated for OUD fail to stay in treatment within weeks to several months of initiation of treatment (Lappan et al., 2019; Lee et al., 2017; Williams et al., 2020). Chen et al. (2020) found that 59% of individuals in their study of factors of relapse started using opioids again after 5 years of abstinence.

Bright and Franklin (2018) suggested it was important to understand world experiences of participants to allow for effective healthcare interventions. Lappan et al. (2019) concurred, adding that if patients' voices could be heard, there may be less dropout potential with patients' lived experiences helping to determine treatment. Therefore, not knowing what the MAT program means to participants with OUD and how they view the benefits of the MAT program was a gap in practice and in the

literature that this study was designed to fill. Gaining an understanding of the experiences of individuals with OUD who have attended a MAT program provided insights into the reasons for retention or attrition of patients in MAT program care. Increasing knowledge by examining the depth of patients' lived experiences of OUD offers insight on how to reengage them once they have dropped services.

I used text mining with in-depth one-on-one audio-recorded interviews with questions written by me and reviewed by other addiction professionals. Those who are familiar with opioid addiction (e.g., social workers, recovery coaches) were asked to read the interview questions and search for any biases in the questions asked. This increased knowledge of this phenomenon within patients who have OUD and have participated in MAT programs and broaden my outlook on potential bias influencing the participants.

This phenomenological qualitative research was done best by approaching the participants in naturalistic familiar surroundings. Due to the complexity of the phenomenon of individuals with OUD who have exited or retained treatment in a MAT program, utilizing a phenomenological approach was an effective way to uncover the meaning of the lived experience of participation (Groves et al., 2013). Posters to request participant involvement were placed in a recovery house/MAT program and an addiction organization. These establishments were notified of the study to introduce individuals with OUD who had been in at least one MAT program and were currently in or had opted out of treatment but were interested in participating in the research project. No volunteers were obtained through the partner organizations, so I turned to social media for recruitment.

Phenomenology allows the researcher to explore the concept being studied through the participants understanding of why attrition or retention in a MAT program occurs and may isolate patterns of participation in treatment as the participants understand it. Understanding attrition or retention participation in care may be difficult due to the complexity of human nature (Neiman et al., 2017). Many participants with OUD presented to clinics with a pattern of drop out from other treatment programs (Allen & Olson, 2015). There may be a shared pattern of why attrition or retention rates occur within this defined group by identifying and reporting on shared experiences within individual narratives (Ravitch & Carl, 2016) with the same diagnosis of OUD. Other types of qualitative research do not seem to fit what was needed at this point to answer the research question. Phenomenology was used to explore the experiences of participants, which were then interpreted by me (see Groves et al., 2013). Merleau-Ponty's belief that the body was no less important than the mind fits the view of addiction for this study. There are biological, physical, psychological, and social changes seen in OUD. MAT programs attempt to address all of these. Research into participants with OUD may lead to a greater knowledge of factors needing to be further examined of treatment programs and participants participation in treatment.

Role of the Researcher

I am an experienced nurse practitioner who practices in a MAT program in a primary care setting and administers frequent medical health interviewing. However, I was new at research interviewing. Being aware of this, monitoring for bias in the way the questions were created and asked required collaborating with other more experienced

researchers and the Institutional Review Board (IRB) to assess for slanting of questions toward one outcome. In qualitative research, the researcher is one of the instruments and is part of the research (Ravitch & Carl, 2016). In a qualitative study, the researcher's influence is seen in how the questions are asked and framed. The integrity, credibility, and transparency of my research showed the alignment of the study design, which strengthened the study results. This approach required field notes for evaluating how my own beliefs on OUD and treatment issues affected how I approached the research such as any preconceived ideas of those with OUD and thoughts about the participants being studied. My committee members were a good source of contact, along with reading other dissertations from the phenomenological aspect and contact with other researchers, which were helpful to strengthen the credibility of my research.

This ethics of research prohibited me from working with my own patients due to the risks of causing overt or covert pressure to answer questions in a particular way. Therefore, no participants were or had been patients in my care as a provider.

Due to the high socioeconomic cost of drug use to many participants with OUD a small incentive, a $20 gift card, for their time was thought would bring more volunteers to the study to recognize their time was also valuable. Telling participants what the study was generally about broadened interest in the study. Allowing participants to have the research done in their recovery homes/treatment centers, or addiction organization housing created an environment of comfort for the participants (see Vinney, 2020).

Methodology

The methodology of this research project was a qualitative phenomenological approach with the lens of Merleau-Ponty to incorporate not just the brain's experience but also the body's perception for this study (Merleau-Ponty, 1945/2012). The examination of the lived experiences and how the participants made meaning of their experiences interpreted by the researcher of unclear situations and uncommon issues is important to understand the phenomenon in question (Grove et al., 2013). Audio-recorded semistructured in-depth interviews began. The initial belief was that 3–10 participants with open-ended questions allowed for evolving answers with possible probe questions for follow up to delve deeply into the subject matter to occur (Patton, 2015). In a vulnerable population such as those participants with OUD, full IRB approval was required for protection of the participants as dictated by the Belmont Report for ethical consideration (U.S. Department of Health and Human Services, 1979). In addition, IRB requested I receive the Certificate of Confidentiality to further protect the participant, so this was obtained (CC-OD-21-2318).

Participant Selection Logic

The participants, ages 18–58, were purposively selected after obtaining IRB approval (09-20-21-0384226) and the National Institute of Health Certificate of Confidentiality (CC-OD-21-2318). The original age range sought was from 18–70 years old. The characteristics and content surrounding the research participants could allow for the research findings to be transferred to other like populations (Ravitch & Carl, 2016). The participants were individuals who had been patients treated in a MAT program

within the last 5 years, had been diagnosed with OUD by a medical provider or a social worker within the last 10 years, and had either remained in the program, reentered, or dropped out of a MAT program. All interviews were held at their homes except for two; one interview was held in a recovery house and one interview was held in the participants car.

The qualitative researcher may adapt their interview process due to the uniqueness of the study being done (Rubin & Rubin, 2012). The initial plan was to have face to face interviews. Since there were no volunteers from the two partner organizations, interviews took place via Zoom (https://zoom.us), a social media platform, or via a smart phone. The participants were studied in their natural environment and reconstructed the events around the phenomenon I had never experienced. This required a flexible interview process to access the complex constructs (Rubin & Rubin, 2012) to answer the research question being asked. In a semi-structured interview, the questions asked allowed for the depth of the experience along with prompt questions to get past the surface knowledge into lesser-known subject matter. The participants had to be able to understand what the study was trying to accomplish, and informed consent was obtained and understood before any data were gathered.

Procedures for Recruitment, Participation, and Data Collection

The recruitment of the individuals began with me placing posters in a transitional addiction housing/ MAT clinic, and addiction organization by myself. It was expected the recruitment would take multiple attempts and extend over 6 or more months. It was necessary with a phenomenological study to have participants who had exposure to the

phenomenon of OUD within a MAT program as humans process and made meaning of the experience (Patton, 2015). After waiting a month for initial recruits to respond to the poster/flyer without obtaining any participants, I then went to social media. This aligned with the research, which suggested patients of OUD were often excluded (Sanger et al., 2018) and may have been hesitant to join a study.

To increase the probability of attaining a higher number of participants, I used snowball recruiting (Rudestam & Newton, 2015). Snowballing, a technique where one participant recruits other participants who may be willing to take part in the study (Patton, 2015). The number of participants did result in saturation of data. However, additional social media requests were made via Facebook and snowballing technique were more assertively pursued by email requests to verify saturation had been fully achieved.

Data Collection

This qualitative study started with initially three participants with OUD and increased in numbers until saturation of data ensured no other new themes were forthcoming (Rudestam & Newton, 2015). Three organizations were contacted: two responded. One recovery houses/MAT clinic, and one addiction organization were contacted by letter seeking permission for posters to be placed in a Midwestern region of the United States explaining the general study. My contact number and a small incentive, $20 gift cards, were offered for those who were able to participate in the study. The participants were told they did not have to finish the study to collect the gift card, but all chose to complete the interview process. Social networking via Facebook was utilized as

this allowed for multi-regional participants to become involved as the use of social media was seen in 79% of the U.S. population (Clement, 2020). Equipment such as smart phones were utilized due to the corona virus pandemic and need for social distancing. This broadened the research for those who did not have computer access.

Instrumentation

The field research audio recorded interview guide consisted of open-ended questions after an informed consent was obtained. The interview questions developed by me kept to the phenomenological approach of having open ended questions with no preconceived thoughts of what would emerge. The semi-structured interview questions concentrated on answering the phenomena of the lived experience of the participant with OUD in a MAT program who retained services, opted out, or reentered the treatment. Prompt questions were then utilized for further examination into the phenomena. The interview process took 20–105 minutes and started on time and ended at the time stated with in a one-to-two-hour window. If participants had been willing to a time extension due to not finishing but felt like they had more to say, this was acceptable to both parties but was not needed. Prompt questions such as "Could you tell me more about the situation(s) you experienced in which you chose to drop out or retain MAT services?", and "What emotion did you experience at the time of your decision which you understood as a reason to stay or leave treatment?" were preplanned due to the researcher's inexperience.

Interview questions were submitted to other addiction professionals prior to the actual interviews who were unable to recognize potential bias in the way the questions

were framed, worded, or spoken. Marginalized, and socially disadvantaged participants may have had a collective distrust of being involved in research due to past historical abuse (Fisher et al., 2010). This was seen by two of the participants who contacted me via my cell phone and verified who I was and if I was preforming the research. They were encouraged to contact Walden University for additional assurances of the validity of the study. Validity enhancement was done by member checking, appropriate recruitment of those with knowledge of the phenomenon, and staying true to the participants story (Grossoehme, 2014). Debriefing at the end of the interview offered a chance for the individuals to offer new information, a stabilizing time to readjust to present situations, to add clarity for myself if there were areas of confusion, and to give a conclusion to the study. Transparency in the research process also increased trustworthiness as study results are more likely to be understood in their natural context within the participants conversation (Grossoehme, 2014).

In member checking, the participants were asked for a follow up email contact at the time of the initial interview to allow for clarification of any part of the interview that was not reflective of what the participant meant. Participation of this follow up resulted in 100% of individuals agreeing and 75% of individuals asked following through. Pilot studies were not done. However, practice of interviewing with co-workers and professional colleagues were performed to allow for a more professional approach and familiarity with content. The process of research interviewing was different than interviewing a prospective patient. This process allowed for restructuring questions, question sequencing and format changes, for better flow.

Debriefing procedures offered determination if the participant had further questions, and observation of the participant for any concerns of triggering adverse emotions and a conclusion to the interview. Additionally, hotline telephone numbers for addiction counseling were offered to participants to decrease risks any ill effects of the study. Local hospital phone numbers were also given out on the consent although this would have only applied to one participant. Participants were urged to discuss risk factors with the nurse researcher but more importantly with their support counselors. As a nurse researcher, offering a limited contact time of one month for any questions or concerns not addressed during the research period seemed reasonable but no time frame was given as I was not sure of how long the time to saturation would be. Each participant but one asked to have a summary of the findings when available and was assured this would occur.

Data Analysis Plan

Participants spoken words were transcribed verbatim by me starting with the first interview and were examined by isolating "In Vivo" codes (Saldana, 2016, p. 4) and themes, staying true to the participant's experience and research question (Ravitch & Carl, 2016). Affective coding methods (emotional coding) were then attempted after the In Vivo first pass coding as it allowed for in-depth examination of "subjective qualities of human experiences" (Saldana, 2016, p. 124). Emotional coding placed the complex emotions of retention or attrition of those individuals with OUD in context with what they had experienced when the decision to stay or leave the MAT program was made (Saldana, 2016). However, coding was emerging within a continuing cycle and emotions became subsumed into the coding process as patterns started to evolve.

Each statement was read and reread to see relevance of the material, removal of all non-essential statements which were repetitive, integration of data into themes and construction of a more concise interpretation occurred (Creswell & Creswell, 2018). The transcripts were then read as the tapes were relistened to. This linking of data to the participant's experience supported the phenomenon being studied (Saldana, 2016). Merleau-Ponty stated, "… *capturing a meaning which until then had never been objectified and of rendering it accessible to everyone who speaks the same language*." (Merleau-Ponty, 1947/1964, p. 9) showed how finding the essence of the individuals with OUD and the individuals' pattern of behavior led to findings not reported before. This was repeated with all transcripts until reduction of data showed a pattern or essence (Rudestam & Newton, 2015). Organizing the decoded data was time consuming and required interpretation (Saldana, 2016). This immersion into the data allowed me to see different themes without any software used for coding.

In this type of a phenomenological qualitative study, discrepant cases were examined and analyzed like any other interview results. The outlier case held different concepts and themes than those whose stories had similar voices and was cause for further research follow up (Ravitch & Carl, 2016). Triangulation occurred when use of several methods was used to examine the phenomenon and added strength to the study's findings (Patton, 2015). Quantitative, mixed methods, as well as other qualitative studies both with and outside of the phenomenological approach were read and synthesized into understanding of how to reduce data from a narrow category to a broad field through focused interpretation.

Member checking held the study close to the participants voice, reflecting their lived experience and how closely the interpretation reflected the individual's experience (Ravitch & Carl, 2016). Qualitative research method allowed the researcher and participant to go deeper into the lived knowledge of the participants, breaking away from the surface consciousness of the phenomenon it questioned. This illuminated the essence of the phenomenon by gaining access to the first-person experience (Patton, 2015). My bias as a researcher was acknowledged as embedded into the research strategy and was addressed and controlled in a qualitative study by field notes and memos. Information gathered and interpreted affected by the biases potentially hindering results was reflected on until a clear view of any slanting of information was able to be controlled. Peer debriefing, or "*dialogic engagement*," done by eliciting those who had impartial views of the study helped identify biases or assumptions made by the researcher (See Ravitch & Carl, 2016, p.16).

Prolonged time in the field meant understanding the culture or social setting in which the research was happening as well has having knowledge of the phenomenon being studied. As a provider in a MAT program, I brought knowledge of those with addiction in a treatment program into the field of study and this knowledge influenced my ability to ask the specific research question by finding a gap in the literature. External auditing may not have had all positive aspects as may assume there was only one fixed reality, but it did offer the ability of the data collection and analysis to be challenged by an outsider or committee members (Cohen & Crabtree, 2008).

Issues of Trustworthiness

Credibility

Credibility related to anticipating the complexity of the phenomenon being studied and the ability of the researcher to interpret the difficult patterns of the findings (Ravitch & Carl, 2016). This allowed the depth of the findings to be displayed and interpreted. My internal question in this research was "Am I looking at the complexity in a rational way and attempting to interpret the information correctly or am I not incorporating the findings due to the complexity?" Credibility is a position resembling internal validity in quantitative methods allowing the alignment of the methods and the interpretation of the data to be seen (Ravitch & Carl, 2016). The design, researcher instruments, and findings was consistent and transparent so future researchers could follow the steps outlined. Triangulation added to the credibility by examine different sources to strengthen my study (Ravitch & Carl, 2016). The participants' voices living through the phenomenon supported my interpretation and the accuracy of the findings (Creswell & Creswell, 2018). Providing thick, detailed descriptions and doing member checking promoted staying as close to the participants as possible (Rudestam & Newton, 2015). Recording my biases also lent to the findings and interpretation (Ravitch & Carl, 2016). The closer the participants' voices were to the findings, the more credible the study. By allowing member checking to occur, staying true to the participants' voice was captured by their statements which supported my findings.

Transferability

Transferability is the quantitative position of external validity. In qualitative research, information is "contextually bound" to the participants and their lived experiences (Ravitch & Carl, 2016). Purposeful sampling was achieved but is not representative on the general population (Ravitch & Carl, 2016). Write up of data included specifics about the researched individual regarding time, place, and what was happening around the participant at the time of the research. Rich descriptions of the participants were needed to transfer the research results to other like populations (Ravitch & Carl, 2016). The qualitative research was not meant to be able to be generalize to the majority population but now may be transferable to other similar groups due to the clarity in the research project. Other researchers may build on the particulars of what and who were studied. The phenomenological qualitative research concerned a shared experience which was what individuals with OUD and treatment in a MAT program live through but was specific to a certain group, in a certain time, at a certain place.

Dependability

Dependability referred to how stable my "reasonable" argument was for my method of collecting the data, and if the data answered my research question (Ravitch & Carl, 2016, p. 189). This was measured by how detailed the explanation was in each step in the research starting with the initial thoughts of what the study will be about, how I conducted the study, the interpretation, and the completeness of the documentation of these steps (Creswell & Creswell, 2018). The emphasis was on the rationale for why the study was conducted the way it was and why this was the right model for this research. It

was the subjective experiences of individuals with OUD who made the decision to leave, reenter, or stay in a MAT program needed to answer my research question.

Confirmability

Qualitative confirmability is equated to quantitative objectivity. Since qualitative researchers have never professed to hold objective views (Ravitch & Carl, 2016), the subjectivity of the research data included the researcher's stance of the phenomenon. This included removing myself, the researcher, with inner biases from the data findings as much as possible but understanding this was not entirely possible to do. This indicated some form of bracketing by reflexivity to isolate researcher bias (Patton, 2015). To do this, field notes and analytic memos were kept. My position on OUD, patients with OUD, and thoughts of treatment programs were needed to be recorded and reviewed as data was gathered, coded, and interpreted. This reflexivity started with the proposed research and did not end until the final write up of the findings had been completed (Creswell & Creswell, 2018). Initial written observations were included when interviews were done to prevent preconceived ideas influencing how the data was interpreted (Creswell & Creswell, 2018). There was a flexibility to the study to allow emerging theory to recognized.

Ethical Procedures

The IRB approval was gained prior to starting any research to safeguard the safety and wellbeing of the individuals in the study (Creswell & Creswell, 2018). Ethical concerns of this vulnerable population were many. First, most of the individuals with OUD may have been through childhood trauma (Evens & Sullivan, 1995; Kim &

Hodgins, 2018) placing them in a socioeconomic and psychological disadvantaged position. Additionally, OUD is a stigmatized illness as is the treatment of OUD further marginalizing this population. Also, the failure rate of many individuals within MAT programs may have caused participants to feel unsuccessful and affect their ability to use their voice and give answers the individuals think was expected for approval.

It was important to have informed consent written in the most basic of language (e.g., who the study was for, what the study hopes to accomplish, why the participant was chosen, how the study was not intended to affect the participants' treatment or recovery) for full disclosure of the study (Rudestam & Newton, 2015). Informed consent was discussed after participants read the statements enclosed in the consent to make sure there were no questions from the participants. I had to distance myself from the nurse practitioner role and transition into the researcher's role to avoid offering medical advice as this would have cross ethical lines. The study of human beings required respect for the individual and a nonjudgment attitude no matter what was heard during the interview. There was continuing discussion of how this study was strictly voluntary with no connection to the individual's existing or future treatment (Rudestam & Newton, 2015). Data collection was done in an area where the participants felt safe, comfortable, and were guaranteed privacy and confidentiality although this could not be guaranteed (Creswell & Creswell, 2018) as they picked the place and time of the interview.

The participants understood they could withdrawal at any time during the study and could refuse to participate or answer any question they were not comfortable answering (Rudestam & Newton, 2015). More stringent confidentiality would have used

composite stories to further shield individuals from being identified but was not accomplished (Creswell & Creswell, 2018) as each participant wanted their voice to be heard. If at any time the individual felt the research had caused an adverse reaction or was detrimental to their recovery, the interview procedure would have been stopped, and support would have been offered by the researcher, but this was not needed. I did suggest to each individual they may wish to contact their support person, or via a hotline addiction number or assistance to find social support through professional organizations or local emergency rooms. Emergency protocols by the partnering organizations had been in place in the event of an emergent crisis but since no participant was connected to the partner organization, these protocols were not utilized. IRB was to be notified in the event of any adverse reaction and this was not needed in any of the cases.

The data gathered will be held in a confidential storage file cabinet and the participants was informed of this. These data will be used for research purposes only with all participant information redacted. The data will be destroyed in 5 years in a secure manner (Creswell & Creswell, 2018). Power differentials the participants and I as the researcher felt was acknowledged and recorded as field notes which were included in the final report. As was expected, multiple realities emerged and all were reported (Creswell & Creswell, 2018). Incentives were used to honor those who give up their time to help promote expansion of scientific knowledge and this was reported in the findings. Incentives may create a bond of sharing information as trust of the participants toward the researcher cannot be assumed. There are usually not any benefits for the participants of most research (Rudestam & Newton, 2015) so there were not any promises for benefits

from this study. Any conflict of interest such as contact with past patients who wish to be part of the study would have reported to avoid making the study's credibility in question.

Summary

This chapter examined why the qualitative phenomenological approach to the research problem was the best choice for lived experiences of participation of individuals with OUD who entered in or left a MAT program. In-depth interviews were conducted on a one-on-one basis in field research to study lived experiences and shared patterns leading to increased knowledge base of the research problem. It was through recruitment by posters, snowballing effects, and possible social media connections adequate participant involvement through purposeful sampling was gained until saturation occurred. This was further approved by the Chair who concluded saturation had occurred. Due to the vulnerability of this population with human subjects, the IRB approval was sought and granted by the full board and there were additional protections, such as my obtaining the NIH Certificate of Confidentiality. Confidentiality of data was assured by redacting, changing, or deleting identifying information needed to secure the participants wellbeing. The wide age of the participants, along with the potential participants being of different regions of the Midwestern United States brought multidimensional aspects to the study. In saying this, many vulnerable populations such as those individuals with OUD have had prior history of research abuses which may have affected both recruiting into and retention in the study (Fisher et al., 2008; Scharff et al., 2010). Due to limited knowledge of this overall phenomenon, ethnicity and racial disparities were not addressed but may be needed in future research studies concerning this topic. Distrust

was overcome by my being transparent in all aspects of the research study, using layman's terms, and having ample time for informed consent presenting which held clear explanation of what my study concerned and who my study will affect. Two participants called my cell phone for verification that I was doing this study. This study examined the concrete and abstract experiences as lived by the participants and data interpretation maintained a closeness with the participants' voice. Member checking was encouraged and revisions to individual transcripts were completed as suggested by the participants for further validity. This chapter concluded with issues of trustworthiness examining issues which might have negatively affect this research. Chapter 4 will provide an introduction, the participants' demographics, the data analyses and interpretation, and the study results.

Chapter 4: Results

The purpose of this phenomenological qualitative study was to explore the lived experiences of participants with OUD who have been treated in a MAT program. The purpose later was expanded into categories of staying in, opting out of, or reentering a MAT program. The research question allowed emerging concepts about experiences of individuals with OUD and treatment in a MAT program to be interpreted through the participants' own words. In this chapter, I define the setting of the study, explain the demographics of the interviewees (see Appendix B), review how the data were collected, and describe the strategies used in the analysis. I explain how the trustworthiness of the study is maintained by examining the credibility, transferability, dependability, and confirmability with alignment of the study components. In the summary, I provide the outcome of the interview process and offer findings to the research question.

Setting

I conducted the study in the Midwest region of the United States. I audio recorded the interviews; three interviews were completed by phone and nine interviews by Zoom. Zoom is a social media platform which allows videoconferencing as well as audio and video recording (Archibald et al., 2019). For the Zoom interviews, I did not video record any participant interview although I used video conferencing to allow me to see the respondents if they chose to use cameras during the interview. All participants who were interviewed via Zoom chose to be viewed. I had my video on when the participants entered the video conferencing as I wanted to be as transparent as possible.

Demographics

Initial study participants consisted of six women, one nonbinary individual, and five men between the ages of 18 and 58. The area of research was the Midwest region of the United States. Participants 1, 2 and 4 had phone interviews captured by audio recording only. All other interviews were conducted by Zoom meetings. There were five participants who had been in one MAT program. Three of them had opted out of MAT services. One was still engaged in her first MAT program although was hoping to wean off suboxone and exit the MAT program within a short period of time. One participant was transitioning out of her first program into the next MAT program. Eight (73%) of the participants had been in more than one MAT program. One male participant who had opted out of a MAT program was excluded from any data analysis or interpretation due to a language barrier, bringing the total of interviewees which had coded data and analysis to 11. This male participant was excluded because his accent was so heavy, I could not understand what he said. After listening to the tape recording repeatedly my ability to understand him did not improve. He was given a $20 gift card via email at the end of his interview and thanked for his participation.

As stated above, my research interviews were conducted by phone contact or by using Zoom meetings after contact with the two partner organizations provided no volunteers after one month of having the poster/flyer placed at their facility. The collection period of interviews was from November 2021 to March 2022. The duration of the interviews was between 20 and 105 minutes. I initially sent a Zoom invitation with the same link to two participants. This Zoom meeting was canceled, and the participants

were informed. The title of the Zoom was *Interview for Research* so confidentiality was maintained. This concluded with losing one respondent by his not feeling comfortable with my access to his phone number. However, the other respondent agreed to the phone interview.

Variations in Data Collection

The research question in the proposal originally asked what the lived experiences of individuals with OUD who had been in a MAT program were. I later expanded the question at the recommendation of the IRB to separate the initial question into categories of those individuals who had stayed in, opted out of, or reentered a program to assure alignment of the study components in an algorithm type guide. Another change included specifying that individuals must be able to speak and understand English fluently to participate. Initially, on the flyer/poster the wording was individuals must be able to speak English fluently. Since there were multiple persons volunteering who were able to speak English on a basic level but were not able to fully comprehend the questions being asked (I had to repeat questions multiple times including changing the wording) as well myself not being able to decipher what was being given as answers due to heavy accents, there was a risk of not being able to represent adequately their lived experiences. This change in meeting the criteria provided clarity and assurance that the participants' perspectives were interpreted as accurately as possible by having the experience of those being interviewed described as closely as possible to the actual experience and not through any misguided guesses of myself. This change of individuals meeting the criteria

was brought before the committee for approval before the next interviews were proceeded with.

Data Collection

To obtain the sample participants for the research, I contacted 11 private and public groups on Facebook. I approached the private groups and stated my reason for wanting to join. Upon approval, the flyer was uploaded to each Facebook site. Potential candidates for the study contacted me via my university email after which a consent and a copy of the study flyer were sent to each interested individual's email address. Respondents then determined whether they met the criteria, and this gave them time to formulate questions before the interview was scheduled. Due to the large number of volunteers who were not fluent in the English language, I included an exclusion criterion on the demographic form that if they could not speak or understand English fluently, they would not be eligible for the study. The question about English language fluency was to prevent any misrepresentation of their lived experience by my inability to form the questions and receive answers which would appropriately voice their experiences. If the respondents did not meet the criteria, they were told why.

Six of the participants did not know how to enter their name onto the consent form or had neglected to do this in the email but still wanted to participate. Verbal consent was obtained and recorded in these events. A recording of acknowledgement to be in the study was also recorded. All participants were assured of the confidential nature of the study and were given a unique identification number that was used during the study. Unique IDs began with Participant 1.

I audio recorded both the Zoom interviews as well as the phone interviews on a portable tape cassette recorder after I obtained a signed or verbal consent and demographic questions confirmed the individuals met the criteria. I used the interview guide to ensure each question on the algorithm was addressed but may not have been followed in a linear way as the semistructured interview was conducted. Initially, I had read the information but could sense the impatience of the participants to begin the interview, so the information acquisition became more of a conversation with better flow and less of a structured interrogation.

I used Zoom to gain access to the participants through the meeting allowing me to hear and see the participant, but I did not use Zoom's option to audio/video record the participants. I used a tape recorder to be able to use the verbatim conversation allowing me to have a transcript of the interview. Only one participant questioned the purpose of the study (not the consent) when I asked the participants if they had any questions. After this question was answered, the participant had no further questions and the interview continued. After all recordings were completed, verbatim transcribing of the interviews occurred within 24 hours after the interview. I transcribed the interviews myself, which provided me with initial immersion into the data. Through the multiple starts and stops of the recordings, I became connected to the conversations through the breakdown of the repetition, the intonation, and eventually the meanings behind the words. Throughout the verbatim transcribing process, I reviewed both the field notes and memos which had been written at the time of the interview onto the individual notebooks as well as my written thoughts after the interviews had taken place. I also jotted down notes after member

checking at each interview's end and with each subsequent review of the tape-recorded interviews and reread of the transcriptions. This step provided further reflection on the content and staying within the participant's voiced experience.

The recruits were told of my obtaining the National Institute of Health's Certificate of Confidentiality for further protection against any information being subpoenaed. All but one individual wished to be contacted to be given a copy of a summary of the study. All individuals stated they would be agreeable to have me contact them with further questions or clarifications.

Data Analysis

I did the initial coding starting after the first recording was transcribed verbatim. Subsequent transcripts were then coded. At interview three, first pass codes were similar. By interview seven and after multiple rereads of the transcripts, relistening to the taped interviews, and viewing field notes and memos no further new codes had emerged and patterns were consistently seen. I completed five more interviews for a total of 12 (minus one interview as this incomplete data was discarded) to verify all codes were similar and no new knowledge would be obtained as saturation of emerging themes was seen. Over 319 first pass in vivo codes were identified which were then placed in a second coding process. Redundant codes were discarded.

I initially anticipated the second pass coding would be the emotion coding (Saldana, 2016), but this did not occur due to continually evolving second codes and subcodes; therefore, emotion coding was subsumed into the second pass codes. To identify categories, I synthesized the code patterns to the shared experiences to bring a

new consolidate level of understanding (See Saldana, 2016). I started to reread the philosophy of Merleau-Ponty and Husserl and found myself lacking in abstract thought, which I needed to complete the coding to theme searching for the essence of the phenomenon I was attempting. As I reflected on what each code represented, the depth of meanings became more evident.

Evidence of Trustworthiness

Credibility (Internal Validity)

Credibility is the ability of the researcher to identify and interpret the complex patterns of the data findings (Ravitch & Carl, 2016). To assure credibility of my study, I kept an audit trail of field notes and analytic memos to distinguish personal bias, used triangulation by referring to the literature, gathering information by published individuals with OUD who had not been in a MAT program to further gain understanding of opioid disorder, and did member checking by confirming my interpretations with the participants. Auditing with field notes, keeping analytic memos, and journaling created a broad understanding of OUD and helped me to better define the confusion around OUD and addiction complexity (Coperu, 2018; Heather & Segal, 2017; Peele, 2016). Repeated efforts of stepping away from the data and returning to it with fresh insight helped me to interpret difficult patterns so the depth of knowledge gained could be better understood. This iterative approach of looking at the information by stepping away from the data enabled me to interpret the findings while staying close to the participants' voices.

During the IRB approval process of my study, I became aware of the need to separate questions into an algorithm or branching system so I could adequately address

the potential situations I encountered. This further strengthened my study by assuring alignment of the methodology and methods of performing the research. I triangulated my study by bringing in published works from those who had OUD, rereading my literature review, and seeking assistance from my Chair and Second Committee member as needed. To become closer to the participants' lived experience, I used in vivo quotes supporting my interpretation of the findings. This allowed for thick description as experienced by the individual. Member checking, further assuring credibility, occurred for all participants to clarify their statements or a situation which I was unclear about at the end of the interview process. I contacted three participants via their email after transcription of the interviews for clarification of words or an event I did not understand.

Transferability (External Validity)

Transferability is the qualitative approach showing ability to have contextually bound lived experiences of participants be understood within the context of the study (Ravitch & Carl, 2016). Transferability in this study was not guaranteed as the information is contextually bound to the participants living in this exact time in this exact region with this exact diagnosis and this exact treatment. However, with rich descriptions of the participants, this study may be transferable to other like populations. As with many qualitative studies, purposive sampling was done to best answer the research question and so would not be representative of the general population

Dependability (Stability of Reason)

Dependability of this study relied on my ability to justify the qualitative approach to the research study, my gathering and interpretation of the data, and my transparency in

how I documented my efforts (Ravitch & Carl, 2016). My method of collecting the data was reasonable because any other method I used would not have allowed me to answer the research question with such flexibility due to the paucity of information. A phenomenological study allows for emerging theory. As the study was conducted and interpretations were done, I documented each step including the steps which had to be revised, the inexperience of the researcher, and the difficulty obtaining this vulnerable population. The lived experiences of the participants I interviewed answered the research question. By keeping my biases bracketed, giving rich descriptions of the individuals' lives concerning the research question, and having the ability to not preselect theory to direct my experiences of those telling me their lived experiences, I was able to answer the research question.

Confirmability

Confirmability was established by highlighting my role as a researcher in the study and not professing to have objectivity within the study (Ravitch & Carl, 2016). I started listing my biases and thoughts in a journal style writing before any participant research was performed, as described by Saldana (2016), who said to include field notes and analytic memos during or soon after each interview. In the interviews, I kept field notes as I interviewed each participant, and although I am a health care provider and work with people who are diagnosed with OUD, none of the patients I interviewed were or had been in my care. Nevertheless, I was aware of the power differential between care giver and patient during the interviews as well and made sure that I bracketed my own

feelings and beliefs so that I was able to hear the perceptions and experiences from the participants view and not allow them to be influenced by me or any of my views.

I was able to recognize my biases by continuous self-reflection to bracket my implicit biases for the entirety of the research. It became equally essential to allow for flexibility and reflective thought to occur to separate myself with known biases as much as possible from my interpretation of the findings.

Results

To address the research question for this study, three major themes emerged from the analysis of the interview transcripts. The original proposed research question was: what are the lived experiences of individuals with OUD and their experience in a MAT program? The research question was later expanded to include those individuals who had stayed in, opted out of, or reentered a MAT program. The first theme to emerge was rhythm of recovery, the second was shattered reflections, and the third theme was transcending the program. I present these themes below including the interpreted definitions, the codes, and the categories that make up each theme with in vivo quotes to keep to the participants' lived experience.

Theme 1: Rhythm of Recovery (See Appendix C)

The Beginning Journey to Get to OUD and Treatment

Participants described the cyclical nature/rhythm of trying to recover as having multiple reasons (e.g., regaining family, prevention of incarceration, to have a normal life) and why they joined MAT programs (e.g., acceptance of need for treatment for OUD, regaining family, prevention of incarceration, avoiding withdrawal symptoms from

opioids). First pass codes showed initial drug use, roads into misuse of the opioids, rhythm of relapsing and the confusing normalcy of taking the opioids, trying to stop opioid use, and failing to achieve recovery. Failure to achieve recovery was seen in the emotional tie to the opioid use and suggested why use may continue. Participant 10 stated, "[heroin was] my first true love and it took me away from having to feel anything". Avoidance of going through the withdrawal symptoms created a road to the MAT program.

Participant 1 explained how she entered into OUD and the effect it had on her. She described being "diagnosed with RA and lupus … my doctor put me on hydrocodone … for some reason I took two instead of one and that started my addiction." When first seeking a MAT program she stated she was "broken and hopeless" and "sick and tired of the cycle of drugs and the addiction."

Participant 2 described being "angry … I wasn't fully ready to get clean … angry that I wanted to get high" and stated "my kids were placed with my Dad. … I wanted them back"

Participant 7 explained how environment played a role and that living in a "small town everybody was messed up. … I don't know if I ever spent any days sober gosh probably like [since I was] 15 [years old]." She stated that relapsing and getting back into recovery was a "hard truth to go back and start over, over and over and over. … you have to recalibrate every single time and its miserable [emphasis added] … sometimes [I would] have suboxone or be able to get suboxone from other people [to avoid withdrawals]."

Participant 9 stated he did not know why he relapsed while on the MAT medications, sounding confused. “It wasn’t as if the medication wasn’t working. … [trying to figure out why he relapses] I asked myself you know – what is it?” When discussing his participation in a MAT program, he said, “I’d be there for an hour and I would say, I am outta here.”

Participant 12 shared that though she was not ready for recovery she would enter MAT programs for fear of withdrawal versus wanting to be “sober.” “My intensions on getting on suboxone [were that] … a little bit I do want to get sober but a lot of it was more so I did not want to go through the withdrawals.”

Theme 2: Shattered Reflections (see Appendix D)

The Changing of Myself

This theme emerged as participants described the changing of themselves from pre-drug use, during drug use, and into recovery (recovery periods ranged between two weeks and five years). Participants who had started using drugs early in their life showed a resilience in trying to achieve recovery. The opioid use had taken their values, who they thought themselves to be, and had changed their self-identity. There were dysfunctional family ties, incarcerations, and illegal acts to obtain the drug causing life changing events. There was a strong genetic connection between opioids and multigenerational ties. Examples of these lived experiences are in the participants statements below and shows the devastation of who they had become during their opioid use. This theme showed multiple layers of loss, specifically of the loss of self-identity, unbalanced living, and the steps of not being ready to change into a life of recovery. The degradation of

becoming someone they never knew they were expressed in their statements below. Childhood trauma (sexual, neglect, dysfunctional family) was seen in this theme.

Participant 1: The" childhood trauma …crap that I had buried"; She tried to "escape by abusing the prescription pills and the heroin"; [stealing from the petty cash as an office manager, being humiliated and ashamed when caught]. She reported being "fired and arrested"; Traumatic events were also linked to addiction when she was abandoned by husband who was also addicted, she states "he left to get our daughter's formula one night and didn't return… I had to call my family and tell them what was going on."

Participant 3: "when I personally was ready to get sober [why they attended a MAT program] "it was my Dad [talking about their stepfather as their biofather was incarcerated for sexual abuse of participant]- "He [stepfather] has since passed away from an overdose but he went through a MAT for most of my childhood and I saw how much it helped him"; [the effects of trauma of their youth] "I am on other medications for like PTSD and depression."

Participant 9" "there is always that one bad decision that leads you back … and I don't know what it is for me. It's not that the suboxone isn't working." "I remember laying in prison every day crying thinking about the things I did. I was like Oh my God, please God forgive me. You know what I mean? I am not that person. I would help an old lady cross the road"[emphasis added]. He then discussed the loss of balance in his life, "You know what I mean? I am NOT that person… like I am the guy who will never

commit a crime so I can't believe some of the stuff I did… "I've been to prison 6 times… it was always drug related…I thought I was going to get it together…"

[Participant 10]: When discussing his father who had started injecting him with heroin starting at age 13 years old mentioned his anger at his father who tried to get him into recovery, "…I was trying to stay away from him because I had chased him and tried to save him my whole life." The lack of appropriate parenting and the unbalance it had caused could have contributed to his "overdosing for probably the 20th time."

[Participant 11]: Participant discussed how her chronic illness often went untreated. She described her behavioral health and her OUD like this "what a roller coaster…I have underlying conditions (anxiety) … and nobody wants to treat that…because I am an addict and so therefore that goes untreated because of my stigma." [when asked to describe her response of hopeless and helpless when deciding on leaving a MAT program] "I would say scared. Yeah. Scared to fail, scared to go back [into relapse].

[Participant 12]: Participant described how people who he respected had let him down. "Me and my Mom were really good buddies, getting high buddies."; "I just never got tired of hurting people it seemed like…I don't really care about anyone else; I clearly need to numb this pain I am feeling." She then went on to show the genetic tie to addiction. Every time I relapsed I relapsed with my Aunt…she has always been a big person in my life but also such a piece of shit…no matter how long I had been sober for…I would say hey I need a bag [heroin] and she would give it to me."

Theme 3: Transcending the Program (See Appendix E)

The Journey to Recovery by Looking Backward Walking Forward

Theme #3 was seen evolving from the journey to recovery by looking backward and moving forward. Code of *that one bad decision* was further developed into *imperfect life – that's okay*. This theme came after codes of recommitment, acknowledging the "not ready" to recover, and the acceptance of self-failure. This theme illuminated the self-reflection and acceptance needed to propel the participants into recovery and how MAT programs may influence decisions to stay or leave a program. This theme's connection to emotions shows anger, fear, hopeless, hopeful, unsteadiness, acceptance, and reflecting.

Participant 1*:* Participant described recovery "building a relationship with God – that peace"; "The program that I found is a faith based program"; "having that connection; [explaining the MAT program] "it is an amazing program but I do not think that is something that umm, should maybe but not necessarily be on forever…get on the program, work through it, work through your issues then start weaning off"; "I became complacent in my recovery and started talking to old friends. I was also suffering from post-partum anxiety and depression and soon relapsed. I was almost 4 months pregnant and so ashamed that I had gone back to drugs. I was living a double life. I walked back into (name of specific MAT program) broken and hopeless… I had a 15-day relapse after I had our youngest daughter…I decided to put in the work and start healing…I've been blessed."

Participant 2: When asked to identify the feelings she had when leaving the first MAT program "ummm, I was pissed…anger, sad, frustrated, stuck…" [transcending in

the second MAT program] "my counselor who I absolutely adored, umm, and I realized I could do this program… we have stable housing… I can be there, I can do this…I felt more at ease…felt more doable…they adjusted your medications for you, not a blanket script"; [what she would say to her younger self or someone else reentering a MAT program] "play the game…they have their rules- you play by it…participate…it makes them a lot better and have patience…do the work, play the game, get through it and it will be, you'll be okay"

Participant 3: described their experience with addiction and MAT programs and the need to" …dismantle the stigma of addiction"; [discussing suboxone use] "Some people…feel it is a crutch or you know replacing one drug with another- which both of those is kinda true but it is not the complete truth…I am taking a medication so I am healthy and I am not using [illicit drugs] and I do all the things I need to do to live for my family and you know like do the things I have always wanted to do but my addiction would not let me."

Participant 7 had experienced MAT medications through multiple relapses. She had dated a heroin dealer and then was forced to use his "product". She states there is a difference between sobriety and recovery and finding the right recovery community has helped her. In her discussion of the MAT program and the MAT staff she reported, *"*it makes my days tolerable… they would not be mean or judge me…very kind and caring and… they worry about other aspects of my life not just how is the suboxone going… you know like how is your life? Like what is going on? Like how do you feel? and it's very, it feels very genuine*."*

Participant 8*: "*I was the dumb one" [explaining why the first program did not work for him]. He later expanded on this saying the MAT providers did not listen when he told them one MAT medication was making him ill and he also did not understand the rules early in his recovery. "when you are first getting clean you don't ahhh you don't agree…you look back and you realize it's for a good reason…*you are in a different mindset.* [emphasis added]"

Participant 9 described his experience "…let me tell you I have left treatment centers multiple times…you know what it is? Its fear. Fear of ah change, fear of going through that pain." [withdrawal]. He offered the reason for recovery "…this last time… I did it for my son. I did it for my fiancé" "I don't want him to be a drug addict. I am trying to break the chains. Break the cycle… [reflecting and looking backward] "I want to have a life so bad. It's crazy. People don't think about this. I am 36 years old. I have never owned my own car, I have never had my own place, I don't have a license…I don't know how to pay bills…" [emphasis added]. "I gotta learn how to be productive in the world. How to hold a job, how to, you know, say no to conflict. I gotta change who I have become in the street." [discussing his taking suboxone and his present MAT program] "I call it a life saver right now…the place I am going to now, they care…I have a counselor. Man, he is so cool, he talks to me like I am his brother… You cannot just take MAT [medication by itself] and go on about your life and just think everything is going to change [emphasis added]." it's not going to…learn about fleeting thoughts and stuff it might come but it will go away."

Participant 10: "I learned about suboxone, and I got a MAT program…seemed to work pretty good as long as I had some type of counseling with it ... I really made an honest effort to get clean when my daughter was born.*"* [emphasis added]

Participant 11: When discussing roads to recovery she shared, "There is a lot there, so many out there [paths to recovery] and you can't say like okay if this doesn't work, even if it works for me, it isn't going to work for the next addict at all. I mean it's a different program, it's it's a road to get there. We didn't all get there the same road, you know"[emphasis added]

Participant 12: When discussing her faith and when fate tried to intervene her stopping use of opioids she shared, "my car actually went *(*broke down*)* ... was just a big God moment for me, like He [God] was 'I have had enough. You aren't going to do that anymore'. "I become homeless…a lot of people say we can't stay with them because we aren't really good people at the time… we had to get to the point to like really truly put our pride to the side and say we need some help…"

Many of the participants told of childhood trauma (sexual, neglect, dysfunctional family relations), first drug use, increasing drug use, untreated behavioral health issues, realization of OUD, seeking or being mandated to treatment by family, the court system, or by themselves in "moments of clarity" [Participant #12]. Relapsing, even when on MAT medications, was normal, not the exception.

Discrepant Cases

I reviewed discrepant cases which involved two participants who had opted out of a MAT program. Participants 4 and 6 who had been diagnosed with OUD, the first

Participant 6 from choice of using opioids as her grandmother was dying, she would self-medicate with her grandmother's pain medication, and the second Participant 4 from prescribed opioids for an injury. Both were placed on methadone, both stopped using methadone, and neither one reported relapse. I originally thought this to be a short-term OUD and time may have been a factor, but Participant 4 stated he had taken opioids "years after the injury had healed". These cases were different as the majority of the other participants in this study admitted to multiple relapses. The two participants [Participants 4 & 6] stated they needed to find a "permanent way to live" without opioids [Participant 4] and "true healing" which could not be obtained by taking methadone [Participant 6].

Participant 4: "I felt control of myself … managed myself better"; [reason to opt out of a MAT program] "have a valid reason for leaving the program."

Participant 6: [how she managed to wean off methadone and opioids] *"*a brother that is always encouraging me… you can do this… you can do this; [when ask what she would tell her younger self or someone else who may be opting out of a MAT program] "…be truthful to themselves… how are they going to manage it…how are they going to cope…they shouldn't just leave…find the real reason they want to leave the program"; *"*we can free ourselves from this rhythm of addiction and go to live a normal life that is fulfilled… find even meaning in life."

These cases were singled out not because of their interview differences from the other interviewees or because they had opted out of a MAT treatment but because their interviews held much of the same emotions and conflicts. Still, these two individual cases stated their outcomes did not hold relapse, had strong family support and encouragement,

and acknowledgment of needing help. There was loss, confusion, sadness, and fear. The only emotion not stated by either was anger which was inconsistent with the other participants.

Summary

The continued misuse of opioids caused negative consequences for these studied participants but being in a MAT program reduced their morbidity and mortality and gave the participants periods of sobriety. This cycle created the theme of rhythm of recovery. MAT programs and MAT medications whether prescribed or not were a way of avoiding the symptoms of withdrawal which occurs with the stoppage of the opioid taking for those with OUD or for avoiding emotions. Entrance in a MAT program by participants in this study were felt to be effective but there was conflict in considering oneself "clean" if on suboxone or methadone (Bentzley et al., 2015). Life in addiction and treatment was described by one participant as a roller coaster reflecting the rhythmic nature of this disorder even within a MAT treatment program.

Theme 2 of shattered reflections showed the detrimental changes seen in behavior, including self-identity loss, degradation and shame, and how decisions to continue misuse of opioids or stoppage of the drug had caused moments of clarity of who each person had become. OUD created a new person with unacceptable behaviors and rendered periods of loss, anger, confusion, degradation, and shame. These emotions were seen in every code level and so were subsumed into the emerging higher code levels. It was unclear what the root meaning of "not ready" meant in this study when discussing relapsing and reentering another MAT program frequently discussed.

However, starting over in recovery was considered “miserable” with the need to reset every time a period of sobriety was approached. Failure in one MAT program did not mean another program would not be effective due to the unstandardized MAT programs available. This was not thought to be detrimental by these participants if a MAT program had not worked for a participant in the past. Going to a new program showed the resilience of each participant when faced with reentering a MAT program. Some MAT programs had personal counseling causing retention of MAT services. Other programs that did not get personally involved with the participants and were thought to be treatment failures by multiple participants. After reflecting about why the MAT program was not successful, participants accepted a larger share of responsibility for opting out of treatment. Attendance of MAT programs were not a guarantee against relapsing. However, two of the eleven participants had not relapsed with no understanding by me of why this did not occur.

Theme three of transcending the program occurred from self-reflection. Facing what the participant had become, what they had done, and how they had lived occurred in this theme. Acknowledging and moving on by reflective thinking appeared to be part of the transcending the program to obtain the ability to stay in recovery. Some participants indicated the education and knowledge learned were taken to the next MAT program and used as a base for the next MAT program. MAT programs, unless seen as having a personal connection, having “doable” rules, having one to one counseling to address behavioral health issues are seen as not “fitting” the patient’s needs. This led up to the pattern in this study for treatment failure and attrition.

Mistreatment and stigma were felt by the patients, both for the OUD itself and in the treatment program by staff members. Decisions were made to leave programs based on how ready the participants were to recover, how the participants or others around them were treated in the MAT program, and if they perceived the clinics were personally involved in their care. Initial treatment rules may not be seen as helpful or understandable in early program attendance and may feel restrictive until further in recovery when perceptions of drug use and the consequences of actions while in active opioid use may change. Multiple traumas, both in childhood and young adulthood, had occurred in these OUD individuals making them seek the numbness capability opioids offer for avoiding painful memories.

In Chapter 5, I will present the interpretation of the findings, offer recommendations for future research and practice, and explore the ways this study impacts positive social change.

Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of the study was to explore the lived experiences of individuals with OUD who were treated in a MAT program. This qualitative phenomenological study included individuals who chose to opt out of or reenter treatment in a MAT program. Due to the limited number of individuals who had stayed in one program (one), patterns concerning retention were not able to be obtained. Key findings of the study showed participants were more likely to attend more than one MAT program, and although MAT programs were described as helpful in recovery, MAT program attendance did not rule out relapsing. Participants described a disconnect between who the participant thought they were and who they became when misuse of opioids occurred.

Interpretation of the Findings

Theme 1 showed a rhythm of recovery. Discussion of OUD and being in a MAT treatment in my study was closely connected to statements of cycles of relapse and recovery. Relapsing occurred in nine of the 11 participants of this study. Although relapse was not a stated desire in 10 out of 11 participants (only one participant stated she relapsed because she wanted to take the drug to get "high"), it occurred in most participants in this study despite the negative consequences associated with relapsing. The percentage of relapse seen in this study was higher than the 40%–60% cited by Satel and Lilienfield (2013), although less than an earlier report by Smyth et al. (2010) where 91% of participants reported relapsing within an inpatient setting. Lappan et al. (2019) cited 40%–60% relapsing with variable rates up of relapse up to 86%. My study's result of individuals' relapse and reentry into a different MAT program was 82%. The findings

of relapse and remission reported by SAMHSA (2019) was reflected in my study showing cycling of relapse and recovery periods.

Reasons for relapse in MAT programs by this study's participants are not fully expressed and were placed by most participants casually in a "not ready" to quit category. Due to my inexperience as a researcher, this was a missed opportunity to follow up and delve deeper into this topic. This missed opportunity reflects Anderson and McCleary's findings of participants not being asked about their perspectives (2015) and of providers' historical precedent of not delving deeper into patient's perspectives.

Failure to achieve a therapeutic alliance within a MAT program in my study had led to program attrition. There was a high rate of reentering a MAT program by my study's participants who cited not having a personal connection to a MAT program's staff, leading to opting out of a program. Personal connection by my study's participants to a MAT program was thought to hold a more favorable view of retention in a MAT program consistent with Marchand et al.'s (2015) study suggesting satisfaction with treatment has a positive link to treatment outcomes. Similarly, Allen and Olson (2015) argued that, without therapeutic alliance in a collaborative aspect in the treatment environment, any major progress toward treatment goals would be unlikely. My study was also consistent with Allen and Olson's report of many individuals presenting to treatment with multiple treatment failures. The "treatment failure" term may add to the stigmatization of entering another program and should perhaps be reworded to treatment attempts.

A potential contrasting view of having most types of behavioral support not being linked to retention for participants in MAT treatment was seen in Timko et al.'s (2016) study showing a positive correlation between contingency management therapy rewards for negative urine testing, which was inconsistent with my findings and not reflected in the majority of my participant's lived experiences. Only two individuals in my study mentioned extended times between treatment if they were active in their treatment. Although the participants did not mention any one type of behavioral health in particular, my participant's reported it was the lack of one-to-one counseling, lack of personal knowledge of addiction by providers and those counseling individuals treating OUD patients, having counselors seemingly not involved in potential life problems, and lack of knowledge of signs of withdrawal/relapse as a reason to leave a program. There was no mention of a reward system for "good behavior" indicative of contingency management programs.

In my study, the lack of a connection caused anger, fear, and confusion increasing the participants' sense of imbalance in treatment. There was confusion seen by participants in my study of why relapse was occurring even when stable on a MAT medication. The study by Beran (2019) supported this confusion of addiction (OUD is considered under this heading) as being poorly defined, seen as a complex issue, and not sufficiently understood. Beran believed the individual could never be simplified to a group of clustered criteria as there was not a single factor that motivated the individual to use drugs. Heyman (2013) preferred to label addiction a disorder of choice and believed individuals could quit using illicit drugs when the cost outranked the benefits. This was

mirrored in my study when most of the participants stated they wanted to enter into recovery for loss of self, loss of family, or to maintain the participants way of life in a family setting. Responsibilities for other living things appeared to have a connection to stabilization in recovery in my study and consistent with findings by Heyman (2013) when correlates of stopping opioid use was determined to be more familial concerns. Having reasons other than recovery for recovery's sake was mirrored in my study by participants wanting to return to being caregivers to children or pets and achieving a normal life (Sackett, 2020).

There have been varying reported outcomes in literature and inconsistency on how effective MAT programs can be due to research measuring different treatment outcomes. Stopping engagement in a MAT program by my study's participants included reasons such as "I wasn't ready," "I would rather get high," "the [MAT medication] drug was making me sick," "it wasn't even touching me" (i.e., the MAT medication dosing was ineffective due to the large amount of street drugs used), "I don't know why," and "they [MAT providers] didn't listen." Some of the above statements are consistent with research by Sanger et al. (2018) suggesting patients may initially want symptom control versus abstinence, whereas researchers may judge program success by abstinence rates, treatment dropout, connections to criminal activities, and continued opioid use.

There were three statements of overdosing and having to be revived by this study's participants, which supports Williams et al.'s (2019) finding of the 5% of all participants in their study receiving medical treatment for overdosing regardless of short or long-term treatment. William et al. cited odds of being seen in the emergency room or

being admitted into the hospital, or filling an opioid script became less if patients had been retained in care for 6–9 months. This speaks to the continued use of opioids even when knowing the negative consequences. Continued use of opioids, as cited by Bech et al. (2019) and Hser et al. (2016), is associated with ongoing dysfunction of the individual to the society level and includes premature morbidity and mortality.

No participant in my study mentioned cravings or environmental cues specifically as reasons for exiting the MAT program as was reported in Kadam et al. (2017) study of relapse although aspects of "I wasn't ready" may be linked to this phenomenon. Torronen and Tigerstedt (2018) mentioned the fluidity and changing of addiction, and this rhythm of recovery was evident in this study.

The hierarchy of importance of clinical outcomes versus participants' perspective of desired outcomes was seen as mentioned in Farre and Rapley (2017) when participants in my study were given blanket milligram prescriptions of suboxone for OUD treatment rather than individualized care, when symptoms of relapse were ignored, when one of the medications of MAT was ineffective for participants and yet not changed by the MAT provider, or when personal connection to a MAT program was not established (Allen & Olsen, 2015).

Failing to follow program rules and not stay within a MAT program did not mean treatment failure but was connected to "not fitting" the participants, causing individuals to exit a MAT program but reenter into a different MAT program. This was consistent with Mitchell et al.'s (2011) findings of the resilience in individuals seen to reenter treatment even though differences between participant goals and clinical goals may have

been evident, causing a broken recovery process. Not allowing the participants to be active in their treatment and providers relying on clinical outcomes caused lack of retention in MAT programs for the participants in my study.

Rules of the MAT program were found to be difficult to follow early in recovery. My study findings refuted those of Haesebaert et al. (2018) that patients played a passive role in their healthcare outcomes. The participants in this study were very active in their care decisions, although their choices may not have supported recovery in each decision. Theme 2, shattered reflections, demonstrated the negative consequences of self-perception during continued opioid use shared by all participants in this study even while in a MAT program. In part, this may be due to the stigma of treatment for OUD and in those with mental health disorders in general. This loss of self-identity ranged from overdosing to traumatic loss of children/family members, watching a friend die and being incarcerated for it, losing jobs or freedoms, not being treated for mental health disorders due to "being an addict," and committing drug-related crimes, causing a demoralization of who the individuals thought they were.

Feeling the stigma of being known as an "addict" and being stigmatized for using MAT medications (Wakeman & Rich, 2016) even within psychosocial programs is well known. There is dissention in the scientific community to defining addiction, yet the expectation is to give the patient medication and have them achieve abstinence. Theodore Dalrymple (2007, as cited in Beran, 2015) stated that it "is easier, after all, to give people a dose of medication than to give them a reason for living. That is something the patient must minister to himself." No clinical test to discover underlying causes of addiction has

been invented (Beran, 2019) or to establish what the quality of life is within OUD and treatment. Wakeman and Rich (2016) cited language used for those with addiction along with the belief that using illicit drugs as a choice leads to the lack of access to care leading to further criminalization of the OUD disorder. Moeller et al. (2020) stated there is an undermining of self-awareness of who the participants thought they were, taking the drug despite the negative consequences of this behavior, along with specific intentions to quit drug use. If the individuals do not appreciate their cognitive and emotional decline as being as serious as it is, there may be ongoing differences in who they think they are and who they wish to be.

Having behaviors inconsistent with who the participants in this study thought they were caused further changes in and demoralizing of character. In my study, environmental chaos and unbalanced living, such as the participants' own parents having addictions, partner abandonment, loss of children, introduction to and continuation of criminal life, or situations of homelessness, may have caused increased risk factors of starting and continued opioid use consistent with other studies. Multiple participants (55%) in this study had family members who were using illicit substances, had environmental ties (73%) to opioids (environment supporting drug use, becoming homeless because of the opioid use, having to live with family members, going to treatment centers), or had been incarcerated at young ages (36%) for drug-related crimes. There was no single motivating factor seen in these participants to stop the cycle of use although avoidance of having symptoms of withdrawal was mentioned frequently, and

statements of wanting to feel “normal’ by taking the MAT medication were reported, as was getting children/family back into their lives.

Reported in this study was the demoralization of who the participants thought they were while in their opioid use, and this did not exclude those individuals in a MAT program. Sussman and Sussman (2011) stated that prior to initial drug use, feelings of being different or disbalanced subside after taking drugs making those who use the drug feel self-sufficient and nurtured. Their study showed social isolation and feeling restless or incomplete in self-described individuals with substance use disorder. The need to belong was mirrored in my study supporting Sussman and Sussman’s belief of incentive to use versus not use opioids causing a temporary balance led to bad choices. This way of dealing with life’s chaos was also reflective of Kane et al.’s (2020) study showing how uncontrolled social structures prior to treatment caused a lack of “personhood.” Making that “one bad decision” in my study showed continuing opioid use caused a space where learning and preforming every day activities became less likely while responding to life stressors by taking opioids allowed the relief and stress reduction, caused desired emotional numbness, and increased pleasurable feelings (Lewis, 2017; Sussman & Sussman, 2011).

Additionally, making a poor decision is also consistent with Volkow et al.’s (2018) stance of the brain hijacking in the brain disease model leading to less inhibitory control and with Barata et al. (2019) where science has not shown self-determination or will power are “not totally preserved nor totally disrupted” (p. 143). Although opioids can make “you feel like Superman” (Participant 9) and “the magical pills can make you

disappear" (Participant 12), the ramifications of continued drug use do not allow individuals to function effectively for long periods of time outside of their drug use (Participant 11). Abstract living becomes attractive as it is a world of possibilities opened up to understanding by reflection (Husserl, 1936/1970). The participants in this study may have chosen to relapse but it is not clear if they understood exactly why they relapsed even when they considered themselves stable in a MAT program.

Lappan et al. (2019) stated that psychosocial problems may go away after substance use is discontinued. My study reflects the ability of the participants to piece together their lives during periods of recovery and build on the positive aspects of their personalities even through worst periods of their lives. One participant chose to give up an infant to adoption and allow healing of the entire family through the OUD period while in treatment. Since her recovery was based on getting her other children back, this shows the incredible strength by this individual to stay in recovery during this time.

Opioid misuse is still considered a crime and not a medical disorder (Wakeman & Rich, 2018). Three of the participants in this study were incarcerated without treatment. Taking unprescribed suboxone to prevent withdrawal symptoms was discussed in my study casually, which meant diversion of the medication by others. This is not an uncommon practice but is also seen within those communities which have no abuse liability (Loftwall & Walsh, 2014). Compliance within the community of OUD individuals is indicative of a systemic problem not specific to those with substance use disorders.

The low rates of compliance within MAT programs mimics other chronic health diseases (Mitchell et al., 2011; Wakeman, 2019), but not taking your blood pressure pills or taking them inappropriately does not hold the same stigma or legal actions as having OUD and taking a nonprescribed medication like suboxone which alleviates the symptoms of the disorder. Lack of treatment for behavioral health, which often goes hand in hand with addiction, was seen in this study consistent with other research showing higher discrimination of those with addiction and with other mental health disorders (Coperu, 2018) versus physical disorders. Connery (2015) showed that increased risk factors of substance misuse are co-occurring mental health and substance use disorders. Many participants in this study had links to anxiety, depression, and PTSD stemming from childhood traumas and neglect. Social isolation and exposure to adverse social environments have been linked to impulsivity and compulsive use of drugs (Volkow & Boyle, 2018) and this was reflective of my participants.

In a posthumously published memoir of opioid addiction with heroin, Scott (as cited in Goens & Nelson, 2020) wrote that heroin "was etched into my soul" while stating it had robbed him of his soul. This is consistent with the confusion of opioid addiction, both by those with OUD (Cooper, 2013) as well as the scientific community not being able to fully define the essence of addiction (Beran, 2019; Kuorikoski & Uusitalo, 2018). This confusion and lack of adequate definition of OUD may help explain how opioid use in a scientific model of either brain disease or a disease of choice may ignore either or both the psychological and biological factors as suggested by Ruane (1989) neglecting

the social aspect of OUD causing further shattering of self-reflection. Statements of "What is it?" when questioning the motive to relapse was reflected throughout my study.

Sussman and Sussman (2011) stated there were 40 credible citations in their search to find the definition of addiction and believed addiction to be composed of numerous elements. It is then plausible individuals remain in some type of confusion when trying to define what treatment may work best for them. In my study, the participant's confusion of relapse was stated. It would make sense to think MAT programs "not fitting" may mean not being able to see a clear path to the individual's recovery. My study reflected how the MAT medication by itself without a personal connection was insufficient in retention in MAT programs.

With a greater majority of this study's participants having environmental exposures to substance use and having a genetic propensity to use illicit substances, there was seen in this study a need for flexible treatment. Differing MAT programs may not be detrimental for the patients as the participants in my study and their high rate of reentry into different MAT programs considered MAT programs ability for "fitness" and personal connections. Since there are wide variations in MAT practices and MAT programs may be varied by provider philosophy in treating those with OUD (Baxter et al. 2015), individuals may seek out programs that hold a personal connection for retaining services.

Mumba et al. (2018) stated those with poor treatment engagement show higher distress than those participants who stayed in treatment. Feelmyer et al. (2013) stated continued use of opioids was linked to an increased number of infectious diseases, an

increase in crime, and a lower quality of life. This was consistent with my study's findings regarding criminality and lower quality of life. It is unknown regarding infectious disease rates as this was not a specific question in my research study. Overall, this population in my study admitted to minor health problems versus major health issues. These health issues consisted of anxiety, depression, PTSD, diabetes type 1, and chronic pain syndromes.

Theme 3 in my study, transcending the program, showed how each individual with OUD in a MAT program had built a foundation for the next treatment. Education and learned coping skills were utilized with the next MAT program. This may be due in part to the social rehabilitation/recovery community staying retained in a MAT program can help provide. Many participants in my study mentioned a community of recovery and this supports Allen and Olson (2015) findings of reduction of attrition to programs can occur with more supportive environments, community engagement, and to prepare the "not ready" patient to ready for treatment. My study reflected the road to recovery may not be a straight path and may hold different important aspects of recovery for each individual. With some participants in my study recovery was linked to a higher power, a desire to nurture their offspring, for some it was self-reflection, and for others it was acceptance of who they had been and who they wanted to become.

Allen and Olsen's (2015) findings also corroborates Palmer et al. (2013) study where social support was linked to retention and who cited dropout rates can be 50% or higher prior to the three-month mark. This cited dropout rate was lower than my study findings (73%) of entering a program and hours to weeks later walking out. Yang et al.

(2015) stated there was no clarity on what individuals lived through and why relapse occurred but during abstinence periods there was a high rate of life challenges, adverse socioeconomic conditions, poor family/social support, interpersonal conflicts, stigma and discrimination. Relapse in Yang et al. study (2015) focused on the negative aspects of recovery. In Yang et al. cravings were experienced but not felt to be perceived as a trigger to use. The specific symptoms of cravings were not mentioned by my study participants. However, avoidance of symptoms of withdrawal was discussed frequently.

In my study, continued abstinence was seen as difficult but "doable" if attendance in a well-fitting MAT program was experienced. Ivers, et al. (2018) found patients had great insight into relapse risk factors, but recovery was seen as a process, and not always linear. Insight was found in their study to be an underpinning of any real growth and development. My study supported the non-linear path to recovery through transcending personal beliefs of failure, wholistic healing, and entering a reflective stage of recovery by conforming to personal important outcomes and eventually following program rules.

My study mirrored another study showing how adjustment to rules and acceptance of need for the MAT program may take time. Moeller et al. (2020) reported abnormal brain functioning related to self-awareness of the need to change patterns of behavior and treatment motivation. In Lagisetty et al. (2017) report three months in treatment was needed to achieve a satisfactory quality health indicator. Participant 8 shared the period of lessening his rebellion to acceptance of the program was about 90 days. MAT programs offer a reduction of illicit opioid use time and the ability to reach sobriety or recovery allowing for better health and reduction of societal problems (Stuart

et al., 2018) and my study corroborated these findings. It was agreed by most participants in my study individual care and having positive interactions with MAT staff led to periods of abstinence and treatment satisfaction and was utilized for individuals even through relapse periods in striving to reach recovery.

Failing to be retained in one program did not mean unsuccessful treatment and the participants perspectives in my study mirrored Mitchell et al. (2011) who reported the participants would rather stay in treatment even if it were not progressing within the clinical expectations of successful treatment. My study participants would find another program with a better "fit" although this may have been done without adequate planning to avoid going through withdrawal from the MAT medication.

Farr and Rapley (2017) suggested that creating a bridge between philosophy and clinical practice has its own barriers but using existing knowledge of the biopsychosocial aspects along with evidenced based knowledge could tailor programs for specific conditions and populations.

Theoretical Framework

Merleau-Ponty and Embodiment

The theoretical foundation guiding this study was Merleau-Ponty's phenomenology of perception and embodiment regarding habits. Embodiment, as defined by Merleau-Ponty, is the fusion of the body and soul entangled that cannot be separated. Humans, become aware of the world through bodily experiences by our motricity (motor function/physiology) and the body's ability to be sense giving. Perception and the body's experience of being in the world are the ways human beings understand their lives.

Treated in a MAT program within my study of participants with OUD was the avoidance of withdrawal with confusion about why the relapse occurred when stable on a MAT medication. There was a rhythm to their recovery by acknowledging the relapsing, changing of their perspectives, and eventually the transcending acceptance of who they were and what the participants had been through while in a MAT program.

Describing habits, Merleau-Ponty (1945, p.143) stated was "*reworking and renewal of the body schema*" (integrated system of sensory-motor capacities situated under habitual bodily actions). In opioid use habits, the body adapts to the meaning of drug taking and becomes conscious of what behaviors are needed to bring the "*self to equilibrium*" (Merleau-Ponty, 1945, p.155). Although opioids can make "*you feel like Superman*" [Participant 9] and *"the magical pills can make you disappear*" [Participant 12] the ramifications of continued drug use do not allow individuals to function effectively for long periods of time outside of their drug use [Participant 11]. Abstract living becomes attractive as it is a world of possibilities opened up to understanding by reflection (Husserl, 1936/1970).

Merleau-Ponty's (1945, p. 151, 153) belief of habits forming due to the body's ability to absorb new things into it and then normalize the environment with the new input explains this. "*Every habit is simultaneously motor and perceptual because it resides…between explicit perception and actual movement."* Since opioid use is considered a part of daily life by the individual's body and mind, things in their environment become connected to the use of opioids. This became normalized for the individuals in this study, each having their own rhythms of drug use, of triggers, periods

of sobriety, and relapse, who had to relearn who they were without the opioid when recovery living was sought.

Husserl (1936/1970, p. 31) explained habits as, "The things of the intuited (knowing by intuition not by experience) surrounding world … have … their 'habits' - they behave similarly under typically similar circumstances." These two philosophies may help explain why those with OUD within a treatment program appear to have individual rhythms of recovery yet hold similar patterns of relapse. My findings support the body and mind are not separate entities in addiction as both were reported key players in the confusion of relapse and avoidance of withdrawal while both play an active role in recovery. The body as well as the mind perceives its need to achieve equilibrium and intuitively seeks out "normal" creating a pattern of lived experiences by those suffering through OUD. My study also supports the theory of cognitive decline, having a positive linear link to continued harmful use, relapsing (Sheth et al., 2018), and not being able to achieve abstinence by diminished insight of the need for change (Moeller et al., 2020) regardless of the psychosocial cost to the individual.

Limitations of the Study

One limitation was the sample size that was limited by the participants who volunteered but did not show up for the interview. The no shows (63.6%) represented individuals who stated they were interested in the study and would like to add their voice (27) but offered no further follow up by contacting my university email account. There were multiple offers which could not be accepted such as wrong region of the United States or the wrong opioid treatment program.

Another limitation was my inexperience as a researcher. In was my inability to regain control of the interview when the conversation was straying from the research question. The participants' stories were at times hard to listen to. There were several opportunities that I missed to inquire further into their answers due to my lack of experience. Examples of missed opportunities would be better defining what emotions such as "hopeless" and "not ready" meant as well as situations such as homelessness and faith-based treatment meanings were and how this effected the ability to be treated and retained in a MAT program.

A third limitation is that it became difficult to separate the nurse from the researcher. The initial interviews felt stilted as I tried to direct the topic away from the actual opioid use fearing this would result in a trigger to use. It was when I stated the research question and said, "but why don't you begin with where you feel comfortable," I felt the power shift from me to the participants. If the initial participants had not been so open in the beginning of their journey into the opioid world of addiction, I would have felt I had failed them by letting my fears of individuals of the research being triggered to use opioids as well as the IRB restrictions obscure the interviewees lived experiences.

This study took place in the Midwestern United States so transferability may be possible due to the depth of description of each unique individual and their experiences to other groups having the same characteristics. Purposive sampling limited the type of participants with OUD treated in a MAT program. However, purposive sampling was most appropriate method to recruit the participants needed for my study.

Participants may have embellished their lived experience; however, confidentiality was maintained to promote honest responses from the participants (see Rubin & Rubin, 2012). Two participant responses were different than the rest of the participants and are considered outliers in terms of their responses. One of the two participants had not experienced OUD for a lengthy period and stated it was easy to come off methadone with family support. A second participant had been on long term opioids for treatment of an injury and misused the prescribed opioids, was later started on methadone and he stated weaning was not difficult. Both stated they had never relapsed. These cases were conflicting with what eight participants were who had reported relapsing. The finding of Participant 6 suggests the period for early addiction may hold a key for early recovery in the former, and "have a valid reason for living" not to relapse in the latter (Participant 4)**.**

Recommendations

Recommendations for future studies may involve studying OUD relapse longitudinally within a participant group who attended MAT programs. Further qualitative studies might shed light on patient perspectives of the effectiveness of different OUD programs in retaining participants using focus groups or interviews methods. Quantitative studies might also provide an understanding of the impact of MAT programs on OUD treatment outcomes compared by race/ethnicity, gender, specific drug type, or geographic region. Comparing OUD treatment relapse potential to other types of chronic treatment relapse may also benefit practice and science given that MAT services have become more widely accepted. Additionally, a mixed methods study may lead to

further understanding after research has made evident more of the factors needing to be quantified or correlated to the findings. There is a pattern of loss such as self-identity, employment, freedom, housing, children, family, life, and self in the rhythm of recovery described by participants as periods of sobriety and relapse, shattered reflections, and transcending the program as well as in all the coding levels extending into the categories except "not being ready". It remains unclear in this research what the root meaning of this statement is. Future research may be conducted to examine the essence of this phrase to see what is below this pattern.

Further quantitative research is needed on quality of life for those with OUD in a MAT program. There is a need for an instrument that measures quality of life for those with OUD to determine factors significant for patients to retain care (Allen & Olson, 2015; Strada et al., 2017). Relapse intervention and advancements in retention should be further examined so individuals could better understand the cycling of relapse and factors leading up to these issues which affects retention and overall health outcomes.

Implications

Implications for Social Change

This study provides an avenue to social change by increasing knowledge of why individuals with OUD may choose to engage in a MAT program. The findings of this study provided information on how decisions were made by individuals to opt out of or reenter a MAT program. Retention of participants in this study who had stayed in one MAT program were poor and corroborated other researcher's findings (Smyth et al., 2010; Williams et al., 2019; Williams et al., 2020). Patients who opt out of treatment fail

to get the benefits of MAT services. This failure to retain patients is linked to increased morbidity and mortality along with higher rates of infectious disease (SAMHSA, 2019).

Implications for Practice

Failure to stay in one MAT program did not appear to be a factor in choosing another MAT program due to the differences and unstandardized treatment protocols which may have hold a different "fit" for the participants. Standardizing MAT programs should occur only after factors become known and are consistent with retention in a MAT program. Science may better be defined through research (Gilbert, 2004) regarding what the patients already knows. Understanding the patient perspectives have been linked to better health outcomes (Sharma et al., 2017) and shows a commitment to improved health outcomes (Vahdat et al., 2014). Healthcare in the United States historically has not included the patient's perspective in creating a plan of care (Frank, 2018).

Further understanding patterns of emotions, trauma, balancing relapse with recovery leading to opting out of, reentering, or staying in a treatment program may help to retain patients in MAT program services and gain clinical understanding on why individuals with OUD make the choices they make during their recovery (Bech et al., 2019; Hser et al., 2016). Allowing the patients to voice their opinions in their treatment may prevent attrition linked to impulsive damaging health behaviors, overdosing, and deaths by longer retention in MAT programs (Williams et al., 2019).

Conclusion

The lack of knowledge of patient's perspectives are both an historical and a present problem in health care (Anderson & McCleary, 2015). Prior to this study, there

was little information regarding patient's perspective on being in a MAT program (Sola et al., 2019). I chose a qualitative phenomenological method because there was a lack of information and insight into the complexity of lived experiences of those individuals with OUD who have been treated in a MAT program. My findings added to the scientific knowledge of how people with OUD live with their experiences to opt out of or reenter treatment services. My study offers new information about a patient's perspective on being in a MAT program which may lead to further retention of MAT services once reentering a program that "fits" the individual's needs.

I sought to answer the question of how individuals who live with OUD experience being treated in MAT programs and how they experience staying in, opting out or reentering MAT programs. I used an algorithm-style guide to conduct the semi-structured interviews because I am a novice researcher and this method provided clear directions for which questions were appropriate for each group of participants (those who entered and remained in a MAT program, those who had chosen to leave after being treated, and those who were treated in a MAT program but returned to the same or a different MAT program.

My findings revealed the experiences of individuals with OUD and retention in a MAT which occurred in some participants after opting out of previous programs. My findings confirmed that confusion exists among participants of why relapse occurs even if they were on a MAT medication. Participants in this study described being in a rhythm of recovery with multiple relapses or attempts at sobriety. Each had their own reasons for ceasing opioid use. Some stopped using opioids for family or for themselves. Connecting

with counselors, especially counselors who had personal experience of OUD, were seen as helpful versus having educational information “thrown at” them. Believing in a higher power for some of the participants was seen as helpful in remaining in recovery and allowed for self-reflection. Better outcomes from the patient’s perspectives may be initially more difficult to understand due to lack of historical reference to MAT program interventions (Anderson & McCleary, 2015) as well as stigmatization of OUD and the treatment of OUD (Livingston et al., 2012). Patients with OUD within a MAT program, are the experts of this phenomenon and should have their perspectives known (Larsen et al., 2019).

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Appendix A: Interview Guide

Time:
Date:
Name/Pseudonym/Number:
Alternate Name/Number
General location:

Hello and Welcome,

My name is Lynda Maxfield. I am a student at Walden University. You responded to the flyer and expressed your interest in being part of the research study I am conducting. I hope to hear your story of how you made your decision to stay in or leave a medication assisted program when you were treated with methadone, suboxone, or naltrexone. This study concerns your story, there is no right or wrong way to answer questions, and you should not feel any pressure to answer any particular way. The purpose of this study is to hear what you have experienced with medication assisted treatment, if you stayed in or chose to leave treatment, and how this choice affected you, if at all.

You have a consent form to sign before we can start the study. The consent form tells you this is voluntary interview and the information you give will be kept confidential. Please be aware the student researcher is a mandatory reporter and incidents of child abuse and self-harm along with involvement with human trafficking must be reported. You will be given a number to preserve your identity. You may stop the interview at any time without any negative consequences. If you have any questions, or something does not seem clear, we can go over this now or at any time. Your signature gives your permission to be part of the research study. This is not connected to any form of treatment you are receiving. This is a research study only and does not affect your care.

Is it okay if we record the interview? I would like to listen to you without missing parts of your story and I may miss something if I try to write everything down. I still will occasionally take notes to highlight those things I want to learn more about or to clear up any questions I might have. Also, in the event the recorder stops working, I will still have notes to follow. Your experience is what allows everyone who reads the study to have a better understanding of how the decision of staying in or leaving a medication assisted treatment program may be made. It is important that I tell your unique life story. This is your experience, and you are the only one who can tell it. The interview may take 1 – 2 hours (this includes a follow up meeting to discuss your transcript if you choose to do this). If you feel you have more to say, we can extend this time or follow up on a different day. I realize you may be busy.

The interview will have initial questions and may have some follow up questions. You may refuse to answer any question (s) or come back to that same question at a later time. I will start by asking some general questions.

Okay, you have signed or verbally given the consent to be in the study. Do you have any questions? Is it okay if we begin? Okay, I will now start the recording.

Branching or Adaptive Interviewing with an Algorithm

You say you are/have:

First Function: (left on the algorithm)- Currently in a Program

1) Are you currently in a MAT program now receiving Suboxone, Vivitrol, or Methadone?

2) What determines your decision to stay in the program? (prompt - Could you tell me more about this?)
3) What could you say to others who might be in your shoes and are thinking of entering into a MAT program?
4) What emotions are you feeling as you choose to stay in the program?
5) Do you feel your words and experiences could make a difference to someone else or your younger self going through the same thing you are going through? (Why is this?)

Second Function: (right on the algorithm) – Exited out of a MAT program

1) Have you ever chosen to leave a MAT program?
2) What determined your choice to leave the program?
3) What would you say to others in your shoes if they told you they were thinking about leaving a MAT program?
4) What emotions were you experiencing as you made the decision to leave the program?
5) Do you feel your words and experiences could make a difference to someone else or your younger self going through the same thing you are going through?

Center Function: (middle of algorithm)- Reentering a MAT program

1) If you have been in multiple MAT programs, was the decision to leave the program the same each time you left a program? (Prompt – what emotions, if any, were attached to this decision?)
2) If you have chosen to stay in a program, could you tell me why?

3) What was the biggest reason you have (had) for staying in the MAT program? (Why was this the most important reason to you?)
4) When faced with the decision to stay or leave a MAT program, what emotions were you feeling at the time the decision was made?
5) Do you feel your words and experiences could make a difference to someone else or your younger self going through the same thing you have been through?

Debriefing

We have now entered into the debriefing part of the interview which just means nearing the end of our talk. Over the last ___ minutes we have discussed your experience of OUD and being in a MAT program. What I heard you saying was __. Is that correct? Are there any questions you think I should have asked or that I should have asked better to answer the interview's main question – which was what was your experience of OUD and being in a MAT program? I just want to touch base with you and bring you back to the present. Sometimes having to discuss this topic may cause triggers and I certainly don't want that to happen. You are encouraged to reach out to your counselor or support person to discuss any issues this interview may have caused for you. Thank you so much for telling your story. Thank you so much for being in this research study. If there are no further questions or comments, I will stop the recording.

Appendix B: Demographic Grid

Unique ID	Age range	Gender	Stayed in	Opted out	Reentered	Childhood/ adult trauma	Relapsed	Emotion Tied to Decision RE: MAT Program(s)
P#1	41-58	F	Y (same program after a 2-week relapse)		Y	Y	Y	Ashamed of relapse/loss/fear Having a connection/peace Faith based
P#2	33 44	F			Y	Y	Y	Pissed-Scared/grateful/not ready 1st program/2nd program) loss/needing personal connection
P#3	26-32	NB	Y (transitioning to new program)		N	Y	NM	Sad/not willing to see others being treated badly, anger, loss
P#4	18-25	M	N/A	Y		NM	N	In control of myself/denial/sad
P#6	18-25	F	N/A	Y	N	NM	N	Needed to find true healing/sad Fear/loss
P#7	33-40	F			Y	Y	Y	Multiple programs–not ready Grateful/loss/anger
P#8	33-40	M			Y	NM	Y	Worried/grateful/not ready/unheard (1st program/2nd program)
P#9	33-40	M			Y	Y	Y	Multiple programs–Not ready Want to have a life/loss/anger
P#10	33-40	M			Y	Y	Y	Multiple programs – Not ready, stopping for others not myself/miracle Faith based/grateful and thankful (current program)
P#11	41-58	F			Y	Y	Y	Scared/hopeless/helpless/not ready First & second program/3rd MAT program - Accepted
P#12	18-25	F			Y	Y	Y	Multiple programs – Not ready Faith based living now in program – Life changing

Note. Y = yes; N = no; F = Female; M = Male; NM = not mentioned; NB = Nonbinary; N/A = not applicable.

Appendix C: Thematic Grid for Theme 1 – Rhythm of Recovery

The Journey to get to Addiction and Treatment

"*…my life is made up of rhythms that do not have their reasons in what I have chosen to be*" (Merleau-Ponty, 1945, p.86)

Categories		
Relapsing into Recovery	Damaging Balance	Loss (merges into every code)
Second Pass Codes		
Over and over and over		no good place
confusion		
Staying clean		
Keeping the needle outta my arm		opioids and normalcy
pissed and scared		
First Pass Codes		
Avoiding dope sickness		**"**sick and tired"
"First true love" (heroin)		
Trying/not trying		failure to achieve
"Everyone was messed up"		
Unbalanced		"rhythm of addiction"
Living in the solution, maybe I won't die		

Emotions

Anger
Fear
Regret
Unsteadiness
Failure
Giving up
Not committed
Fed up
Love
Confusion
Loss

Appendix D: Thematic Grid for Theme 2 – Shattered Reflections

The Changing of Myself

"*Each of us has our own appearance and for each of us they count as that which actually is*" (Husserl, 1936, p.23)

Categories

Necessary Resilience | Secrets, Degradation, and Shackles | Dodging bullets | Don't Ever Give Up

Second Pass Codes

Over and Over and Over	Unbalanced	What I would tell my younger self (or others)
All your morals and values	Not ready	Running and Numbness
The way I was treated		I would walk away
Choices- that one bad decision		
Staying stable		Failure on my shoulders
Dishonesty and the trouble with it		

First Pass Codes

Drove him to the dope man	not forever loyalty
Still, I relapsed	buried crap
You'll be okay	I would walk away
They should have known	abandoned
That wasn't me	A family affair
Fired and arrested	Trauma

Emotions

Loss	
Anger	Fed up
Love	Confusion
Fear	Humiliation
Regret	Disappointment
Unsteadiness	Persistence
Failure	Unheard
Giving up	
Not committed	

Appendix E: Thematic Grid for Theme 3 – Transcending the Program

"*for all my truths are, after all, only evident truths for me*" (Merleau-Ponty, 1945, p. 418)

The Journey to Recovery by Looking Backward

Categories

Personal connections/A higher power | True Healing | Don't ever give up

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Second Pass Codes

Recommitment
Wasn't ready
Dodging bullets
Proud of who I am

Imperfect life -that's okay
Assimilating - looking back…looking ahead
Failure on my shoulders

First Pass Codes

Dying…again
Broken rules
First month is dangerous
Double life

That one bad decision
Faith based
complacency in recovery
Today is a gift

Emotions

Anger	Giving up/Giving in	Hopeless/Hopeful
Not committed	Fear	Believing
Acceptance	Regret	Personally connecting
Love	Reflecting	Peaceful
Unsteadiness	Loss	Failure
Happy		