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A Phenomenological Study of Methadone Treatment by Opiate-Dependent Individuals Ages 50-55 Years

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Abstract

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MSW, Western Michigan University, 1985

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Dissertation Submitted in Partial Fulfillment

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Abstract

Today's methadone patients differ from those of the past due to increases in polydrug use, mental health issues, and medical needs. Patients requiring methadone treatment for their opiate addiction are now older than those who initially presented for treatment when methadone treatment first started. The number of older opiate users will continue to grow as the population continues to age. Although previous studies on opiate addiction focused on using methadone in treatment of younger adults, this study used phenomenological methodology to explore the lived experiences of opiate addicted methadone users between the ages of 50 to 55, an understudied population. A sample of 8 older addicts from the Midwest, using methadone in their treatment, provided data collected in face-to-face interviews for this study. Content analysis of the data was conducted with the assistance of NVivo 11 to code and identify categories and themes. Emergent themes included: the impact of methadone use on participants' relationship with others, participants' attitude of being an older methadone user, mental health stressors related to being an older methadone user, struggles in attending the methadone clinic daily, and needing other treatment besides treatment for methadone use. The study impacts social change by informing addiction professionals who may want to develop appropriate treatment interventions for this population.

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Dedication

This dissertation is dedicated to my Lord and Savior Jesus Christ. Through him all things are possible. To Oscar and Robin, thank you both for teaching me about what you as older addicts needed to stay clean and sober. You overcame that day.

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I want to thank everyone who helped, inspired, encouraged me, but more importantly stood by me throughout my doctoral journey. To my late parents Dorothy and William. You instilled in me the importance of getting an education. To the love of my life, Nancy, you are the wind beneath my wings. To my children, William and Elizabeth. I am proud of the adults you have become. To my friends and brothers at the Jellema House, Derrick and Johnny. I appreciate you more than you will ever know. To my colleagues at the Southwest Clinic. Thank you for your prayers and encouragement telling me that I can do it. To my Oakdale CRC family. Your prayers lifted me up and helped me keep my eye on the prize. To two very special people, Veneese and Bernice. To Danielle Hopwood, my transcriptionist and data interpreter. You helped me interpret what I learned. I always felt your prayers and heard your words of encouragement. To my academic advisor, Joe Underwood. You helped me navigate some choppy waters. To my supervising committee members, Dr. Barbara Benoliel (chairperson and context expert) for her consistent thoroughness, rigorous guidance, strong support, and tireless persistence. Dr. Jason Patton (methodologist) for his steadfast brilliance, kind understanding, and most importantly, for his accurate and reliable assistance. Dr. James Castleberry (university research reviewer) for his hard work, genuine cooperation, and unwavering support throughout the entire dissertation process. I want to express my deepest appreciation to the professional guidance and able direction provided by the Walden family. You made my dissertation stronger. I also thank you for being there when I needed you. To my editor, Sonia Castleberry. Thank you for getting me across the finish line. Finally, I want

to profoundly thank all the participants in this study for their willingness to share their life stories and unselfish cooperation during the data collection process.

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Chapter 1: Introduction to the Study

Drug addiction is increasing in the United States. According to the National Institute on Drug Abuse (2011), in 2010 more than 23,000,000 Americans age 12 years and older had used some type of illicit drug or abused psychotherapeutic medication. According to the Substance Abuse and Mental Health Services Administration (SAMHSA, 2014), illicit drug use in older adults increased 3.4% in 2002 to 7.9% in 2013. Among individuals ages 55–59 years, the rate of current illicit drug use increased from 1.9% in 2002 to 5.7% in 2013. Among individuals ages 60–64 years, the rate of current illicit drug use increased from 1.1% in 2003 and 2004 to 3.9% in 2013 (SAMHSA, 2014).

Opiate dependency is becoming a major issue. From 2000 to 2010, opiate use and dependency nearly tripled (SAMHSA, 2011). Among people ages 50–59 years, the rate of illicit drug use including opiates went from 2.7% in 2002 to 5.8% in 2010 (SAMHSA, 2011). This increase also reflects more people with an opiate addiction seeking treatment. Treatment admission for opiate-addicted clients increased 271% between 1995 and 2005 (SAMHSA, 2011). Figure 1 illustrates the increase of opiate use among older adults over a 10-year period.

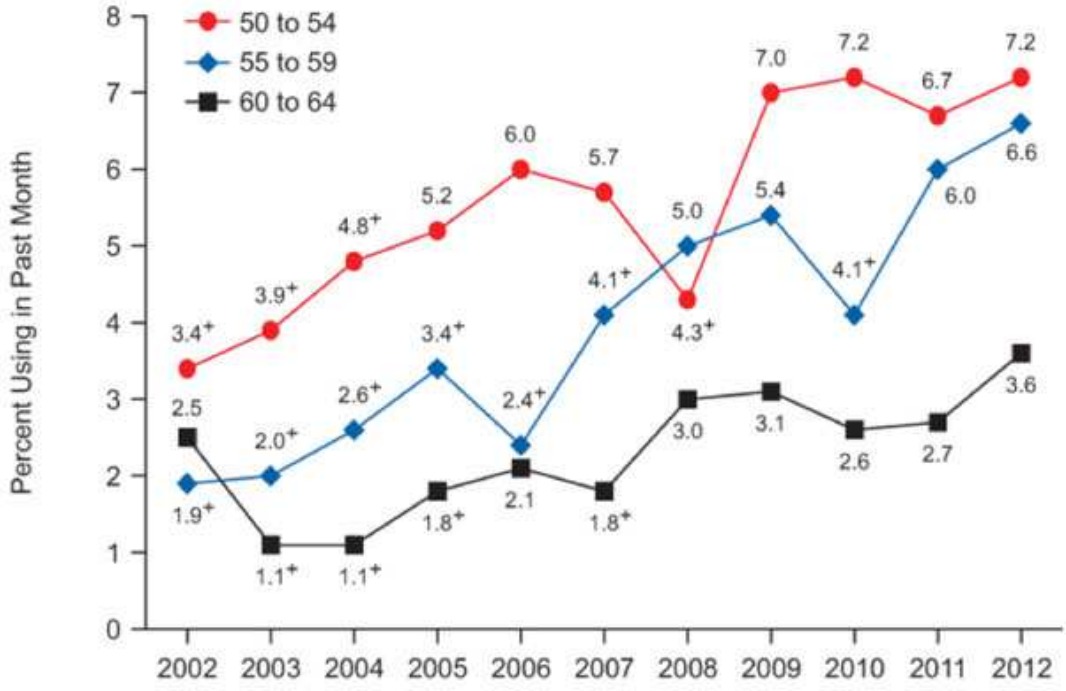

Figure 1. Opiate users by age, 2002–2012. Adapted from *Results From the 2013 National Survey on Drug Use and Health: Summary of National Findings*, by the Substance Abuse and Mental Health Services Administration, 2013, p. 24. Copyright 2014 by the Substance Abuse and Mental Health Services Administration.

Many people who were addicted to drugs and alcohol are now experiencing successful abstinence from their addiction and are living a life of recovery. According to a 2007 study by National Institute on Drug Abuse, there was an 86% abstinence rate after 3 years of recovery (National Institute on Drug Abuse, 2011). Previous research regarding addiction has shown that opiate addicts continue to use substances long after being involved in treatment despite the high death rate associated with opiate use (Scherbaum & Specka, 2008). However, there is a positive correlation between individuals taking methadone and staying in treatment. This correlation is attributed to the need for long-term management for opiate addiction (Bart, 2012).

The concept of recovery is sometimes unclear and difficult to define. T. McLellan (2012) indicated that many people, professionals, and laypersons use the term *recovery*, but there is no standard definition for the term. T. McLellan noted that in 2006, the Betty Ford Institute presented a working definition for recovery in order to dialogue about its meaning. The institute defined recovery as "A voluntarily maintained lifestyle comprised of sobriety, personal health, and citizenship" (Betty Ford Institute, as cited in T. McLellan, 2010, p. 137). This definition was consistent with experts who also saw recovery in the same manner (Belleau et al., 2007).

Others have indicated that in order for addicts to be successful in their recovery, they must be abstinent from their drug of choice for at least 2 years (Del Toro, Thom, Beam, & Horst, 1996). Recovery is seen as the primary reason for treatment in most behavioral health care policies (Institute of Medicine, 2006). This is especially true when examining government-funded service initiatives, such as the Center for Substance Abuse Treatment's Community Support Program and Access to Recovery Program, as well as community programs that work to develop recovery-oriented care (White, 2009). Individuals who are involved in recovery often need additional support such as a 12-step program or a relationship with a higher power (Laudet, 2007). De Maeyer et al. (2011) concluded that it was important to support opiate-addicted individuals in their daily lives by providing them practical, social, and environmental support in addition to their methadone use to improve their quality of life.

Methadone treatment dates back more than half a century, and programs for methadone clients are seeing people older than ever before (Marion, 2005). Using a small

clinical trial to demonstrate methadone's effectiveness, Dole and Nyswadner developed a new approach to opiate addiction treatment (as cited in Kuehn, 2005). Their research suggested that doctors could use medications to help control addicts' cravings and withdrawal, which often led to relapse in individuals with opioid addiction. Their work began to give credence to the idea that opioid addiction is a chronic disease, similar to diabetes, requiring long-term treatment. Methadone is the primary medication for treating heroin addiction (Mattick, Breen, Kimber, & Davoli**,** 2009). Addicts are given a daily dosage of methadone as it remains operational in their system for 24 hours, blocking heroin's euphoric properties (Jaffe, 1990). Methadone continues to be the most accepted treatment for opiate addiction. Under the supervision of trained medical professionals, methadone has been shown to provide effective treatment for people addicted to opiates (Amato et al., 2005).

Although several countries use methadone for treating opioid dependence, there has been some discussion about its effectiveness. Methadone helps opiate addicts reduce their withdrawal symptoms and has been seen as a lifesaver for many people (Bart, 2012). However, it is not an addiction cure-all. Research has shown that some addicts use other addicting drugs such as cocaine and benzodiazepines while engaging in other disruptive behaviors that affect their treatment (Kleber, 2008). Keys (2008) noted that there has been significant debate about the reasons addicts continue to use opiates and indicated that addicts seek a feeling of euphoria or they are trying to avoid the pains of withdrawal. When opiate addicts fail to complete treatment or have a negative attitude about methadone, they are at higher risk of relapse (Keys, 2008). Gossop, Stewart,

Browne, and Marsden (2002) studied relapse involving heroin users and learned that addicts who failed to complete treatment or had a negative attitude about methadone were at a greater risk of relapse than those who were successful in treatment.

In their study on addiction, Stephens, Roffman, Fearer, Williams, and Burke, (2007) noted that one reason for people not seeking treatment was that they were not ready to stop using their drug of choice. Orr-Brown and Sibert (2007) noted that if child welfare or other systems order people into treatment, they are resistant to treatment if they do not want to change. Collins and Slesnick's (2011) study on motivation for discontinuation showed that people were reluctant to change despite the consequences of their continued usage. Methadone has been the most studied treatment modality for opiate dependency, and previous studies have shown it has been effective (Clausen, Anchersen, & Waal, 2008; Degenhardt et al., 2011; Mattick et al., 2009). However, research and treatment recommendations regarding methadone treatment for individuals age 50 and older are lacking. Although the literature review conducted for the present study revealed that many researchers have studied methadone treatment as well as addiction and its impact on society and families, I found little about methadone use and older adults. Without this information, human service professionals cannot adequately meet the needs of older individuals on methadone.

Purpose of the Study

The purpose of the present study was to assess the relationship between methadone maintenance and the life experiences of opiate users ages 50–55 years. I examined an underserved area in opiate addiction that also reflects an aging population.

Ten percent of people involved in some type of methadone treatment are age 50 years or older (Gossop & Moos, 2008). As methadone users age, treatment providers and others may need to review the physical and mental health and the continued illegal drug use among this population. Further, results from this present study can be used to help treatment providers determine the best modalities for helping opiate-dependent clients, particularly older opiate addicts who seek assistance in treating their addiction to opiates and other drugs.

Research on methadone treatment and substance abuse among the identified population may help change the negative stigma associated with older addicts. Understanding the interconnectedness of older addicts' needs is necessary for providing adequate care for this particular population. Researchers, legislators, and treatment providers may benefit by understanding the lived experiences of older opiate addicts. With the changes in methadone practices and policies over the years, research on this particular population may provide some clarity on the impacts these changes will have on continued methadone use.

Significance of the Study

There continues to be a significant gap in the treatment of addiction in the United States. As previously stated, 23,000,000 Americans acknowledge a need for treatment, but only 2,5000,000 addicts receive treatment (National Institute on Drug Abuse, 2011). Older adults in the United States consume over one third of all prescriptions drugs, which may place them at risk for developing a substance abuse problem (Gossop & Moos, 2008). Greater rates of lifetime drug use among older drug users combined with increases

in the aging population suggest that there will be a growing number of older people who may misuse or abuse drugs. Older opiate addicts, who began using early in their lives, are now aging and are changing the demographics of people needing substance abuse treatment (Rosen, Smith, & Reynolds, 2008). Reported drug use among older adults places greater demands on treatment programs (Ayres, Eveson, Ingram, & Telfer, 2012). Given the indications of increased drug use by older drug users, there needs to be a way to monitor the impact their drug use has on their lives and their communities. Research has shown that there is a major difference between people who receive therapy before age 25 years and those who first come into treatment at a much older age (Chi et al., 2014).

Methadone treatment programs are now working with older individuals who also present themselves with other significant problems such as complex health issues, transportation issues, and financial issues (Doukas, 2011). Methadone's ability to decrease early deaths in opiate addicts has caused some people to stay on methadone for years (Doukas, 2011). Given the small amount of research specific to older methadone users, the present study's focus was on examining their lives and understanding what it means to be an older addict dependent on methadone. I examined the lived experiences of older adults on methadone to help treatment providers meet the needs of this growing population.

Little research exists regarding this population; therefore, this study is important to the addiction field as it increased the understanding of older opiate users and their specific variables such as family, medical and legal issues, and other relationships. Study findings can help promote changes through improved understanding of methadone use

among older adults. Study results can help inform substance abuse therapists and future areas of research. It was my hope to further the understanding of what is happening with this population and how society reacts to older people addicted to opiates.

Problem Statement

Studies have shown that heroin addicts who do not use methadone have a greater chance of relapsing or dying due to their drug use (Bell, Trinh, Butler, Randall, & Rubin, 2009). With the exception of addicts who quit treatment in the beginning of their methadone therapy, those who stayed in treatment were able to maintain their sobriety longer than those who failed to use methadone (Bell, Trinh, et al., 2009). Although methadone has successfully been used as a major therapy tool for people addicted to different opiates, some questions remain regarding its long-term use (Ducharme, Knudsen, & Roman, 2006). Though relapse occurs for people addicted to alcohol and other drugs, opiate addicts are more likely to relapse than those addicted to other illegal drugs and alcohol (Marissen et al. 2006). In researching the literature regarding opiate use, I did not find much information regarding long-term methadone use in the older population.

With the increase in dependency on prescription pain medications, as well as the increase on other pharmacological remedies for addiction, additional treatment methods are needed to address long-term recovery for opiate users, particularly older opiate users. Doukas (2011) noted that as methadone treatment has entered its sixth decade, programs that provide services to this population are now treating clients who are in their 50s, 60s, and 70s.

Research Questions

The present study's focus was on understanding the lives of older people addicted to opiates using methadone treatment to overcome their addiction. Two research questions were formulated to guide this inquiry. First, what are the lived experiences of opiate users ages 50–55 years who take methadone to manage their addiction? A follow-up question was how do these same individuals remain consistent in their methadone treatment so that they can stay in recovery? Second, how do opiate user ages 50–55 years relate their particular experiences to the idea of recovery?

Conceptual Framework

The primary theoretical framework in this study was from Beck, Wright, Newman and Liese (1993), who developed a treatment modality for addicts using cognitive behavioral therapy (CBT). According to Pascoe (2008), the combination of behavioral and cognitive therapy created CBT. CBT is a psychotherapeutic approach that works to change clients' behaviors by having them develop specific goals to meet their needs (A. C. Butler, Chapman, Forman, & Beck, 2006; Epstein, Hawkins, Covi, Umbricht, & Preston, 2003; Shah, Scogin, Presnell, Morthland, & Kaufman, 2013). CBT is not one specific approach to therapy but includes several approaches that share similar theoretical frameworks (MacLaren, 2008). These frameworks involve a variety of methods and therapeutic systems such as rational emotional behavioral therapy, cognitive therapy, and behavioral activation (Dobson & Dozois 2001).

Therapists use CBT to treat a variety of problems including mood disorders, anxiety, and eating disorders, as well as addiction (Cooper, 2008). When using CBT for

addiction treatment, therapists view substance dependency as a learned behavior acquired through experience (Pascoe, 2008). Therapists may use CBT in individual and group therapy as self-help applications for relearning or changing peoples' thought patterns, emotions, and habits (Kadden, 2002).

CBT's framework is based on the idea that people's problems result from their maladaptive or negative thinking that influences their emotions and behaviors (O'Donnell & Cook, 2006). Conducting a study on CBT combined with methadone treatment, Kouimtsidis, Reynolds, Coulton, and Drummond (2012) concluded that addicts who used methadone and CBT gained coping skills that helped them remain abstinent after 12 months. Kouimtsidis et al noted that clients who underwent CBT increased their problem-solving skills and sought alternatives to their drug use. Kouimtsidis et al. showed results similar to a previous study on CBT in group therapy where addicts showed improvement regarding drug use, employment, and other aspects of their lives after 6 months (Scherbaum et al., 2005).

CBT does not immediately eliminate drug use, but based on the Addiction Severity Index (ASI) this approach helps reduce their dependency over time (Epstein et al., 2003). One of the reasons for the improvement of dependency over time is that CBT focuses on present, not past behavior (O'Donnell & Cook, 2006). Using CBT for substance abuse clients involves identifying such issues as the severity of their addiction, the extent of their problems, their motivation for change, and the therapeutic relationship (McCrady, 2001). CBT further involves helping the client engage in self-monitoring and honesty as it relates to any drug use, including the amount consumed and the regularity of

use. Working with addicts over time will help them identify and eliminate other triggers that lead to drug use and abuse.

Therapists should encourage CBT clients to make changes based on their thoughts and belief systems. As clients' belief systems help them achieve their goals, therapists should not dictate who the clients are or how they should be. CBT can help addicts cope with life more effectively by learning and relearning the way they think, feel and behave, which is consistent with how they want people to see them (Pascoe, 2008).

Harm reduction has been one of the most influential ideas influencing drug treatment policies since the early 1980s (McKeganey, 2011). The idea of harm reduction began in the 1970s when Sobell and Sobell (1976) endorsed previous research that indicated some addicts were able to control their drinking after completing treatment. Methadone as a tool for harm reduction has been used in European countries since the late 1960s (Jarvinen, 2008). Early treatment in Europe was similar to that in the United States in which abstinence was the only goal for any drug regardless of what the addict wanted. The prevailing view in the United States has long been against any type of maintenance and has held methadone treatment as the addict continuing to engage in drug use (Drucker & Clear, 1999). Some drug courts have insisted that defendants on methadone reduce their usage or agree to become totally abstinent (Csete & Catania, 2013). This position has given way to methadone treatment being stigmatized and misunderstood. Methadone treatment needs to become a standard psychopharmacological treatment for heroin dependence and an important tool in harm reduction.

Nature of the Study

The nature of this study was qualitative, which involved collecting data by interviewing methadone maintenance clients ages 50–55 years involved in a methadone clinic for at least 2 years, and who had been sober for at least 1 year. In addition, I conducted interviews with clients and gathered information regarding their history of use, relapses, length of time on methadone, any relapses while using methadone, and other treatment modalities they had used while taking methadone. Interviewing these clients provided information regarding how they perceive their lived experiences, addiction, and treatment experiences. The population I researched came from methadone programs in West Michigan. These programs have a large methadone population to choose from which allowed me to use a hermeneutic phenomenological approach in which participants described their experiences that I interpreted to understand their experiences on methadone and its significance in their lives.

Definitions

Addiction Severity Index: The Addiction Severity Index (ASI) is a tool used in the field of addiction. Clinicians interview potential clients and gather information covering seven specific areas in their lives: legal, employment, relationship, alcohol, drug, psychiatric, and medical (Alterman et al., 1998; S. F. Butler et al., 1998). These seven areas serve as a rational inductive basis for the ASI items and their aggregation into scales (McLellan et al., 1992). The ASI can cover a person's lifetime. However, the interviewer summarizes each of the fields using the composite scores for the addicts' previous 30 days to assess their problems levels when they are ready to enter treatment

(Bovasso, Alterman, Cacciola, & Cook, 2001). The ASI is seen as reliable, valid, and consistent from intake to follow-up regardless of gender, age, race, or drug of choice.

American Society of Addiction Medicine: The American Society of Addiction Medicine (ASAM) is an organization for physicians with a focus on addiction and its treatment. The ASAM criteria are a broad set of strategies therapists use to place addiction clients in treatment and to discharge them (Kosanke, Magura, Staines, Foote, & Deluca, 2002). The ASAM criteria, also known as the ASAM patient placement criteria, are the most renowned professionally developed guidelines for ensuring addicts are placed in the correct level of care (Hays, 2006; Magura et al., 2003; Mee-Lee, 2013). The criteria allow therapists and others to evaluate and determine the severity of the client's needs based on the six dimensions (Hays, 2006). The criteria are used for placing people with addiction in the level of treatment needed for recovery. In addition, therapists use the ASAM as a guideline for addicts continued stay or transfer to a lower level of care.

Antagonists: Opioid antagonists reduce the rate of relapse in clinical trials and reduce reinstatement in animal models of drug seeking (Perry & McNally, 2013). Using different antagonists helps limits overdosing and provides safety for the opiate users (Bickel & Amass, 1995). Antagonists also work for opiate-dependent clients. According to Carrol, Walsh, Bigelow, Preston, and Strain (2006), Tramadol has been used as an antagonist for opiate users. Tramadol has been marketed for approximately 50 years and has not shown to have abusive tendencies (Woody et al., 2003).

Co-occurring: Co-occurring refers to the treatment of both substance abuse and mental health disorders (Shively, 2008; SAMHSA, 2005). Chambers (2008) defined co-

occurring as individuals who are diagnosed with a mental illness and substance abuse; however co-occurring is different from a dual diagnosis, which could indicate having more than one mental health disorder. Chandler, Peters, Fields, and Juliano-Bult (2004) used the terminology *co-occurring disorders*, *co-morbidity*, *dual disorders*, *and dual diagnosis* when a person was involved in the criminal justice and other systems (p. 433). Although there continues to be no universal agreement on how to treat clients with co-occurring disorders, Minkoff and Cline (2006) argued that co-occurring disorder should be seen as the expectation not the exception.

Disease model: The disease model of addiction is supported in the United States. The disease model uses medical language to frame how people think of addiction in general (Shaffer, 1991). Thinking of addiction as a disease provides therapists a way of working with addicts by removing the notion of perspective treatment in addition to eliminating the therapists being too empathic to the problems (Margulies, 1989). Shaffer (1991) indicated that the disease model works with programs that encourage abstinence, but accept the idea that addicts will slip while in recovery. The disease model indicates that addicts have physiological differences from nonaddicts, and the reason for this could be genetic (Shaffer, 1991). Based on the disease model, addiction cannot be cured as addicts will be in a constant state of recovery.

Medication-assisted treatment (MAT): This approach has been available for treating alcohol and opiate use for some time. It is important in improving the health of opiate-dependent clients (Bruce, Kresina, & McCance-Katz, 2010). MAT treatment

providers have understood the use of MAT is as an important tool for treating addiction (Kelch, & Piazza, 2011).

MAT's function is to serve as a platform on which a recovery lifestyle can be built. Although MAT treatment reduces harm and physically stabilizes those who participate, it does not guarantee abstinence or guarantee being socially responsible (Rabinowitz, 2009). Although it continues to be a topic of debate in the United States, in other countries people using methadone are thought of as being in a MAT program (Laudet, 2007). MAT has been shown to improve opiate users' lives by reducing the impact of addiction on their families and the community. Ginter (2012) noted MAT participants benefit from being involved in recovery groups and that it is important for recovery groups to support MAT's use.

Recovery groups: Recovery groups are self-help groups of people who acknowledge having similar problems and try to help each other work through their problems (Flora, Raftopoulos, & Pontikes, 2010). Self-help groups have grown significantly, particularly Alcoholics Anonymous (AA) and Narcotics Anonymous (NA). Using AA or NA as part of an addict's aftercare treatment has demonstrated decreases in relapses and increases in abstinence from drugs or alcohol (Gossop, Stewart, & Marsden, 2008).

Addicts who are involved in recovery groups develop new relationships with people who are also abstaining from drug use and learn new coping skills to avoid relapse. One of the reasons people are involved in self-help groups is to identify with recovery as opposed to being identified with addiction (Buckingham, Frings, & Albery,

2013). B. S. Brown, O'Grady, Farrell, Flechner, and Nurco (2001) noted that older addicts attended NA meetings more often than younger addicts and have a more serious drug problem.

Others have indicated that AA's and NA's approach is not for everyone. Ellis and Velten (1992) developed a self-help guide for people who wanted to stop drinking but did not believe in AA. They concluded that the main reason people used drugs and alcohol was due to their negative belief system in which they needed to develop strong goals and find a way to achieve these goals. Others have questioned recovery groups' effectiveness. Peele, Bufe, and Brodsky (2000) argued the programs are not effective simply because they are popular. From their perspective, people do not benefit from being involved in AA or NA for a long period of time but rather from being motivated to make changes.

Visual Analogue Scale: The Visual Analog Scale (VAS) is a measure used in research to determine pain intensity (Jensen, Chen, & Brugger, 2003). Researchers often use the VAS as it does not require as much explanation for participants compared to other measurements such as discrete scales (Reips & Funke, 2008). VAS is presented as a horizontal line fixed with two extreme descriptors (Flynn, van Schaik, & van Wersch, 2004). Study participants who completed a survey using the VAS showed their agreement on the continuous line between those two points. The VAS is different from a Likert-type scale as the participants may respond to specific points on the scale. Savvas, Somogyi, and White (2011) used the VAS to measure opiate addicts' emotional reaction to methadone use. Savvas et al. concluded that opiate addicts on methadone maintenance appear to have less reaction to any mood induction during the peak of their methadone

injection compared to nonaddicts who were in the study. This suggested that methadone reduces elative and depressive emotional reactivity (Savvas et al., 2011).

Assumptions and Limitations

A major assumption in conducting a phenomenological study is that people will understand this methodology. Although some researchers have embraced phenomenological research for learning about people's experiences, few are aware of the structure involved in this research methodology (Giorgi, 2006). Another assumption was that due to more multifaceted barriers, older methadone users may find it more difficult to follow methadone treatment expectations as compared to their younger counterparts.

Three limitations were accepted regarding this study. First, phenomenological studies need only a small number of participants. Therefore, the results cannot be generalized to a larger population. Second, the success of any phenomenological study depends on the competency of the participants who share their stories, and what the researcher concludes (Valle & Mohs, 1998). A phenomenological study's success also depends on whom the researcher chooses to be involved in the study and these individuals' capacities for sharing the appropriate information. These limitations were applicable to the present study. The third limitation was that I may have had a bias as a nonaddict who is not in recovery. A variety of triangulation techniques were used in the present study to limit my perspective's potential impact. Triangulation is further discussed in Chapter 3.

Summary and Organization of the Study

The present study was intended to contribute to the literature regarding opiate dependency, with an emphasis on methadone use among older opiate users. The present study includes a definition of addiction, an examination of opiate user treatments, and a review of the information specifically addressing methadone users ages 50–55 years.

Chapter 2 includes a comprehensive exploration of studies on methadone use, opiate dependency, addiction, and lives of methadone users. I also identified specific definitions and attempted to see them from the perspective of methadone users ages 50–55 years. As such, each topic in this chapter was analyzed using a generalized and comprehensive evaluation that focused specifically on addiction, opiates, methadone, and relapse.

Chapter 3's focus is on the present study's design, including participant enrollment procedures, informed consent procedures, and data collection methods. This chapter also includes a detailed description of the interview process and questions that were included in the interview as well as the analysis method.

Chapter 4 includes information on how the data were generated and how participants were recruited. It also includes an account of the results and how participants answered the research questions and aided in initiating the origin of a theory related to opiate dependence and methadone use.

Chapter 5 completes the present study with a discussion of results, implications for social change, recommendations, and conclusions. Chapter 5 also includes a review

and explanation of the findings reported in Chapter 4 as well as discussion of my experiences conducting this study.

Chapter 2: Literature Review

Research since the early 1980s has shown the high rate of relapse and mortality for heroin users who are not involved in a methadone maintenance program (Bell, Shearer, et al., 2009). Today's methadone clients are different from previous methadone users due to an increase in polydrug use (Doukas, 2011). There have been numerous longitudinal studies on heroin users; some have noted that 30% of heroin users continue to use in their old age (Hamilton & Grella, 2009).

The purpose of this literature review was to explore current research concerning addiction, heroin, methadone use, and opiate dependency, specifically looking at opiate users age 50 years and older. I gathered information on opiate addiction and also looked at different ways to prevent relapse. Addicts ages 50 years and older who were diagnosed with an opiate dependency were the focus. Few researchers have examined the lived experienced of this population and their methadone experience.

Literature Search Strategy

I obtained literature through an online search at Walden University as well as online research databases from Grand Valley State University and Western Michigan University. The primary instrument used was EBSCOhost, which included PsycINFO, PsycARTICLES, and SocINDEX. I used the following keywords to locate studies to review: *opiate*, *relapse*, *methadone maintenance*, *gender*, *mortality*, *age*, and *addiction*. I focused on journals specific to addiction such as *Addiction*, *The American Journal of Drug and Alcohol Abuse*, and *Substance Use and Misuse*. I also identified additional relevant articles by examining the reference lists of articles previously located.

Introduction to the Literature Review

Research has shown that many addicts continue their drug use despite the possible consequences of incarceration or death (Scherbaum & Specka, 2008). Society has often overlooked or failed to report drug abuse in the elderly (McGrath, Crome & Crome, 2005). Widlitz and Marin (2002) called it the *invisible epidemic* due to the symptoms of abuse in older adults not being reported as compared to their younger counterparts. Although there is a wealth of information related to substance abuse, most researchers have focused on either prevention or treatment from a youth to middle-aged perspective. As a result, insufficient research regarding older adults and their addiction raises questions regarding public policies for addressing substance abuse in this population.

Though society has considered addiction to illegal drugs a problem only young people experience, addiction has no age limit. With an aging population in the United States, more baby boomers who have acknowledged using or misusing drugs will need treatment (Briggs, Magnus, Lassiter, Patterson, & Smith, 2011; Gfroere, Penne, Pemberton, & Folsom, 2003). Entering their sixth decade for the treatment of opiate addiction, older clients are coming into methadone treatment programs not only seriously addicted to opiates but also with other major problems such as health issues (Anderson & Levy, 2003; Doukas, 2011; Firoz & Carlson, 2004; Kwiatkowski & Booth, 2003). It is important to determine how well these programs are meeting the needs of these clients and identify any gaps in service.

Definition of Dependency and/or Abuse

There are different definitions of addiction. Some describe addiction as a disease state caused by the pharmacological outcomes of an incapacitating and ongoing drug use (Larance, Degenhardt, Lintzeris, Winstock, & Mattick, 2011; Naliboff, Wu, & Pham, 2006; Sellman, 2010). Others define addiction as being compulsive and chronic with relapse being possible despite abstinence for several years (Miller & Gold, 2007; Van den Oever, Spijker, Smit, & De Vries, 2010; Witkiewitz, Lustyk, & Bowen, 2012). People who acknowledge having an addiction admit it becomes habit forming in that they constantly need the substance, engage in activities to secure their drug, and develop withdrawal when the drug is no longer available (Falcon & McClung, 2009; Witkewitz & Marlatt, 2004).

Loss of control is another hallmark of addiction. Loss of control involves losing previous desires and acting impulsively and uncontrollably to obtain the drug (Prendergast, Podus, Finney, Greewell, & Roll, 2006). Addicts' compulsive behavior may lead to other problems in their lives. Addicts may not realize how their behavior may become compulsive.

Researchers have identified what they describe as the bottom-up and top-down processes involving the development and maintenance of compulsive behaviors (Koob & Le Moal, 2005; Redish, Jensen, & Johnson, 2008). Sellman (2010) noted that people who engage in addictive behaviors may have damaged the decision-making part of their brain, which contributes to the debate on whether or not addicts act compulsively. The debate centers on the idea that while most people exercise free will to make decisions, the

primitive region of addicts' brains puts their drug-seeking behavior into motion; therefore, they make decisions without thinking (Sellman, 2010). Vohs and Baumeister (2009) indicated that accepting the idea that people are responsible for their actions has some social implications for addicts. People who accept the idea that they are responsible for their actions are less likely to engage in behaviors society deems unacceptable.

Researchers have found that opioid dependency is a chronic disease in which the addict may participate in the same negative behavioral pattern of using opiates despite the negative consequences (Elora-Orosa et al., 2010; Hellemans, Dickinson, & Everitt, 2006; van den Brink & Haasen, 2006). The *Diagnostic and Statistical Manual* (4th ed.; *DSM–IV*) defines opiate dependency as "a maladaptive pattern of opioid use leading to clinical impairment or distress manifested within a 12-month period" (American Psychiatric Association, 1994, p. 248).

Opiate dependency involves serious withdrawal symptoms that occur when opiate addicts are no longer consuming the drug (Hellemans et al., 2006; van den Brink & Haasen, 2006). To reduce their withdrawal symptoms, opiate addicts may return to their previous usage level and medicate themselves to reduce their stress level. Larance et al. (2011) noted that some researchers want to distinguish between the physiological dependency, which includes going through withdrawal, and the disorder itself. Larance et al. indicated that there are specific characteristics associated with dependency such as loss of control, craving, solely focusing on using the drug, and continued use knowing there could be consequences. Therapists need to identify these characteristics when diagnosing a person with dependency. Larance et al. further noted that there is some

argument as to whether addiction should be the primary diagnosis for people who use drugs or alcohol. Until there is a definition that supports the views of researchers and treatment providers, there will continue to be some debate regarding the definition and diagnosis. It remains unclear how the substance abuse profession will deal with diagnosing dependency.

Definition of Opiates

Opioids give addicts a euphoric feeling, and when that feeling is no longer there or they experience physical withdrawal symptoms addicts may return to their previous drug-seeking behavior and continue using the drugs (Bart, 2012; Ling, Mooney, & Hillhouse, 2011). Opiates commonly used are oxycodone and heroin.

Oxycodone

Oxycodone is a prescription opiate taken orally to relieve moderate to severe pain. Oxycodone is known to have a high potential for misuse and dependency (Middleton, Lofwall, Nuzzo, Siegal, & Walsh, 2012). People who misuse oxycodone may have severe withdrawal symptoms and may take more of the drug without their physician's permission (Birnbaum et al., 2011; Miller & Gold, 2007). People who are addicted to oxycodone may snort the drug to achieve the feeling of euphoria (Middleton et al., 2012).

Oxycodone withdrawal is similar to other opiate drugs. The symptoms, which are the same as other opiate-based painkillers, include anxiety, insomnia, muscle pain, panic attacks, and weakness (Beardsley et al., 2004). There is a risk of severe withdrawal symptoms if oxycodone is abruptly discontinued ("Oxycodone," 2005). Gradual withdrawal is recommended. As a result, therapists may need to refer clients who

acknowledge using oxycodone to detox before these clients can begin residential or outpatient treatment.

Heroin

Heroin was designed to help addicts deal with their addiction to morphine (Gruber et al., 2006). Despite its negative effects, heroin use among adults has increased (Gruber et al., 2006). According to the National Survey on Drug Use and Health, older heroin users continue to use the drug despite their age (Rosen, Hunsaker, Albert, Cornelius, & Reynolds, 2011; SAMHSA, 2004). People who use heroin are more likely to become dependent on it within 2 years of taking the drug as opposed to people who use other drugs (Mowbray, Perron, Bohnert, Krentzman, & Vaughn, 2010). Roddy, Steinmiller, and Greenwald (2011) found that the majority of 109 heroin users interviewed engaged in similar behavioral patterns when it came to their drug use. These addicts admitted using the same amount of heroin daily, working with the same drug dealer, and participating in similar rituals during their usage (Roddy et al., 2011). These rituals included using the same amount of heroin in the same setting as well as where usage took place.

Heroin abuse is a serious worldwide health issue (Cousins et al., 2011; Degenhardt et al., 2011; Haile, Kosten, & Kosten, 2008; Nordit & Stohler, 2008). One reason for the abuse is that heroin addicts acknowledge that their addiction is chronic, which includes periods of relapses, increased tolerance, and unusual behaviors in order to continue their usage despite some negative consequences (Levran et al., 2009). A number of problems are associated with heroin use. High mortality levels and serious health problems are associated with long-term heroin dependence (Ross et al., 2005). Heroin use

can lead to increased risk of overdose, legal problems, and some health difficulties (Roddy et al., 2011). Others have indicated that heroin addicts crave the drug or become involved in illicit activities to secure the drug (Faarred, Vayalapalli, Casarella, Amar, & Drexler, 2010; Greenwald, 2002; Roddy et al., 2011). Therefore, it appears that the continued use of heroin causes major problems in users' lives. As one moves forward into examining how the United States engages in the treatment of heroin, it may be important to examine other countries' policies for treating heroin addiction.

Harm Reduction

Harm reduction is the policies, programs, and practices that aid in reducing the negative impact of drug use on the addict (Jarvinen, 2008; McKeganey, 2012). Although total abstinence may be the goal for some programs, others see harm reduction as a reduction in drug use or using alternatives such as methadone to treat the addiction (Jarvinen, 2008). Although treatment focusing on being abstinent from drugs and alcohol use is effective, treatment providers and policymakers are seeing the importance of developing harm reduction interventions as both valuable and pragmatic (Phillips & Rosenberg, 2008).

Although some people think harm reduction measures, like needle-exchange services and methadone treatment, increase illegal drugs, De Preux, Dubois-Arber, and Zobel (2004) indicated that harm reduction did not increase heroin use in Switzerland. Other countries have developed different strategies for working with people addicted to heroin. Nordt and Stohler (2006) noted that while other countries support harm reduction for heroin treatment, the United States continues to incarcerate people for their drug use

as policy leaders believe that the United States is fighting a drug war. Only recently in the latter part of the 20th century did some U.S. policymakers consider engaging in harm reduction for treating heroin addiction. Jarvinen (2008) examined inconsistent attitudes between treatment providers and addicts and found that harm reduction is providers' primary treatment goal.

Definition of Relapse

Relapse is a challenge for addicts, particularly in chronic addiction in which people are likely to relapse even after being in treatment. Relapse is prevalent in people experiencing addiction (Sinha, 2011). Treatment providers have indicated that relapse is a symptom of the problem and can be continuous over the addict's lifetime (Alemi, Haack, & Nemes, 2004). Society has often considered the term relapse to indicate a person's failure in recovery (Sinha, 2010). However, in view of the previously mentioned studies relapse should not imply that addicts will remain sober for their life. The studies led to improving the understanding of how relapse is a challenge for addicts dealing with urges and cravings associated with stress, depression, and poor support system. In studies by R. M. Brown and Lawrence (2009) and Sinha (2011), more than two thirds of opiate addicts relapsed within a few months after completing treatment. Several factors can predict relapse risk, including stress, depression, craving, coping skills, and a person's support system (Sinha, 2010; Witkiewitz & Marlatt, 2004).

Regardless of the amount of time in and type of treatment, relapse is significant among opiate addicts. As such, it is important for people working in the field of addiction not to attack addicts who relapse, but to help them pinpoint their triggers and develop a

relapse prevention plan to overcome them. Understanding why treatment providers see methadone as the reliable treatment for opiate addiction will give therapists information to share with clients regarding their treatment choices.

Drugs Used to Manage Opiate Addiction

Methadone

Methadone is a morphine-like drug for treating opiate addiction (King & Best, 2011) that can stabilize opiate users. Methadone is a form of opiate replacement therapy designed to decrease heroin use and other health problems associated with opiate use (Dobler-Mikola et al., 2005). Physicians have prescribed methadone for heroin users in the United States since 1963 (Uchtenhagen, 2011). Methadone is considered one of the most valuable options in managing heroin and other opiate addiction (Kastelic, Dubajic, & Strbad, 2008).

Methadone appears to be effective in treating most opiate addiction. Reviewing data over a 22-year period, Kornor and Waal (2005) noted that heroin addicts who started methadone treatment but stopped were more likely to relapse and return to the same level of usage. Methadone may help improve some opiate addicts' lives. Banta-Green, Maynard, Koepsell, Wells, and Donovan (2009) completed a 12-month study on individuals addicted to opiates in the state of Washington. Examining the addicts' retention in a methadone treatment program, Banta-Green et al. concluded that methadone treatment significantly improved the lives of people who were diagnosed with prescription opiate dependency as compared to individuals who only used heroin.

Despite its proven effectiveness, not everyone who needs methadone can get it. Schwartz et al. (2008) noted that due to a lack of funding and equality regarding payment for treatment, some people are unable to secure methadone. Schwartz et al. further noted that some opiate users may be hesitant or have negative attitudes about quitting their drug use, which excluded them from a methadone program. As methadone has been the most recognizable treatment for opiate dependency, therapists should become familiar with its properties. Termorshuizen et al. (2005) studied 732 participants in Amsterdam and found that opiate addicts who used methadone maintained their abstinence on a dose of 80 mg a day or higher. Kayman, Goldstein, Deren, and Rosenblum (2006) identified the importance of social conditions, program factors, and clients' characteristics and attitudes in predicting how long an individual may stay in methadone treatment.

Buprenorphine

Approved in 2002, buprenorphine is an alternative to methadone for treating opiate dependency (Tetrault & Fiellin, 2012; Wish et al., 2012). Buprenorphine is often used as addicts are unlikely to abuse it yet has effectiveness similar to methadone (Tkacz, Severt, Cacciola, & Ruetsch, 2011). Combined with another opiate blocker such as suboxone, buprenorphine helps reduce opiate abuse (Proctor, Copeland, Kopak, Herschman, & Polukhina, 2014). Although methadone has been the main pharmacotherapy used in the United States for treating opiate dependency, buprenorphine treatment has increased (Gryczynski et al., 2013). Early studies on buprenorphine indicated that it was a safe alternative to methadone as heroin addicts on buprenorphine reported using less heroin (Ling & Wesson, 2003). Riksheim, Gossop, and Clausen

(2014) completed a 10-year study on opioid maintenance treatment. When comparing methadone and buprenorphine, Riksheim et al. found that buprenorphine use increased three times during the study period while treatment attrition decreased.

Buprenorphine minimizes any abuse of the drug as well as the addict seeking other opiates while maintaining all positive qualities of methadone (Tkacz, Severt, Kassed, & Ruetsch, 2012). Although some addicts acknowledge abusing methadone, buprenorphine's abuse levels are lower, and its treatment qualities are similar to methadone (Tkacz et al., 2011). Buprenorphine has helped reduce early stages of relapse and was demonstrated safe as compared to another opiate agonist (Wilford & Maxwell, 2006). Buprenorphine is effective in treating opiate addicts, is accepted for treating addicts, and is another medication-assisted treatment for opiate addiction (Mendelson, Flower, Pletcher, & Galloway, 2008).

Naloxone

Naloxone is an artificial antagonist used for treating addition to various opiates, including heroin, morphine, or buprenorphine (Hill & McCauley, 2012). Naloxone is used to reduce mortality from opiate overdose (Strang et al., 2008) and was designed to reverse heroin's effects by reducing respiratory depression, the primary cause of death in an overdose (Kerr, Dietz, & Kelly, 2008). Naloxone can be effective in treatment and can reduce methadone dose monitoring (Bell, Shearer, et al., 2009).

Nondrug Treatment for Opiate Addiction

Addiction treatment may range from detoxification to 12 step meetings. Haile et al. (2008) noted that most individuals who use illicit drugs do not develop an addiction

and do not need treatment. However, people who do develop an addiction may require specific treatment. Detoxification is a form of treatment for addicts who are physically dependent on their drug and may need medical and mental health treatment to aid the recovery process (Sigmon et al., 2012). Some individuals may need a detox program before they can address their addiction. Miller and Gold's (2007) study on opiate prescription medication showed that the perception of pain diminished if the person was involved in a detox program. Addicts and providers should not view detox as a standalone treatment as by doing so increases the chance of relapse (Tuten, Jones, Lertch, & Stitzer, 2007). Although some opiate addicts may need to detox before addressing their addiction, some may continue presenting with symptoms indicating that they may struggle without their pain medication. Nonetheless, more than 50% of individuals who start detox treatment fail to complete it (Marhe, Waters, van de Wetering, & Franken, 2013).

Providers have recognized and accepted the need for residential treatment for some addicts. Conner, Hampton, Hunter, and Urada (2011) reviewed treatment data from the California Alcohol Drug Data System from July 1, 2001 to June 30, 2006 and found higher treatment completion for individuals who were involved in residential treatment compared to traditional outpatient treatment. Witbrodt et al. (2007) compared addicts who completed a residential treatment program to those who were only involved in outpatient treatment. Study results showed that more than 50% of addicts involved in either treatment modality reported maintaining their abstinence from drugs 1 year after completing treatment. Although there appears to be different thoughts as it relates to the

impact residential treatment has on maintaining an addict's sobriety, no one has questioned the need for other treatment resources (Witbrodt et al., 2007). Opiate addicts may need additional resources for completing treatment. Milligan et al. (2011) studied women's treatment and found that helping women address their childcare needs and locate appropriate housing after completing treatment improved the women's stay in treatment.

Some individuals may need to go through treatment numerous times to address their addiction. The Department of Alcohol & Drug Services of Santa Clara County, California's report on nearly 1,000 addicts involved in the criminal justice system indicated that 38% returned to treatment within 18 months of their initial treatment experience due to a lack of additional programming following their residential stay (Stanford, Banerjee, & Garner, 2010). In drug addiction treatment, as with other chronic conditions, addicts are likely to relapse without some type of monitoring.

Although the percentage of people who acknowledge having an addiction to various opiates has increased, there has been a decrease in the number of addicts receiving treatment in programs that can address their specific needs (Conner et al., 2011). People are not always placed in the best program for their addiction needs. Tetrault and Fiellin (2012) stated opiate addicts need to be in treatment programs that allow them to use different medications in order to remain sober. Despite the idea that some addicts will do better in treatment if they are allowed to take medications, Ducharme et al. (2006) stated that some treatment programs often discourage or prevent addicts from using methadone maintenance treatment while in the treatment program.

Thus, the debate continues on whether medication benefits individuals who are using other treatment modalities.

Problems Associated With Opiate Use

Many opiates, legal and illegal, can be misused. Morphine, oxycodone, and fentanyl are legal opiates for pain management (Byrne, Lander, & Ferris, 2009). Opium and heroin are illegal opiates (Wesson & Smith, 2010). Ling et al. (2011) identified several studies regarding drug abuse in the United States and concluded that prescription opiates misuse has increased to an epidemic status since 1990. People may be using methadone and buprenorphine medications for addiction treatment (Degenhardt et al., 2011; Weiss et al., 2010). Older adults use as much as one third of all prescription medications, which include opiates and benzodiazepines (Gossip & Moos, 2008). Older adults may use more medication than their doctor prescribed or use medications belonging to someone else. In addition, older adults may swap or sell their prescription medications thus impacting their well-being and support network (Doukas, 2011).

Pain Management

People use prescription opiates for managing pain. Some pain management organizations support using opiate medications to help people manage their pain (Larance et al. 2011). Miller and Gold (2007) studied individuals using different opiates for pain management and noted that less than 1% became addicted to opiates. Pain management workers who treat older adults need education on how a person may become dependent on pain medications (Byrne et al., 2009). Therapists may need to develop different treatment strategies for addressing opiate addicts who take specific opiates for pain

management and collaborate with medical professionals to provide the best possible treatment for these clients.

Dangers of Opiate Drugs

There are benefits and problems associated with using opiates. One benefit is that opiates help manage acute or chronic pain (Larance et al., 2011; Naliboff et al., 2006). One problem connected with the use of prescription opiates is that people may develop an addiction to the drug and need more of it. Another problem associated with opiate use is the impact on society such as violence inflicted on others, property damage, crimes related to acquiring and selling the drugs, and death (Cruts, Buster, Vicente, Deerenberg, & Van Laar, 2008; Grau et al., 2007; Panchanadeswaran, El-Bassel, Gilbert, Wu, & Chang, 2008). Heroin use may lead to overdose. One in 10 heroin users is likely to die because of an overdose (Degenhardt et al., 2011; Fatovich, Bartu, Davis, Atrie, & Daly 2010).

Drug use is connected to violent behaviors including intimate partner violence (IPV). Women involved in IPV may develop serious health problems (Chermack et al., 2009; El-Bassel, Gilbert, Wu, & Hill, 2005; Stuart, O'Farrell, & Temple, 2009). Women who admit to being addicted to various drugs and also involved in an IPV relationship related to their drug use reported experiencing anxiety, depression, posttraumatic stress disorder, and an increase in alcohol and drug use compared to women not involved in an IPV relationship (Temple, Stuart, & O'Farrell, 2009). According to Panchanadeswaran et al. (2008) women who are addicted to various drugs and who are involved in an IPV relationship may also isolate themselves from family and friends, which may make them

more vulnerable to violence. Drug treatment programs and establishments that provide services to IPV victims need to collaborate on policies for assisting victims in recovery and life issues (El-Bassel et al., 2005).

Women involved in substance abuse and who are victims of physical abuse need to work on reestablishing their social networks. Several studies have indicated that interpersonal relationships may have conflicting effects for women with addiction problems as these relationships may be supportive but also may be an impetus for relapse (Hamilton & Grella, 2009; Walitzer & Dearing, 2006). Stuart et al. (2009) noted the importance of identifying and treating the violence and addiction in the relationship early on. Stuart et al. found that abusive partners reported a significant decrease in their violent behavior a year following their treatment. IPV, psychiatric issues, and high-risk sexual behaviors are just the tip of the iceberg regarding issues among opiate users.

Previous research has suggested a correlation between addiction and violent behavior against another person (Lipsky, Caetano, Field, & Larkin, 2006). When considering both demographic and substance use factors, Lipsky et al. concluded that people connected to drugs are more likely to use emergency rooms and shelters due to some type of violent behavior. Older addicts are subject to violence as well. Older addicts have indicated being the victims of violence and power struggles with drug dealers due to their age (Anderson & Levy, 2003). Older users noted that having a different background or social status than their dealers may have caused some of the personal conflicts (Anderson & Levy).

Illegal Drug Use

Illegal drug use among older individuals is major concern. Like younger addicts, older addicts use illegal drugs (Colliver, Compton, Gfroerer, & Condon, 2006; Hamilton & Grella, 2009; Rosen, 2004; Rosen et al., 2008; Simoni-Wastila & Yang, 2006). Studying the connection regarding life stressors and exposure to illegal drug use, Rosen (2004) researched 143 adults over age 50 years and found that their exposure to illegal drugs greatly increased their involvement with the substance.

Much attention has been paid to the harmful effects of prescription medications. Cleland, Rosenblum, Fong, and Maxwell (2011) noted that during a 10-year period, treatment programs reported a 4% increase in prescription opiates being people's primary drug of choice. As opiate addicts aged, they have gone from using heroin as their primary drug to other opiates in order to meet their drug needs (Anderson & Levy, 2003). This behavior may suggest that even though society does not accept the idea that older drug addicts use illegal drugs compared to their younger counterparts, older drug users will find a way to secure their drug needs.

Similar to younger people, older adults may abuse legal and illegal drugs. Older adults may become addicted to psychoactive medications (Gfroerer et al., 2003). Like younger addicts, older addicts obtain psychoactive medications without having a written prescription (Crome, Sidhu, & Crome, 2009). Older adults may also share highly addictive medications or take higher doses for longer periods than were originally prescribed (Anstice, Strike, & Brands, 2009; Simoni-Wastila & Yang, 2006). Older adults' illegal drug use is expected to rise as the population ages and enters retirement

(Simoni-Wastila & Young, 2006). Continued exposure to illegal drugs in the older addicts' social network and community will likely increase the chances of their continuing such behavior.

Addiction and HIV

The incidence of alcohol or other drug addiction among HIV-infected individuals is significantly higher than that of the U.S. population that does not have HIV (Benard et al., 2007). Users of injected drugs are at high risk of contracting HIV through reusing and sharing syringes and other injection paraphernalia. In 2006, 24% of persons living with HIV had been infected through injecting drugs (Meade, McDonald, & Weiss, 2009). Approximately two thirds of heroin users inject the drug and thus are at high risk for HIV infection. Compared to nondrug users, female drug users are at a greater risk of HIV due to their increased sexual behaviors (Cohen et al., 2009; El-Bassel et al., 2005; Kelly et al., 2009). Burns, Conroy, and Mattick (2010) noted that women who have a substance abuse problem are more likely to be exposed to health problems due to injecting drugs and engaging in unprotected sex in exchange for drugs. Significant comorbidity exists between HIV infection and substance use disorders as they are linked (Byrd, Murray, Safdieh, & Morgello, 2012). Opiates abuse is a major transmission route while abuse of other illicit substances, such as cocaine and methamphetamine, has become a primary risk factor for HIV infection (Centers for Disease Control, 2007).

Sexual Behaviors in Addiction

There is a link between drug use and sexual risk behaviors. Several researchers have found that people who use illegal drugs are more likely to engage in risky sexual

behaviors (King, Nguyen, Kosterman, Bailey, & Hawkins, 2012; Kopetz, Reynolds, Hart, Kruglanski, & Lejuez, 2010). Hayaki, Anderson, and Stein (2006) found that heroin users engaged in risky sexual activities such as acting without thinking. Cohen et al. (2009) indicated that a disproportionate number of women involved in substance abuse treatment acknowledged childhood sexual abuse that contributed to their drug usage. Women are more susceptible to the negative consequences of drug use and high-risk sexual behaviors. Programs designed to treat women with drug problems, particularly those who may be a victim of childhood sexual abuse, may provide a special opportunity to focus on and treat both issues. Treating both is relevant and beneficial for reducing drug dependency and improving the lives of these women and their families.

Mortality From Addiction

Mortality is an issue for opiate users. The mortality rate for opioid-dependent users is 30 times higher than the general population (Clausen, Waal, Thoresen, & Gossop, 2009). The reasons for their deaths include taking more of the drug than intended, being the victim of a homicide, committing suicide, or failing to secure appropriate medical care (Clausen et al., 2008; Clausen et al., 2009). Woody, Kane, Lewis, and Thompson (2007) found fewer deaths for users who stayed on their methadone regime. These findings, along with those from previous studies, demonstrate that staying on methadone reduces mortality as the addict is less likely to return to his or her using behavior. Figure 2 illustrates the number of deaths contributed to heroin and prescription opiates over an 11-year period.

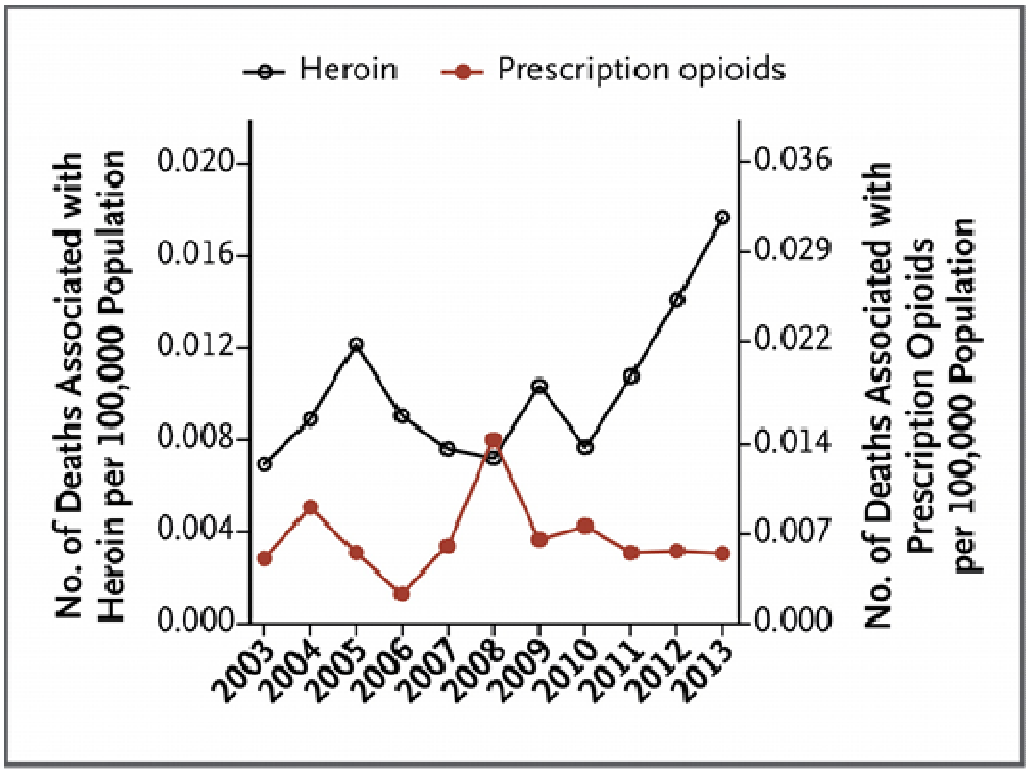

Figure 2. Rates of death associated with heroin and prescription opioids, 2003–2013. Adapted from "Trends in Opioid Analgesic Abuse and Mortality in the United States" by R. C. Dart, H. L. Surratt, T. J. Cicero, M. W. Parrino, S. G. Severtson, B. Bucher-Bartelson, & J. L. Green, 2015, *The New England Journal of Medicine, 372*, p. 241. Copyright 2015 by *The New England Journal of Medicine*.

Mortality affects older addicts as they are at least 6 times more likely to die from their addiction or from other issues when compared to younger addicts (Crome et al., 2009). Older addicts are likely to die from an overdose or suicide although medical issues such as cancer and heart problems may also contribute to their death (Hser et al., 2004; Kwiatkowski & Booth, 2003). Although older people are nearing the end of their life cycle, Doukas (2011) found limited research focusing on mortality and the reasons for their death. Older addicts who continue taking methadone may also continue some

unhealthy behaviors that could increase the probability of death such as smoking, failing to exercise, and overeating (Fareed et al., 2009).

Psychiatric Problems in Addiction

Some addicts with an identified psychiatric problem may also self-medicate themselves with drugs and alcohol. The reason for using drugs and alcohol is to relieve distresses that may or may not be connected to specific psychiatric problem (Gil-Rivas, Prause, & Grella, 2009). Because of the stigma of mental health diagnosis, some people may use opiates rather than address their psychiatric problem (Green, Grimes Serrano, Licari, Budman, & Butler, 2009; Zacny, Gutierrez, Kirulus, & McCracken, 2011). Using information gathered from the *National Epidemiological Survey on Alcohol and Related Conditions*, Martins, Keyes, Storr, Zhu, and Chilcoat (2009) found that people who were already diagnosed with generalized anxiety disorder were at an increased risk of taking nonprescription opiates and had a higher risk of developing an opiate dependency.

Therapists need to understand the impact mental health issues have on people with addiction. Maremmani et al. (2010) identified several studies on the differences between men and women with psychiatric disorders. Maremmani et al.'s research indicated that women are more likely to be diagnosed with depression and anxiety while men are more likely to be diagnosed with schizophrenia and antisocial behaviors. Further, researchers have found that women who abuse drugs are more likely to be diagnosed with psychiatric problems than men (Eiroa-Orosa et al., 2010; Green et al., 2009).

Older opiate addicts are likely to identify with having some type of mental health issue. Rosen (2004) interviewed older methadone users and found that 57% of the

interviewees acknowledged having at least one mental health disorder. Depression or generalized anxiety disorder were the primary diagnoses. Rosen's results appear to be similar to those of Firoz and Carlson (2004), who found that at least 25% of older methadone users admitted to having a psychiatric disorder. Comparing older opiate users to younger ones, both groups acknowledged mental health problems but older users denied experiencing posttraumatic stress disorder (Wu & Blazer, 2011). Regardless of any physical conditions, older addicts are less likely to seek treatment for mental health issues than their younger counterparts as older addicts see depression and other mental health disorders as part of the aging process. (Braden et al., 2008).

Medical Problems Associated With Opiate Addiction

Prescription opiates are a problem that treatment providers cannot ignore. Weiss et al. (2010) indicated that most opiate treatment focused on heroin addiction even though people had increased the prescription opioid use. Weiss et al. further noted that with increased opiate prescription use, it is important to understand how these individuals may engage in treatment. Using different sites for opioid addiction treatment, Weiss et al. viewed how people addicted to different opiate responded to outpatient treatment of buprenorphine along with therapy. Weiss et al. stated that most people who take prescription opioids for treating specific chronic pain do not see themselves as addicts and want to classify themselves in a different subpopulation.

Older opiate users may have some medical issues that their addiction impacts. Rosenblum et al. (2007) interviewed 140 methadone clients age 50 years and older. Fifty-four percent acknowledged having arthritis problems, and 41% suffered from

hypertension (Rosenblum et al., 2007, pp. 495–496). Data from methadone treatment programs have indicated that older clients present with pulmonary problems and liver and kidney diseases as well as other serious infections affecting the quality of their lives (Rosen et al., 2008). Comparing two different opiate maintenance client groups, Lofwall, Brooner, Bigelow, Kindbom, and Strain (2005) found that older opiate users had more medical problems and poorer overall health than younger opiate users. Studying more than 90 clients age 40 years and older involved in methadone, Fareed at al. (2009) found that more than 70% had hypertension as well as coronary artery issues. Fareed at al. concluded that continued methadone use correlated with serious medical problems that put these clients at risk for premature death.

Criminal Behavior Associated With Opiate Addiction

Addiction may increase the possibility of criminal justice system involvement. Many heroin addicts are incarcerated because of their drug habit and criminal behavior (McMillan, Lapham, & Lackey, 2008). Of the 2,000,000 people who were incarcerated in the United States in 2002, 12%–15% admitted to being addicted to heroin and/or other opiates (M. S. Gordon, Kinlock, Schwartz, & O'Grady, 2008). Studying research from several countries, Oliver et al. (2010) found that most opiate addicts supported their drug use by engaging in illegal activities such as dealing drugs. Even though addicts in the United States may be incarcerated 4 times as often as compared to other industrialized countries, their decisions to continue using heroin and other opiates following their incarceration remains a major problem (A. J. Gordon et al., 2011). Incarceration can be an opportunity for treating people with opiate addiction. Some opiate-dependent addicts

may receive treatment while incarcerated or when released (Taxman, Cropsey, Young, & Wexler 2007). Research supports methadone as highly effective in reducing an inmate's addiction to heroin or in reducing criminal behavior (A. J. Gordon et al., 2011; Lobmann & Verthein, 2009; Oliver et al., 2010; Werb et al., 2008).

Cravings for Opiate Drugs

Opiate addicts experience cravings, which are a physical state that may cause addicts to seek their drug of choice despite the negative consequences (R. M. Brown & Lawrence, 2009). Cravings can be part of a withdrawal during which the addict may identify problems such as lack of sleep, mental health issues, and other discomforts lasting for an extended period of time (Fareed, Vayalapalli, et al., 2010). Heroin addicts admit that they often crave for a greater amount of the drug (Fareed, Vayalapalli, et al., 2010; Wang et al., 2011; Weiss et al., 2010). Clinical studies on heroin addicts have shown that opiate addicts who use methadone report a decrease in their cravings for heroin (Fareed, Casarella, Amar, Vayalapalli, & Drexler, 2010; Wang et al., 2011). Wang at al. (2011) studied 14 former heroin addicts who were medication complaint in long-term methadone maintenance programs. Using an event-oriented functional magnetic resonance imaging task involving heroin- and non-heroin-related cues, Wang et al. found that although there were no significant craving changes connected to the task, opiate addicts' blood oxygen levels significantly increased when shown heroin-related cues. Study results showed that even though people may be sober from their drug for a significant period of time, former opiate addicts continue to react to drug-related stimuli

and that opiate addicts reported having strong cravings and could relapse when exposed to heroin cues.

There are medications that may help reduce the cravings for heroin. Fareed, Vayalapalli, et al. (2010) noted results from seven studies showing that methadone could reduce heroin cravings. Studying brain activity, Fareed, Vayalapalli, et al. found that heroin craving is connected to different neural circuits in the brain. Using the 10-point VAS scale, Fareed, Vayalapalli's study indicated that rapamycin reduced heroin cravings. In a study on dopamine transporters, Shia et al. (2008) found a reduction in heroin craving and anxiety in opiate addicts taking methadone maintenance. Barta, Kurth, Stien, Tennen, and Kiene's (2009) study of heroin craving, indicated some inconsistency on whether or not methadone would decrease cravings in opiate addicts. If addicts using methadone experienced high self-efficacy they were more likely to have low heroin cravings (Barta et al., 2009). These studies suggest that methadone could decrease or have no effect on cravings.

Methadone dosage appears to impact heroin cravings. Greenwald (2002) suggested that heroin cravings increased when methadone dosage decreased. Results from later studies supported Greenwald's findings in noting that addicts had better craving control when receiving 100 mg of methadone or more daily (Donny, Brasser, Bigelow, Stitzer, & Walsh, 2005; Fareed et al., 2009). It is important to be careful when interpreting data from these studies: One issue noted in the majority of these studies is that cravings may be impacted by other illicit drug use rather than changes in methadone dosing. Cravings may play a significant role in people's continued heroin use in spite of

being in a methadone program. Even though methadone is recognized as a safe substitute for their heroin use, some participants in Fareed et al.'s 2009 study admitted that their cravings could be a relapse trigger.

Barriers to Treatment for Opiate Addiction

There are some significant barriers to receiving treatment. Many heroin users rely on public funding to pay for their treatment, which could be a major barrier due to the limited number of treatment beds available in many communities (Mowbray et al., 2010). Research on how addicts engage in their drug use and current barriers to treatment is needed to develop strategies for organizing treatment programs and developing appropriate interventions for all opiate users.

Several barriers may affect treatment for substance abuse in older individuals. One is the stigma associated with drug use. Stigma is seen as one of the most extensive barriers preventing older addicts from seeking treatment (Conner & Rosen, 2008). Completing a qualitative study at a methadone clinic, Conner and Rosen (2008) found that older adults identified how society views people with addiction as a negative stigma. Older female addicts indicated that some family members had discouraged them from being in treatment as the family members may struggle with the stigma of having a close relative with a drug problem (Conner & Rosen, 2008; Koenig & Crisp, 2008).

Having a drug problem is one of the most significant stigma older addicts identify. Older addicts admit feeling angry and embarrassed by society stigmatizing them as drug addicts (Ayres et al., 2012). This feeling of shame and embarrassment often keeps older users from being honest about medical problems related to their drug use.

Koenig and Crisp (2008) noted that these barriers can impact service delivery and treatment for older addicts. As older individuals age and are identified with an addiction problem, treatment program providers need to understand how stigma impacts older opiate addicts and develop treatment strategies that are sensitive and ready to address these stigmas.

Policymakers may need to revisit existing policies to see if these policies meet the needs of older addicts. Service providers who accept Medicare are limited in the number of treatment contacts with Medicare recipients, which makes it difficult to treat clients consistently (Kaskie, Imhof, & Wyatt, 2008). One problem associated with aging individuals who present with mental and substance abuse problems is that services do not correspond very well with the need for their care as less than 25% of older adults needing treatment will receive individual therapy (Kaskie et al., 2008). Completing a report on the aging, the Administration on Aging called for the improved integration of services between the aged person's primary care physician and his or her treatment provider (Hinrichsen, 2010).

Older Addicts

Substance abuse affects people regardless of their age. There is some discrepancy in how older adults are defined. Researchers in the United States have defined an older adult as anyone 50 years of age and older (Gfroerer et al, 2003; Simoni-Wastila & Yang (2006). Other countries such as Great Britain have defined an older adult as anyone 40 years of age and older (Crome et al., 2009). As the U.S. population ages, there will be a major increase in the number of older adults needing addiction treatment (Gfroerer et al.;

Gossop & Moos, 2008). It is estimated that the number of individuals 50 years of age and older needing addiction treatment may increase as much as 300% by the year 2020 (Crome et al., 2009; Gossop & Moos; Gfroerer et al.; Rosen, 2004; Simoni-Wastila & Yang, 2006).

Despite the increased amount of information regarding the epidemiology and/or treatment for addiction among older adults, there was not research on this subject until the early part of the 21st century (Kwiatkowski & Booth, 2003). There has been limited research regarding methadone treatment for opiate addiction in older adults. Doukas (2011) stated that while methadone maintenance treatment programs have existed for over 60 years, these facilities are now treating patients who are older and may be presenting for treatment for the first time in their 50s, 60s, and even their 70s. Rajaratnam, Sivesind, Todman, Roane, and Seewald's (2009) study of methadone clients indicated that older methadone users presented with greater medical needs as well as a greater need for medications. Unlike their younger counterparts, older drug users are more likely to use medical treatment and follow up with medical care. With the increase in older drug users, there needs to be improved communication with health care professionals. As older addicts are emerging, program providers who serve older people, particularly drug programs, will need to identify this population's unique needs (Rosen et al., 2008). Increased substance use among the baby boomer population will place greater demands on treatment programs not equipped to address this population's needs (Lofwall et al., 2005; Rosen et al., 2008).

Levy and Anderson (2005) labeled older drug users as having a *drug career* due to their long history of drug use. The idea of having a drug career has been used to explain how addicts begin using their drug of choice and continue as they become chronic drug users (Kwiatkowski & Booth, 2003). With addicts' continued use as they age, addicts are no longer the primary persons involved in the drug culture, and their involvement in the drug world may be unknown to others unless they become the victims (Anderson & Levy, 2003). As the drug world older addicts first became involved disappears, older addicts may lose their social status as and try to hold on to past self-identity and cultural values.

Summary

Opiate addiction is a complicated issue. People who continue their opiate use despite such consequences as death and incarceration recognize that many factors can possibly affect their usage. Feelings of powerlessness and unmanageability are so great that people addicted to opiates understand that their lives have become unstable.

There is limited information supporting any significant gender differences for older opiate addicts. There are considerable similarities related to the interactive effects of substance use and aging and social relationships. Such gender problems may continue and even intensify as these addicts age. As women age, they may face different barriers and facilitators to gaining access to treatment as opposed to younger women. Younger women often see their parental roles impeding their decision to seek treatment while older women identify issues such as mobility and age-related health problems affecting their ability to engage in treatment. As addicted women age and become more involved

with the health care system, additional research is needed on possible gender differences in the course of their addiction and treatment. Even though substance misuse is increasing and is becoming a significant problem for older adults, there is little information about older adults who may misuse substances. Professionals who work with this population may lack practical skills needed for addressing some difficult ethical issues that may come about in the context of working with older opiate addicts.

Further discussion regarding the techniques used to gather information for the literature review as well as the techniques used to gather information regarding methadone usage, relapse issues, and live experiences is in Chapter 3. Chapter 3 includes a discussion of ethical considerations, study methodology, the sampling method, and the recruiting process.

Chapter 3: Research Method

Understanding a phenomenon requires in-depth knowledge of the perspectives of those who have lived through the experience. Qualitative research serves as a conduit for this process in an organized and systematic fashion (Marshall & Rossman, 2006). Tesch (1990) stated that individuals assign meaning to their objective world and that their valued experiences are situated in a historical and social context. Tesch further stated that there can be multiple realities for these experiences.

My intent for the present study was to use a heuristic phenomenological approach to explore the lived experiences of opiate users ages 50–55 years currently on methadone. I examined their lives, their addiction history, and how using methadone has influenced their lives. Treatment providers may need to review this population's physical and mental health as well as continued drug use. I gathered data related to participants' history of use, any relapses, and length of time on methadone. I also wanted to know about any relapses as well as other treatment modalities participants used while taking methadone. Interviewing these individuals provided information regarding how they perceived their lived experiences, addiction, and treatment experiences.

Examining Lived Experiences

Van Manen (1990) stated that when studying a phenomenon, a qualitative method is the most relevant tool to use as the study will be exploratory in nature. The goal of qualitative research is to provide information to gain a better understanding of an occurrence (Braud & Anderson, 1998; Creswell, 2007; Denzin & Lincoln, 1998; Moustakas, 1994). I selected a qualitative study because my focus was on conducting a

thorough investigation of the lived experiences of older methadone users. Patton (2002) described a lived experience as researchers having direct involvement with the phenomenon of interest instead of gaining the information from secondhand sources. Denzin and Lincoln (1998) indicated that a qualitative method is the best scheme for studying human experiences in order to gather the phenomenon's complexity.

Phenomenology

Phenomenology is the study of lived experiences or the life world (van Manen, 1990). Husserl designed the phenomenological research method in the early part of the 20th century as a response to the traditional scientific method (Giorgi & Giorgi, 2001; Laverty, 2003; Lin, Huang, Chen, & Shao, 2009). Husserl argued that the traditional scientific method could not adequately or appropriately capture a phenomenon's abstractions due to its focus on measuring observable concrete events (Powers & Knapp, 1995). Phenomenology is the chosen methodology when wanting to understand the essence of an experience (Creswell, 2007). Phenomenological research invites the researcher to observe the participants' world and learn different human behaviors (Valle & Mohs, 1998).

In review, the focus of a phenomenological study is on exploring the relationship between people and their lived experiences, taking into consideration their customs, community, and historical environments. Combined, these factors may impact the ways in which people observe, identify with, and make sense of their daily experiences (Heidegger, 1962). Therefore, a hermeneutic phenomenological study of older opiate

users coincides with an informative concept for examining participants' lived experiences on methadone.

Taking a phenomenological approach allowed me to explore participants' lived experiences from a first-person point of view (Smith, Flowers, & Larkin, 2009; van Manen, 1990). Basically, phenomenology allowed me to examine participants' life worlds as they were deliberately and purposely reflected upon (Husserl, 1998). Taking a phenomenological approach allowed me to explore the significance, for some people, of their lived experiences in relationship to a particular phenomenon (Polkinghorne, 1989). The present study focused on the lived experiences of opiate users ages 50–55 years currently on methadone. I examined their lives, their history of addiction, and how methadone use has influenced their lives.

Braud and Anderson (1998) indicated that phenomenology is used to create a clear explanation and awareness of a specific human experience. To acquire a good understanding of the lived experiences using the phenomenological approach, researchers need to study fewer participants but do so more meticulously (Creswell, 2009; Moustakas, 1994). In the present study two different heuristic techniques were used to study older methadone users.

The Heuristic Approach

Heuristic research characterizes the phenomenological emphasis on meaning through personal experiences. The two methodological techniques used for heuristic inquiry in the present study were engaging in a face-to-face conversation with the participants and personalizing the phenomenon. The phenomenon is personalized by

having the participants' experiences as the focal point throughout the research (Moustakas, 1990; Patton, 2002). For the present study, I engaged in conservation as part of the heuristic approach. I spoke, listened, reflected, and talked again to the participants to gain a clearer understanding of the phenomenon. Moustakas (1990) suggested that this method involves cooperating and sharing to open a pathway for explicating the phenomenon being investigated.

There are four approaches to phenomenology research: traditional, experimental, hermeneutical, and empirical or transcendental (Klein & Westcott, 1994). For the present study, the hermeneutical approach to phenomenology using the work developed by van Manen (1990) was chosen as a suitable methodology. Hermeneutic phenomenology has become a more popular research method as it is used to examine life world or human experiences as the study has a focus on revealing the specific and seemingly trivial aspects in the experience that others may take for granted (Laverty, 2003; Wilson & Hutchinson, 1991). Hermeneutic phenomenology also involves a presupposition that the essence of an experience is interpretable, and therefore knowable.

Hermeneutic phenomenology is attentive to the philosophical foundation of hermeneutics and phenomenology (van Manen, 1990). Ajjawi and Higgs (2007) noted that to be successful, research strategies need to flow directly from the project's research question and goals. This methodology aligned with my goal of attempting to understand the lived experience of methadone users ages 50–55 years. In essence, phenomenology best fit my desire to explore the lives of older methadone addicts. Few studies have been published on the lived experiences of older methadone users. I chose specific procedures

consistent with the philosophy of phenomenology to give richness, depth, and insight into the phenomenon under investigation.

Research Questions

I focused on understanding the lives of individuals who were addicted to opiates who were using methadone as a tool for relapse prevention. I also looked at other treatment modalities participants were using or had used to remain sober. I formulated two questions to gain this understanding. The first question was what are the lived experiences of opiate users ages 50–55 years who take methadone to manage their addiction? A subquestion was how do opiate users ages 50–55 years on methadone remain consistent in their methadone treatment so that they can stay in recovery? The second question was how do opiate users ages 50–55 years relate their particular experiences to the idea of recovery? Although the literature review showed that many researchers have studied methadone treatment as well as addiction and its impact on society and families, there remain gaps in the research when it comes to methadone use and older adults. It is possible that continued dependency on a substance, despite it being legal, is construed differently than maintaining total abstinence from any substance.

Informed Consent Process

To gain access to participants, I obtained the approval from Walden University's IRB (Walden University's approval number for this study: 09-18-15-0133502) to make sure the interview questions posed no harm to the participants and were asked in such a way that information flows smoothly and willingly during the interview process (Charmaz, 2006). During the IRB process, I also addressed my recruitment procedures

and data collection steps to make sure they were within the ethical guidelines established by Walden University. Once I received permission, I sent fliers to various places that addicts are known to frequent. To maintain an ethical study, individuals who agreed to participate signed a consent form prior to study participation. Participants were invited to contact me prior to signing the consent form with any questions or concerns they may have, and I responded appropriately and promptly. Participants could withdraw from the study at any time without prejudice.

Participants

I sought male and female participants who had been on methadone for at least 2 years, who were involved in a methadone clinic, who were not currently involved in a residential treatment program, and who resided in one of three metropolitan areas in the state of Michigan. I identified individuals from a purposive sample based on their ability to comprehend the research problem and the primary phenomenon being examined in the study (Creswell, 2007). According to Dukes (1984), eight to 10 participants are an adequate sample size for a phenomenological study. For the present study, I interviewed participants until I reached a saturation of methadone users who were 50–55 years of age. One of the reasons for choosing this particular population is that previous research has shown that inequalities in being admitted to appropriate treatment programs for substance use correlate with a greater risk of substance-related death for older adults using methadone (Clausen et al., 2009).

Sampling Method

I used a purposive sampling to recruit prospective participants. Purposive sampling was appropriate as I sought an in-depth understanding of lived experiences from the participant's standpoint (Babbie, 2010). Sample sizes for these types of studies are typically small (i.e., five and 10 participants) to allow for an in-depth, incisive examination of a phenomenon of interest. Also, purposive sampling is preferred when the goal is to draw from hidden or marginal populations that are difficult to access (Creswell, 2007). Unlike quantitative studies in which the goal is to generalize to larger populations, phenomenological research's aim is to acquire a deep, contextual understanding of lived experiences (Denzin & Lincoln, 2011).

According to Creswell (2007), purposive sampling refers to selecting people and the place for the study because both can purposefully inform an understanding of what the researcher is attempting to learn. Using a purposive sampling allowed me to study a small subsection of a larger population (Babbie, 2010). It was my hope that by including only participants who meet the predetermined criteria, these individuals would be credible informants about the phenomenon under investigation. I chose participants who met the following criteria: male or female, 50 -55 years old, diagnosed with opiate dependency, involved in a methadone maintenance treatment program for at least 2 years, and no relapse reported in the previouss year. This information was gathered from the background questionnaire that potential participants completed after providing their signed consent form.

Participant Recruitment

To recruit participants for the study, I send out fliers to specific places near methadone clinics in three counties in the state of Michigan to identify potential participants. I sent fliers to places such as soup kitchens, recreational facilities, homeless shelters, and churches near the clinics. I also placed fliers in NA/AA meeting places in the three counties. I contacted therapists who work with people with addictions and asked them to place fliers in their waiting rooms for possible participants to view and consider. One agency placed a copy of the flier on its Facebook page, and I put a copy on my LinkedIn page. Appendix A is a sample of the recruiting flier.

I used insiders to gain access to potential participants. Creswell (2007) identified insiders as individuals used to gain access to a group or cultural site. Insiders for the present study were leaders of NA/AA groups and therapists. Because of the close-knit culture of addiction and possible mistrust of researchers, insiders were vital to the present study as they helped ease any preexisting tension between the field of social science and the addiction community. This relationship gave me access I may not have been able to gain on my own. These insiders were individuals with whom I have trusted relationships and who either were working with the subjects in their clinics or had access to the subjects via contracts. To ensure no perceived coercion, the insiders' role was to advertise in their clinic or meeting place for possible study subjects. The insiders did not know who participated in the study and who did not. The selection process continued with selection based on criterion sampling until the *N* of eight was reached. Once I had eight participants who met the criteria for the study, I interviewed them.

Of all of the recruiting modalities, placing fliers in treatment programs provided the most responses for potential participants. In response to the fliers, I received 12 phone calls from people in the greater Grand Rapids, Michigan, area who indicated they were interested in being in the study. I kept a log of all phone calls to keep track of who called and determined how to send information to them. Although 12 people agreed to participate in the study, only eight people, four men and four women, completed the study. As all participants came from the greater Grand Rapids area, there might have been concerns regarding previous relationships with me. To ensure that there would be no issues in this area, I eliminated any potential participants who were former clients of mine. Even though it was a purposive sampling and recruitment fliers were also sent to large African American and Latino communities in Detroit and Muskegon, Michigan, none contacted me to participate in the study. As Rencher and Wolf (2013) indicated, African Americans are often reluctant to participate in research studies due to the feelings of mistrust about the researchers and how the researchers will treat them.

Once interested individuals agreed to be in the study and appeared to meet the criteria, I scheduled an appointment for an initial interview. All of the participants indicated that they did not have an email address to send information before the meeting. To confirm the interview appointments, I called each participant before the scheduled interview date.

Individuals who expressed an interest in participating in the study completed the consent form, which I reviewed with them. I delivered the consent form and questionnaire in person. The participants were asked to sign the consent form prior to

completing the background questionnaire. The signed consent form was collected at the time of the initial interview. To show my appreciation, each study participant received a $20 Walmart gift card.

Research Procedure

Data Collection: Individual Interviews

I conducted an in-depth interview with each participant. This in-depth interview consisted of open-ended questions. By using open-ended questions, I could consider the views, attitudes, and experiences related to older methadone addicts. I recorded all interviews for accuracy and clarification.

Transcripts from the interviews were analyzed for any significant statements using NVIVO 11 software, and significant statements were grouped into larger units or themes. These themes were then analyzed. I asked the subjects if they would be willing to have a follow-up meeting in the event I needed clarification as the data emerged. This follow-up was an option and did not limit people from being in the study. The follow-up interviews helped me explore themes that developed from the information each participant shared during the initial interview phase.

Initial Data Collection: Background Questionnaires and In-Depth Interviewing

Each participant signed an informed consent and was instructed to complete a background questionnaire. The background questionnaire served as a means to illicit descriptive data about each participant and to ensure that each participant was best suited to help me examine and explain phenomenon in question. After the background questionnaire was completed, each participant was invited to take part in a face-to-face

interview. Participants were notified on the consent form that the interview would be face to face.

I spent 60 to 90 min conducting a semi-structured interview with each participant. The interview consisted of open-ended questions related to the research topic that allowed the participants to respond in their own words. Using specific questions and probes helped me explore the participants' responses and descriptions of experiences related to the research questions. I recorded all interviews with a digital recorder and saved the recording on a flash drive. I also took notes to document any of my perceptions and biases related to older methadone users.

Questions for the participants were the following:

- What does it mean to be an older person who takes methadone?
- What types of opiates were you addicted to?
- How long have you been on methadone?
- Besides methadone, what other treatment are you using to stay sober?
- Can you describe any past or present issues that helped you continue your recovery from your opiate addiction?
- Describe the circumstances that led you to decide to discontinue your drug use and use methadone.
- What types of barriers prevent you from accomplishing treatment goals established by you and your case manager?
- How did your addiction impact your relationships with others?
- What are your family and friends' perceptions of methadone users?

- What factors do you contribute to shaping these perceptions?
- How do your family and friends interfere with your treatment program?
- Do you feel that race, gender, or social status play a role in the services you receive for your opiate addiction?
- Can you identify any health issues that are preventing you from being involved in your treatment program?
- How could treatment providers best serve you therapeutically if you were to seek additional services?
- Are there any other aspects, being your age on methadone, such as views and attitudes on help-seeking that have not been explored that you would like to add?

Interview Procedures

All participants selected interview sites that were convenient for them to travel to with few issues. I conducted the interviews in places near the participant's home. Half of the participants used public transportation or walked to the interview site. Before interviewing, each participant read and signed the consent form (see Appendix B) and then completed the demographics form (see Appendix C).

I gave each participant ample time to read the consent form and ask any questions. I also reminded all participants that their participation was voluntary and that I would treat any information they disclosed as confidential. I asked all participants if they wanted a copy of the consent form, but all refused. I kept the completed demographic questionnaire and consent form for my records. During the initial interview, I asked participants questions crafted to evoke detailed accounts of issues related to their

addiction and methadone use. To show my appreciation, I gave each participant a $20 Walmart gift card.

Initial interviews ranged between 60 to 90 min. As stated on the consent form, I audio recorded each interview. I secured all information, audiotapes, and written notes in a locked cabinet located in my office. As stated on the consent form all information will be kept in a secured file cabinet for 5 years after study completion. Except for the consent form, I did not provide any other identifying information on any other form, and I gave each participant a pseudonym that only I knew. I also kept this information in a locked cabinet located in my office.

In a phenomenological study, the researcher typically uses a long interview to collect data on the topic and questions (Moustakas, 1990). As I asked open-ended questions, which varied depending on the participant's responses, time was not the sole factor affecting research completion. However, I valued the time of anyone who agreed to be part of the study. Therefore, I limited the interview to 1.5 hr, and I met the participants at an establishment of their choice.

Researcher's Role

My role as the researcher was to direct the research study toward its established goals (Creswell, 2007). For the present study, I strived to gather information about opiate addiction and methadone use. I interviewed eight people ages 50–55 years and using methadone to treat their opiate addiction. It was important that I assured the questions I asked were appropriate and that the questions reflected the information needed from participants (Creswell, 2007). It was also important that I avoided showing bias as much

as possible. Therefore, I informed all participants of my work as an addiction therapist. I further allowed them an opportunity to ask me questions regarding my attitude about addiction and older addicts. During the data analysis process, I needed to use the data very analytically and as appropriately as possible in order to derive themes from the phenomenon of opiate addiction and methadone use (Lien, Pauleen, Kuo, & Wang, 2014; Patton, 2002).

My main responsibility was to ensure that the participants understood the questions asked of them, felt comfortable talking about their addiction and that they finished discussing their answers to the questions at their own pace in order to bring about the best possible and most usable answers. Although I may have some perspectives regarding methadone use, it was also important for me to realize that the participants had important information that must be explained and analyzed in order to accurately interpret the results. In addition to recording the information, I took notes and listed such issues as facial expressions, body language, and other nonverbal expressions that helped me interpret the data.

Transcript Preparation

I used a transcriptionist who has had confidentiality training to transcribe the interviews and to ensure participant confidentiality. The transcriptionist was identified in my application to Walden University's Institutional Review Board. The transcriptionist signed a confidentiality statement, agreed to keep all interview data confidential, and agreed to delete and/or destroy all electronic or paper copies of the transcribed interviews. The transcriptionist did not live in the area, which further ensured

confidentiality as the transcriptionist did not know any of the participants. In addition, I ensured accuracy by using the digital recordings to review each transcription. This also provided another means of data immersion.

Recorded information from the present study was limited to only those who needed it; that is, the transcriptionist, my dissertation committee, and myself. The signed consent form notified participants that their information will be held in confidence. All information was kept at my office in a locked file cabinet. Participants' real names were only kept while the data were being collected and were separated from any of the data collected. In keeping with Walden University regulations, I kept copies of the participant list separate from transcribed data in my office in a locked file cabinet. The audio recordings were erased from the flash drive after the transcripts were completed and checked for accuracy, pauses, or emphasis.

Data Analysis

I used a modified form of the Stevick-Colaizzi-Keen method (Moustakas, 1994) for data analysis. This method consists of the following six steps:

1. I began with a full description of the personal experiences of the participants concerning the phenomenon.
2. I developed a list of any significant statements.
3. I grouped the significant statements into meaning units or themes.
4. I wrote a textural description.
5. I wrote a structural description.

6. I wrote a composite description of the phenomenon incorporating both the textural and structural descriptions (Creswell, 2007).

In addition, my committee chair and methodologist reviewed the material with me to assure the accuracy of my assessment and theme building.

Themes

Themes were generated from identifying significant statements in the interview transcripts or other forms of data**.** These significant statements dealt with how individuals experienced the phenomenon being studied. After this process was completed, the significant statements were gathered in larger units of information known as themes (Creswell, 2007). For the present study, themes were established through identifying each participant's significant statements. I used NVivo 11, a qualitative data analysis program, to verify groupings of codes and to put them into nodes. I organized each theme area into one of three domains: views, attitudes, or barriers. These areas were used as salient themes for the study if at least five of the participants have experienced relating to the identified theme area.

I connected any relevant portions of text to nodes in the NVivo program. As this process was evolving, I deliberated on the meaning of each significant text and made decisions as the text related to the study's essential themes. NVivo 11 allowed me to review all of the text and organize the document into a final thematic analysis. The summary of the information gave me a detailed account of supporting text for each item, after which I crafted each participant's phenomenological narrative.

Bracketing

Bracketing, also known as epoche, is the process where the inquirer removes his or her experiences, as much as possible, in order to take a nonbiased look at the phenomenon in question (Moustakas, 1994). This is a major step in conducting empirical phenomenological research. The goal of bracketing was for me to set aside my experiences so that I could be as neutral as possible. Several researchers described phenomenological reduction or what Husserl defined as bracketing (Jones, 1975; Klein & Westcott, 1994; Polkinghorne, 1983). Husserl saw bracketing as identifying any personal biases while observing the outer world so that contact with participants can be successfully achieved. I delayed my decisions or particular ideas regarding the phenomenon in order to have a clearer understanding of it. Jones (1975) encouraged researchers to expand their understanding of bracketing beyond postponing their beliefs about the phenomenon in order to create some skepticism to help expose themselves to the study. Though Husserl acknowledged the unusualness of this position, he continued to support it as a viable pursuit (Edie, 1987).

Moustakas (1994) stated that postponing one's belief is never truly reached. One way in which I demonstrated the bracketing process was by including a description of my own experience with the phenomenon and bracketing out my view prior to moving forward with the lived experiences of others, as suggested by Creswell (2007). I informed all participants of my work as a substance abuse therapist and acknowledged any negative encounters I may have had with methadone users.

Establishing Credibility of Qualitative Data

Immersion

In phenomenology research studies, the immersion process is in place from the onset of the research through the completion of the study. Immersion began when I used my experiences to develop opinions about the phenomenon being studied. The immersion continued by my reading related literature to explore the topic and gain a deeper understanding as a whole. For example, my experiences with older methadone users who are dealing with legal issues, family problems, relapse, and cravings who feel they are unable to access treatment due to stigmas about opiate use prompted me to look for previous research on treatments for opiate users. I asked participants about their views, opinions, and any barriers they faced accessing treatment. Exploring treatment issues that older methadone users face helped me develop interview questions that were situated in the context of the literature and that spoke to the daily lived experiences of this population. It was my hope that the participants' voices were not lost and that their voices help shape the direction and content of the services that older opiate addicts need.

Member Checks

Member checks require presenting the findings and/or interpretations of the findings through descriptive triangulation, which creates consistency between the participants and myself (Leech & Onwuegbuzie, 2007). Member checks are considered one of the most critical techniques for establishing credibility in qualitative research designs (Lincoln & Guba, 1985). Member checks was instituted in the present study by letting the participants know they had the opportunity to read the completed transcripts

from the initial interview. This gave participants an opportunity to comment or correct any information that had been gathered. Although member checks are strongly recommended to ensure data trustworthiness, Carlson (2010) advised beginning researchers to be cautious prior to carrying out this procedure. Carlson further encouraged placing any relationship between the researcher and participants up front to ensure the validation process. Carlson also warned that giving participants large amounts of information could be overwhelming, especially if any participants have difficulty comprehending the information.

Research Auditor

The research auditor serves as a mechanism for analyzing the study. The auditor assists in "keeping the inquiries honest" (Lincoln & Guba, 1985, p. 243). The auditor may also serve as a source of new ideas or perspectives that will help the researcher see the bigger picture at hand (Lincoln & Guba, 1985). For the present study, the research auditor, a member of my dissertation committee, reviewed the initial interview transcripts for each study participant. The research auditor also used the data to identify the salient themes that were consistent across the participants. This helped determine if the themes I identified were evident to an outside researcher. The auditor was also trained in confidentiality protocol and signed a confidentiality statement agreeing to keep the content of all of the interview data confidential and to delete or destroy all electronic or paper copies of the transcribed interviews.

Transferability

According to Merriam (1998), transferability or external validity concerns the extent to which study findings can be applied to other situations in a different time or at a different place. Merriam further noted that transferability indicated that the research will be applicable or that similar findings for similar participants could be found. Transferability is also a direct function of the similarity between two contexts known as fittingness. This idea can be defined as the level of congruence between sending and receiving contexts (Lincoln & Guba, 1985, p. 124). To demonstrate how this phenomenon was practical in application to the present study and in other settings, discussions were provided on how the study was situated in literature, who the participants were, the chosen methodology, and data analysis.

Triangulation

Triangulation improves the study's legitimacy by evaluating the honesty of the interpretations that the researcher draws from more than one vantage point (Lincoln & Guba, 1985). According to Denzin (1989), triangulation involves using additional data sources, researchers, different theoretical perspectives, or several methods combined. With regard to triangulation, I sought data from multiple sources, methadone users from three different locations through multiple methods (semistructured initial and follow-up interviews and field data). This provided a more detailed and balanced explanation of lived experiences of older methadone users. Furthermore, immersion in related literature helped me examine and interpret the data. For example, contrasting emergent themes and

patterns with existing literature helped me make meaning of what is similar and different, and why, thereby increasing my understanding of the investigated phenomena.

Validity

Validity describes a measure that accurately reflects the idea it is intended to measure (Babbie, 2010). Validity is also defined as "the best available approximation to the truth of a given proposition, inference, or conclusion" (Trochim & Donnelly, 2008, p. 20). Qualitative validity involves the researcher checking for findings accuracy by using certain procedures that accept the reliability of the research by testing it against previous research (Creswell, 2009). To verify that the findings in the present study represented the experiences of older opiate users, I agreed to share the research findings with study participants. I also agreed to make revisions if any participants indicated that I failed to identify their perceptions of their lived experiences as older methadone users. Trustworthiness involves ensuring that study outcomes are credible or acceptable to the people involved in the study (Trochim & Donnelly, 2008). As the present study's purpose was to explain or recognize the phenomenon from the participants' point of view, participants were the only ones who could determine the study's trustworthiness and credibility.

One threat to validity is research bias, where the researcher may place his or her expectations into a study (Isaac & Michael, 1997; Maxwell, 1996). The concern is that the researcher's bias and expectations may invalidate the study results. One bias in the present study was a concern that I do not have a history of opiate dependence and methadone use. Another bias I had to acknowledge was that I grew up in an addictive

family; as such, I have firsthand experience of what addiction does to family members. Therefore, I may have made assumptions as to whether or not addicts may have healthy and appropriate lives without relapsing to their drug of choice.

Summary

To summarize, in Chapter 3 I provided an overview of the research methodology employed in the present study. My discussion included hermeneutic phenomenology, the specific approach taken, and the qualitative paradigm employed. I also discussed study participants and the methods that were used to recruit the participants. My role and worldview were also discussed. In Chapter 4, Iwill discuss results from the information gathered.

Chapter 4: Results

The purpose of this research study was to provide a description of the experience of older methadone users. The research objectives were fourfold: (a) to acquire an in-depth understanding of the phenomenon of older methadone users, (b) to elucidate and describe participants' experiences of addiction and treatment using their own voices and perspectives, (c) to extract and develop themes from the data, and (d) to interpret participants' lived experiences and meaning constructions in an addiction-related theoretical framework.

In Chapter 4, I presented the findings of the lived experiences of older methadone users and their views, attitudes, and barriers regarding using methadone for their addiction. As will be seen in their discussions of their experiences, participants talked about their thoughts on needing methadone, having relationships with others due to their addiction, attitudes about using methadone and their opiate addiction, and stigma as it related to being an older opiate addict needing methadone. The collective core of the participants' experiences concerning help-seeking was examined to uncover common themes in the participants' individual narratives. By analyzing each participant's narrative through a phenomenological analysis structure, I established certain themes.

Chapter 4 begins with an overview of participant demographics and biographical sketches of each participant. This is followed by a discussion of my findings, including the identification of five qualitative themes that emerged from the data analysis process. I recorded all interviews with a digital recorder and had all of the information erased once it was transcribed.

Participant Profiles

This section includes descriptions of study participants. All demographic and biographical data are presented and discussed as being current at the time of the study. All participants were involved in a methadone clinic and were using methadone on a daily basis. All but one relied on public funding to pay for their methadone, and most were not involved in other treatment programs to help in their recovery. Two participants knew each other, and I omitted all personal information that could make them identifiable in the following descriptions. Participants were assigned pseudonyms to protect their identities. Table 1 shows participants' demographic information.

Table 1

Participant Demographics

Participant	Age	Marital status	Race	Gender	Education
Nancy	50	Single	White/NA	Female	Some high school
William	54	Single	White	Male	Some college
Elizabeth	53	Divorced	White	Female	High school graduate
Danny	55	Single	White	Male	High school graduate
Anna	55	Single	White	Female	College degree
Bernice	50	Single	White	Female	High school graduate
Rex	53	Married	White	Male	High school graduate
James	55	Single	White	Male	High school graduate

Table 2 shows data related to the participants' time involved in the methadone clinic, the amount of methadone taken, and whether or not they had other addiction treatment.

Table 2

Participants' Treatment History

Participant	Years in recovery	Years on methadone	Daily amount of methadone	Other treatment for addiction
Nancy	7	7	135 mg	Yes
William	2	2	120 mg	No
Elizabeth	2	2	90 mg	Yes
Danny	4	2	125 mg	Yes
Anna	5	5	145 mg	No
Bernice	6	6	85 mg	No
Rex	8	8	133 mg	No
James	22	20	165 mg	Yes

Nancy

Nancy is a 50-year-old single biracial female who reported being involved in methadone treatment for the past 7 years. She stated she lives alone in a subsidized housing unit and receives Supplemental Security Income (SSI). She reported using a variety of opiates, including heroin, and has been an intravenous (IV) drug user. Her involvement with drugs began with a former boyfriend. She stated that her low self-esteem prevented her from saying no when her former partner encouraged her to use drugs. Nancy reported that to help her eliminate her addiction to opiates in the past, she was involved in residential treatment three times and used Suboxone for 1 year. She reported she stopped taking Suboxone due to its cost and not getting the public funders to continue paying for it.

Nancy stated that her reason for using methadone was that she was "sick and tired of being sick and tired." She acknowledged that she engaged in many different activities to support her drug habit and had to deal with both shame and guilt. She expressed how she felt that being a female impacted the services she received and stated that the nurses do not believe that women are clean if they wear makeup. She voiced a commitment to staying sober and not returning to opiates in the future.

William

William is a 54-year-old White male who said he had been involved with methadone for the past 2 years. He stated that he lives alone in an apartment and is employed full time. He reported using Vicodin 10 mg, pills and Percocet 10 mg pills as both were easy to obtain on the street as well as snorting heroin. He acknowledged using these drugs until he became high. According to William, his history of using opiates began in his mid-30s when he started associating with friends who were using opiates.

William stated that his primary reason for using methadone for his opiate addiction was that he was "sick and tired of being sick and tired," but mostly tired of chasing the drug and then getting caught. He also reported that he engaged in some illegal activities to support his drug habit but did not want to talk about that part of his life. Although he did not see his race or gender impacting his methadone treatment, he reported feeling that some of the staff treated some of his minority associates differently than him and some of his White associates. William stated that importance of being involved in treatment was to let everyone know that addiction is a disease and that it affects all major parts of the addict's life.

Elizabeth

Elizabeth is a 53-year-old single White female who stated she had been involved with methadone for the past 2 years. She stated she lives alone and is employed part time to help supplement her SSI. She reported using morphine and Fentanyl for her cancer treatment and later began misusing her medications. Before using methadone, she said she was involved in outpatient and residential treatment. She also acknowledged trying Suboxone but said she stopped because it did not relieve her cravings for opiates.

Elizabeth stated that her reason for using methadone was that she needed it to remain sober while trying to treat her cancer. She indicated that due to her addiction she became involved in the criminal justice system and spent 3 years in prison. She acknowledged that she spent money earmarked for household expenses to support her drug habit. She also reported that because of her addiction, and her history of being an enabler, she is unable to have healthy relationships or be emotionally close to other people. Elizabeth expressed concern that treatment providers do not do enough to eliminate or change the stigma of being on methadone and that there needs to be more education about the need for methadone clinics due to seeing too many of her friends dying from their drug use.

Danny

Danny is a 55-year-old single White male who had been involved with methadone for 4 years. He reported he lives by himself in an apartment and works to support himself. He reported using a variety of opiates such as Tylenol 3 and 4, Vicodin 10 mg pills, and OxyContin 80 mg pills all of which he obtained on the streets. He also stated that he

began using heroin after he developed a high tolerance to these opiates and that he has been an intravenous drug user. Danny reported that he was previously involved in residential, intensive outpatient, and traditional outpatient treatment programs to address his addiction. He stated that he started using opiates after he became involved in the criminal justice system. He also admitted that he had to deal with some depression and felt that his drug use helped him overcome this problem.

Danny said his reason for using methadone was that after being involved in the criminal justice system for the third time he was motivated to stay out of jail. He stated that he supported his drug habit by using his income and later engaging in some illegal activities. He reported that he did not feel his gender or race impacted his treatment experience. He reported that he wants to remain sober, and his goal is to wean himself off of methadone.

Anna

Anna is a 55-year-old divorced White female who had been involved with methadone for 5 years. She said she lives with a roommate who also attends the methadone clinic, so they try to keep each other accountable. Because of her medical issues, Anna reported that she is unable to work and receives SSI. She stated that her drugs of choice were Fentanyl patches, heroin, hydrocodone 10 mg, and morphine, but that she was never an intravenous drug user. Anna acknowledged that she sees a therapist on a weekly basis in an outpatient clinic to help her substance abuse treatment. She said her drug use began as she was involved with someone who was using different opiates. She further stated that once she began having some medical problems, she self-medicated

with various opiates. She stated that once she decided to stop using opiates she had to be hospitalized due to the physical impact of her withdrawal.

Anna indicated that her medical issues from withdrawing from opiates were the impetus for starting on methadone. She admitted she was "sick and tired" of using opiates and the impact they had on her life. She reported that she lied to relatives and friends to get money to support her habit. Anna stated that her gender or race has not impacted her ability to receive services, but felt there were times people at the clinic did not make her feel welcome. Anna said her primary goal is to remain sober and not use again. She also expressed concern that society is starting people out on methadone too soon. She would like funding for more outpatient and residential treatment programs before starting younger people on methadone.

Bernice

Bernice is a 50-year-old single White female who has been involved with methadone for 6 years. She stated that she is not employed and receives SSI to support herself. Bernice reported using a variety of opiates, including heroin, hydrocodone 10 mg pills, and methadone 5 mg pills, all of which she stated she obtained off the streets, but said she has never been an intravenous drug user. Bernice reported previous involvement in classes to help her understand her drug history. She also said that she would begin an intensive outpatient treatment program soon. She said her opiate use began to help her with pain management and said that part of her reason for using methadone is to help her with her pain management.

Bernice stated that her reason for using methadone was two-fold: pain management and she too was "sick and tired of feeling sick and tired." When she began using opiates, she was working and supported her habit by using her income. She also reported stealing from her family, and this behavior caused some strains in her relationship with family members. Bernice said her gender or race has not impacted her ability to receive services for her opiate addiction, but at times she felt that clinic workers did not treat her with dignity and respect. Bernice stated that her goals are to remain sober, improve her relationships with her family, and begin developing a relationship with her grandchildren. She also stated that she would like to be treated with dignity and respect and feels that due to being an older person addicted to opiates she is not.

Rex

Rex is a 53-year-old married White male who has been involved with methadone for 8 years. He stated that he lives with his wife and their children in an apartment and is employed. Rex reported using a variety of opiates such as heroin, OxyContin, and Fentanyl patch. He also admitted a history of IV drug use. Rex stated that he had no previous treatment experience before starting methadone. He has been involved in NA but reported no sponsor or other support. Rex's opiate use began as a way to manage some pain, but it got out of control. He stated that he has also had to deal with some losses in his life, and the opiates temporarily addressed his depression.

Rex said his reason for starting methadone treatment was that his son told him that unless he got help, Rex would not see his granddaughter. He also stated that his wife became upset with his behavior and threatened to leave him. Rex admitted that he used

his income to support his habit in the past and did not pay his bills. He said that he did not feel his gender or race impacted his treatment experience. He stated that his goal is to remain sober and improve his relationship with his family.

James

James is a 55-year-old single White male who reported being involved with methadone for 20 years. He lives with friends, one of whom is also using methadone to maintain his sobriety, and they support each other. James reported using a variety of opiates such as heroin, OxyContin, 80 mg, morphine, and Demerol, 50 mg which he took from people who were taking the medications for their pain management. He has also been an IV drug user. James admitted that he has been in residential and outpatient treatment to address his opiate addiction. He stated that he began using opiates as he wanted to be part of the crowd at the time and found that he could not stop.

James said he began using methadone for his opiate addiction after he saw several friends die from an overdose and realized it could happen to him. He also stated that he was "sick and tired of being sick and tired." He said he was tired of using needles and sick of the behavior he engaged in to support his habit. James stated that he supported his habit by using his income and hustling others for money for his addiction. He stated that he did not feel his gender or race impacted his treatment experience. He said his goal is to remain sober and wean himself off methadone.

Themes Derived From Data Analysis

The purpose of this study was to explore the experiences of older addicts and their use of methadone to maintain their sobriety. To gather significant meaning from the

formal interviews, I used van Manen's (1997) selective highlighting technique. This particular data analysis approach allowed me to identify key portions of the text and highlight them to find specific themes. Initially, text highlighting was done in the transcriptions, but I also highlighted the salient text in NVivo 11 during the final data analysis.

As the data analysis process unfolded, I identified certain thematic statements for each distinctive meaning that I discovered in the transcripts. Van Manen (1997) indicated that themes are statements or thematic statements that sum up each major portion of the text and that present a special facet to the overall understanding of the phenomenon. Van Manen saw their development as being distinctive in qualitative methods. Using NVivo 11 allowed me to link significant text with essential themes. This process of linking themes that NVivo 11 recognized further illustrated the iterative nature of theme development. Each time I reviewed the transcript, I found new linkages and expanded my perception of each essential theme.

After completing my analysis, I identified five main themes: relationships with others and how methadone has impacted these relationships, attitude of being an older methadone user, mental health stressors related to being an older methadone user, attending the methadone clinic daily, and needing other treatment besides methadone to address their opiate addiction. Table 3 shows the complete list of the themes, the number of sources each theme came from, and the number of times each theme was referred in the participants' discussion. Themes were derived from eight interviews. All participants engaged in the process and provided additional information when asked for clarification.

Table 3

Final Themes With NVivo 11 Data Analysis Summary Demographics of Participants

Themes	Number of sources from which each theme was derived	Number of references across all sources
Relationships with others and how methadone has impacted these relationships	8	16
Attitude of being an older methadone user	8	20
Mental health stressors related being an older methadone user	8	22
Attending the methadone clinic daily	8	36
Needing other treatment besides methadone to address their opiate addiction	8	18

The following sections include the interview content that related to the major themes. Throughout these sections, quotations are used as evidence of the themes. These quotations are not meant to serve as exhaustive examples of the influential factors that were shared during the interviews. Instead, the quotations are intended to give the reader a flavor of the thoughts the participants had about their lived experiences regarding methadone use and some of the actual experiences that motivated them to get sober or made it difficult for them to maintain their sobriety. The quotations serve as a textural description of the participants' lived experiences. The quotations that detail actions that were taken or how different behaviors were manifested in their lives serve as a structural description of their lived experiences. The collective narrative summary was constructed to highlight the essence of their needs as consumers of addiction therapy.

Methadone's Impact on Participants' Relationships with Others

Several study participants shared concerns about how their addiction has affected their families, especially their children and grandchildren. All participants spoke to the point that they, like other people, are human and have flaws. There was a concern that due to their addiction, others saw them as being extremely weak and unable to resolve issues in their lives. This idea appeared to be especially true for the male participants. Danny spoke openly about his struggles with opiates and needing methadone to remain sober. He stated that others had indicated to him that people who need methadone, particularly older adults, were simply trading one drug for another.

> My family and friends do not know that I am taking methadone. I feel they would see it as me just using another drug. I won't tell my family that I am using methadone until I am using less so that they won't judge me. When I became addicted to OxyContin, and I was struggling to try and get sober, my family and some friends did not want me around. Their view on addicts was that I would steal from them to support my habit. I couldn't tell them that I was hurting both physically and emotionally as I felt they abandoned me.

Bernice provided information suggesting that she received mixed support from her family and friends due to her involvement with methadone. She spoke of how some of her family supported her being on methadone while others felt that she needed to end her dependency on other drugs.

> Some of my family thinks that it is good that I am using methadone to treat my addiction, while I have some who have an issue with it feeling that I traded one

> drug for another. They thought when I was hurting, I should find a way to suck it up and be strong. I was a wife and mother and wanted to be there for my family, but could not find a way due to my drug use.

Anna, who has been struggling with her addiction for over 20 years, stated that it was difficult for her to be open and honest with her family about her addiction, especially being a female.

> My family treats me like I am still on street drugs. If my family sees me using methadone, they treat me like I am no good. They said that if I wanted to stop using drugs, I would get off with no problems. They also saw methadone as being something that is short term and don't understand that without methadone I could return to my drug of choice. Because I am a woman, I am supposed to know better and should be the caregiver for others and not have others take care of me.

Nancy, who spoke of her concerns about needing methadone to stay alive, shared how her family blames her for other family members becoming addicted to drugs and stated that her relatives wish she did not use methadone.

> My mother and other relatives hate me being on methadone. They do attach a stigma to being on methadone. My family blames me for my daughter and others becoming addicted to drugs and needing methadone. Some family members think that I am using methadone as a way to continue my drug use and get high.

When Elizabeth spoke about the importance of family, she talked about it from a self-need approach. As a person who was involved in the criminal justice system due to her addiction, she learned that she sometimes cannot depend on others for care.

> Some of my family members see people using methadone as being IV drug users. When I struggled in the past, I could not be honest with them for fear of being rejected and ostracized. I had to find treatment on my own and be able to answer their questions about addiction. I found it necessary to pull back from others for some time to reflect, refocus, and reenergize to continue working on my recovery.

William also indicated that his family does not support him needing methadone to work on his recovery. He further indicated that he did not seek support from his family for his recovery and reported that he is on his own when he works his recovery.

> My family sees me using methadone as a way of getting high. They think that I should just be able to stop on my own. I don't get my family and others involved in my treatment, I work it by myself. I don't think they understand the pressure and that comes from me trying to be sober. My family is unsure what to say or how to help at times, but continues to tell me not to use.

There were two exceptions to this position. James indicated that he receives a great deal of support from his family but not his friends. He indicated that his family supports his recovery efforts but stated that he has hidden his issue from some of his friends.

> My family is all for me using methadone to stay sober and not return to my previous behavior. My family is also very supportive of my treatment, especially my mother. I know that if I did not have her support, I would become upset and probably use again. I have not told my friends about me using methadone because I feel they would judge me too much due to my previous behavior. They

> categorize being on methadone as hanging out with other drug addicts and not doing anything about my life. I don't think they understand the need to be on methadone and that my addiction is a disease. When it comes to people other than my family I feel that I am fighting a losing battle trying to get them to understand.

Rex indicated that he receives support from his family and friends as it relates to him being on methadone and not using. He acknowledged that he seeks his family and friends' to help him remain sober.

> My family and friends are okay with me using methadone. They saw how I was in the past and feel that methadone has had some positive effects on me. The people who don't know about how methadone works are uneducated about addiction and its impact on people's lives.

All study participants provided examples of their humanness and how others find it difficult to view them as being less than human or not having others accept them as they are. This common theme speaks to the need for older methadone users to have healthy relationships with family and friends without feeling that others are judging them or placing unrealistic expectations on them.

Attitudes Related to Being an Older Methadone User

Participants' attitudes appeared to be mixed relating to older opiate users needing to be on methadone. Several of the women interviewed had a negative attitude about being on methadone at their age while most of the men reflected a positive attitude.

Nancy reported feeling upset that no one talked to her about how long she would be on methadone and some of its physical effects on her.

> I wished someone had warned me about the ultimate downfall. I would have never started using methadone had I known that I would be on it forever. I would have loved it if they had advised me about why I needed methadone for as long as I have taken it and I might have changed my mind.

Nancy also spoke about the physical and emotional rollercoaster she felt being on methadone. She acknowledged that despite needing methadone to maintain her life, she was unhappy about depending on it, and said, "I wished someone would have warned me about the withdrawals when methadone wears off, I would never have started using it."

Even though Bernice acknowledged that it has been hard for her to remain sober in the past, she has problems with not being able to eliminate her need for methadone.

> To me methadone is more addicting than other drugs, and I wish I had never started it. I feel like being on methadone has made me age more and sometimes I feel that this drug should be for younger people.

William also acknowledged his displeasure about needing to take methadone.

> Even though I need it to help deal with my physical pain, I do not like being dependent on methadone. I wish that they would counsel you or tell you about all that it takes to maintain your sobriety while, on methadone, I may have made a different choice. As you get older, it becomes harder to get along without the drug.

Danny indicated mixed feelings about being on methadone. He spoke about his struggles being an addict for as long has he has been, but also the importance of being on methadone.

> Methadone makes me feel like I have lost a lot and now it is catching up to me. Methadone has also helped me stay straight. I see methadone as a tool to get the most out of myself and it has also helped treat my chronic pain.

Anna also expressed some mixed feelings about being on methadone. She saw methadone as a lifesaver but also a curse.

> Methadone has saved my life and I may have been dead without it, but it has also put some serious stress in my life. When I don't take the methadone, I will go through some significant withdrawal. I need to go to the clinic daily to get my dosage and I hate it. I can't go anywhere due to needing to be dose daily.

Others expressed a more positive attitude about the importance of being on methadone at their age. Elizabeth stated that as she has an addictive personality, and recognizes the need to take methadone.

> I am grateful to this means of treatment, especially for someone my age. I have tried other medical treatment, including Suboxone, but I had trouble transitioning and eliminating other opiates out of my system when taking Suboxone. Methadone was the only medication that has worked for me.

Rex stated that it is difficult for someone his age to connect with other people of similar ages and with similar experiences who have also struggled with opiate addiction and needing methadone. He said, "It has helped me become more stable. I feel more

content and can be more active in society. Methadone has helped me reconnect with my family as I am now more involved with my family." Rex stated that before taking methadone, he felt as if he was alone at times as an addict and that others would not want to be around him or want him around their family.

James also acknowledged that at his age he struggles with feeling alone in his battle with his opiate addiction. He said, "I would rather be on methadone than be out hustling. At my age, I can't do what I did in the past, so taking methadone has saved my life."

Five participants directly expressed issues with taking methadone at their age. One participant who reported not having a problem being an older methadone user at her age said she felt it important to use whatever tool is available to overcome one's addiction. The importance of her needing methadone was still evident in her response to trials in her life.

Mental Health Stresses

As older methadone users, many participants expressed that there were certain stressors and experiences that came with being on methadone. The areas of life that were affected the most varied in intensity and frequency. Participants who shared concerns about stressors and experiences indicated that others cannot comprehend the gravity of maintaining their recovery.

For Nancy, the mental health stressors and experiences related to being an older opiate user centered on a myriad of emotions that she experienced and dealt with on a

daily basis. She spoke openly about the emotional ups and downs that she has to address while trying to help her daughter balance her emotional state.

> During different times when I was struggling with some of my issues, I could not address them as my daughter would call me upset because of problems with her boyfriend. I know that I have a co-occurring disorder and it is difficult for me to talk to others about my issues. I find it difficult to trust others because I have been burned so many times in the past. We do need help with our self-esteem for using methadone at our age.

Elizabeth shared how her mental health problems are related to her poor relationships with others. She also indicated that being over 50 years of age and knowing that she needed to make changes in her life has caused her some mental health problems.

> When you feel like you let others down you begin to feel some stress and realize there is no magic wand to fix your problems. A lot of times older addicts are misunderstood and so it becomes quite stressful. There are times I feel that trying to maintain my sobriety can feel overwhelming and I need to find someone I can talk to.

Saying no to others has been a major mental health problem for Anna.

> For many addicts, including myself, we want relationships with people who understand us so we hang out with the wrong people. As I want someone to like me, I am willing to do nearly anything. I feel that if I don't I won't have anyone who will like me. I become depressed when I say no and I become depressed when I do something I should not. In the past when I became depressed I would

use. Being an addict I feel that others may judge me for my past behaviors and not want to listen to my story.

Bernice also shared how being an older methadone user has caused her some mental health issues and feelings of depression. She acknowledged that she has found it difficult to share with others and that she feels that when she needs to talk, people will find all sorts of excuses not to be there for her or do not have the time or want to engage with her at an intimate level.

> You can always try to get some help from somewhere, but a lot of people look down on you for that. Some people think we should know better, but it would be good to get help from others. It becomes a problem so you feel like you are all by yourself.

Danny also acknowledged that he struggles with depression, but stated that he turns to his faith to help him through his problems. He said, "For me when I feel down, I go to church and try to retain my faith in God." He shared a personal experience of seeing someone overdose and struggling internally as he could have done more to help his friend or look for signs that his friend was in trouble.

> I was devastated when my friend died, but did not know how to deal with it except continuing to use. There was a definite weight of having to come to terms with being an older addict when you see someone die from doing the same thing you do. I think one of the challenges for us an older addicts is to recognize the mental health problems within yourself. You see others misbehaving and you can't help them because you are doing the same thing.

Older addicts face many mental health stressors on a daily basis. Five study participants shared examples from their lived experiences that have affected them as being an older person needing methadone. All of the women in the present study reported some form of a mental health problem related to being an older methadone user that could speak to the added stress of being an addict. Danny shared the emotional loneliness that he experienced for not feeling that he connected with his family and how some turned their back on him when they learned he was addicted to different opiates.

Although all participants expressed concerns about not being viewed as a human who has hurts and pains, most admitted that being seen simply as an addict has not allowed them to openly display their hurts and troubles. There was an inherent pressure of at least appearing healthy because they struggled to find emotionally safe people they could confide in.

Attending the Methadone Clinic Daily

Having to attend the methadone clinic daily to obtain their methadone was an issue evident throughout many participants' narratives. Not being able to have a normal life was not lost in this collection of older methadone users. For the participants in this study the inability to spend significant time with family and friends affected them having a normal life. Several participants spoke of being fearful of being penalized if they missed time at the clinic.

Anna was very outspoken about having to go to the clinic on a daily basis for her methadone. She expressed frustration about not being able to spend time with her father who lives outside the area and has some significant medical issues.

> I wished that we could find other ways to get our dosage. I feel as if I am chained to the clinic and I cannot go anywhere for a significant period due to needing to go the methadone clinic every day. I would like more of a life.

Bernice talked about feeling embarrassed having to go to the clinic and get permission from others to feel better. She explained that she felt that the clinic staff and others may treat her like a child and said, "I sometimes feel like they treat me as a child and not as an adult." Bernice spoke of her frustration of having to get herself ready to go to the clinic every day along with the stigma of being seen at the clinic. She indicated that due to her physical problems she struggles to have to go to the clinic every day and said, "I would like to get methadone from my medical doctor as he has a better understanding of all of the medications I need for my life."

Elizabeth expressed how she felt the system does not trust her by requiring her to come to the clinic daily.

> I know that there are consequences if I was to relapse. Making me come to the clinic every day does not guarantee I won't do anything I shouldn't do. I need to do be able to do other things with my life besides worrying about getting to the clinic every day.

For James, going to the clinic daily was very troublesome. As he does not have his own transportation he has to rely on people to get him to the clinic and does not like how others look at him being an older user.

> Even though my family wants me to get and stay sober, I know that they get frustrated about having to take me to clinic all the time. I also hate asking people

> for a ride and wish that I could feel like I have regained their trust. I feel people look at me differently because I am much older than what others expect people who are addicts look like who use methadone.

Nancy also felt that going to the clinic daily at her age made her feel that the staff did not trust her. She also talked about the difficulty of her family believing that she needs to attend the clinic daily.

> Trust is an important issue for me and when I have to go to the clinic daily, I feel as if I am being put down for being an older addict. Even though my family sees methadone as medicine, they don't see why I have to go every day as other people needing medicine are able to get it and go home.

William talked about how having to attend the clinic daily affects his ability to work. He indicated that he would like to have a normal life and be able to show others that he can care for himself. For him attending the clinic daily prevents him from being able to work overtime or different schedules. He said, "I would like to work first shift or get promoted, but I can't because the times I would have to work would interfere with me getting my meds."

Six participants shared their frustrations about going to the clinic on a daily basis. These participants all shared their negative experiences that spoke to them having to ensure that they will not misuse their medication. The need to attend the clinic daily appears to add to the stigma of being an older methadone user and the feeling of being alone and isolated.

Needing Other Treatment Besides Methadone

The need for additional treatment services for older and younger opiate addicts was not lost on study participants. Participants stated that for additional treatment to take place it was important that those who fund the programs understand and see that methadone by itself is not a cure for people's opiate addiction. Some participants identified what they felt would be appropriate treatment modalities for older opiate users.

Additional treatment for Nancy centered on the ability to find someone she could trust.

> I need to talk to someone about some of my past issues that contributed to my addiction. My problem is that I have tried counseling in the past, but I have felt betrayed by some people. "I know that other addicts and I need more than just our daily dosage, but I am not sure how to go about getting it."

She also indicated that therapists need to talk to clients about the clients' needs and not assume that as the therapist they know everything.

Elizabeth expressed her gratitude for being able to talk to someone about her problems and other issues that did not solely include using methadone.

> Treatment providers in the community have knowledge of additional resources for addicts. Working with a case manager, I was able to get decent housing. The other thing is that I know there is someone who will hold me accountable if I make a mistake, but not make me feel as if I was the worst person in the world.

Elizabeth said that one thing that helped her talk to her therapist was knowing that the therapist was duty bound to keep the secrets of others, which made her feel safe talking about issues that she did not feel comfortable sharing with family and friends.

Outpatient treatment is something Anna values and has used to deal with some significant problems in her life. She shared how in most instances she needed someone who forced her to talk and share thereby helping her overcome past issues.

> For me it has been difficult to share and I know that I have some issues from my past that need to come up. If they don't I could use again. I need a person who will push me to talk more about my addiction and what I went through. I need to talk about what I lost and if I go astray, they need to hold me accountable.

Bernice stated that involving older opiate users in additional treatment is imperative for their recovery. When asked what she could get out of therapy she said it would help her improve her self-esteem.

> I know that I have a lot of past issues that have impacted my life. I have been feeling depressed for a number of years and need to find out why so that it does not continue to cause me to want to return to using again.

For Bernice, treatment centers on feeling safe and being able to share. She also stated that being able to talk and speak out about her life helped ensure that she does not return to some old negative habits.

James said he is aware that treatment besides methadone would help him in his recovery but said that he has not found anyone he feels he could trust.

I know that I need other treatment as it will help keep me sober. I am selective about what I will use as I need to know that I can trust the person or the program. I would like to find someone near my age who also has experienced issues with addiction. I need to know that they can understand what I have gone through.

Five participants provided specific reasons for being involved in additional treatment. The most common themes were working with a therapist who is empathic, who will treat them with dignity and respect, and who hold them accountable if they were to relapse.

Summary

Participants in the present study discussed and shared a multitude of experiences and issues that they face on a regular basis when dealing with their need to use methadone to maintain their recovery. Data analysis resulted in five themes. These shared lived experiences or themes help broaden the understanding of the views, attitudes, and barriers for older methadone users. A discussion of study findings, limitations, recommendations, and social change implications is presented in Chapter 5.

Chapter 5: Discussion, Conclusions, and Recommendations

The present study's findings contribute to the understanding of the lived experiences of older methadone users addicted to various opiates and their thoughts about needing methadone. In this chapter, I summarize and expand on the results I presented in Chapter 4, discuss the findings in comparison to existing help for older methadone users in the literature review, examine the study's strengths and limitations, and offer directions for further research based on data from this study. It is also my hope that findings from this study will stimulate positive social change by increasing the education of addiction professionals and funders who have a vested interest in creating relevant interventions for this particular population.

The purpose of this phenomenological study was (a) to acquire an in-depth understanding of the phenomenon of older methadone users, (b) to elucidate and describe participants' experiences of addiction and treatment using their own voices and perspectives, (c) to extract and develop themes from the data, and (d) to interpret participants' lived experiences and meaning constructions using a theoretical framework of addiction. This research study was conducted to address a gap in the literature on older methadone users, a population that has not been the subject of many studies. I hoped that findings generated from the study could inform therapeutic interventions designed to improve the treatment experience for older methadone users.

Through this phenomenological study, the lived experiences or unique phenomenon of the treatment needs, views, and attitudes of older methadone users was established. Participants all stated that treatment providers treating them with dignity and

respect was important and sometimes overlooked. The idea of decreasing their current methadone dosage was not identified as an issue that current treatment providers encouraged or felt older methadone users needed to consider. Instead, current dosage was valued and supported, although accessing actual care was more difficult for many reasons and rationales.

Male and female participants all identified as being opiate dependent and needing methadone for their addiction but reported that they were not given the opportunity or social permission to be seen as having flaws. This failure on the parts of others to accept their defects did not prevent them from seeking out care but made it more difficult.

In the fall of 2015, eight methadone users ages 50–55 years were recruited from the greater Grand Rapids, Michigan, area to participate in the present study. The participants agreed to share their stories about being on methadone at their age, their history of opiate addiction, and their treatment experience. As a result of extensive qualitative data analysis, five prominent themes materialized from the study. These themes were (a) relationships with others and the impact methadone has on these relationships, (b) attitudes of being an older methadone user, (c) mental health stressors related to being an older methadone user, (d) attending the methadone clinic daily, and (e) needing other treatment besides methadone to address their opiate addiction. Through these five themes, the lived experiences of older methadone users and their treatment needs, views, and attitudes about being an older methadone user were explained. Based on the participants' responses to the interview questions as well as the constructed

meanings and interpretations that emerged from the data analysis process, answers to the research questions and a discussion of findings for each identified theme were as follows.

Hermeneutic Reflection

As the participants reflected on their lived experiences, their perceptions of what it means to be an older methadone user began to materialize and form. Interpreting the addicts' productions of this enigmatic, socially constructed phenomenon, I observed that being an older methadone user means understanding and developing the need to rise above their previous hardships, which for study participants includes the challenge of trying to maintain their sobriety along with developing a normal life. Participants' need for methadone and their disappointment in needing the medication have caused them mixed feelings about their current treatment. Having survived their addiction, the participants discovered the need to have others involved in their treatment experience recognizing they cannot remain sober on their own. The participants in this present study understood that their addiction has caused them problems in their lives and has also caused them to rethink their relationships with others.

Research Questions and Answers

This hermeneutic phenomenological study was guided by two main research questions and one subquestion:

- RQ 1: What are the lived experiences of opiate users ages 50–55 years who take methadone to manage their addiction?
- RQ 2: How do opiate users ages 50–55 years relate their particular experiences to the idea of recovery?

- Subquestion: How do these same opiate users on methadone remain consistent in their methadone treatment so that they can stay in recovery?

Research Question 1

As the study findings illustrate, the participants ascribed meaning to their traumatic experiences regarding finding that they need methadone to have a life. The participants also indicated an increased dependency on others such as family and friends, a need to increase their self-worth and a need for personal growth, and a greater dependence on a treatment program. The most significant, compelling, and integrated meaning participants drew from their lived experiences is that their dependency on methadone was based on previous issues. In other words, the participants believed poor decision-making in the past had contributed to their dependency on methadone. As the accounts reflected in Theme 2 revealed, the participants' lives became more consequential and focused through their telling others of their pain and suffering. Because of their live experiences, the majority of participants perceived that younger methadone users need to listen to them and understand the impact of their poor decision-making.

Research Question 2

Based on the participants' meaning-making constructions, the participants' idea for needing recovery was the linchpin that held their unstable and complicated lives together. All participants endorsed the belief that recovery supports them during times of crisis and inflamed disturbance. The participants'accounts, the information indicated that they would not have lasted, let alone improved, without being in some type of treatment.

Although their commitment to recovery was tested when participants were being tempted, they reported that once they began using methadone participants never lost sight of the importance of being in recovery. As Elizabeth stated, “Recovery saved my life and I would not be here if I had not begun to believe in it and work the methadone program.” Consequently, as the participants reflected on their lived experiences and as they gained awareness and perspective about recovery, their belief in the need for recovery grew stronger and more resilient.

Follow-Up Question

All participants acknowledged that despite their feelings about taking methadone, they do not miss an appointment. These participants stated that if they missed an appointment they could experience some physical and emotional withdrawal. These particpants also indicated that they would be expelled from the program and have to start all over again. Several participants expressed a desire not to have to attend the clinic every day. Some participants stated they wished there was a way to get the methadone treatment without going to the clinic daily. Anna stated that she felt chained to the clinic and could not spend time with others without having to report in. William indicated that he did not think the need to be involved in a recovery program is necessary for him to stay sober.

For the most part, all study participants readily identified the importance of being in recovery at their age in at least some aspect. In light of their problematic lives, most participants found important meaning in being involved in recovery that includes additional support. With the possibility of relapse, the participants held firmly to their

belief of being in recovery to keep them from returning to previous behaviors that were problematic for them.

One advantage that clinic attendance provides is consistency. According to Madden, Lea, Bath, and Winstock (2008) public clinics provide structured treatment that oversees the client's dosing and access to medical staff and other support like case management, if needed. The negative of not attending the clinic daily is that there is no guarantee the participant will take the dosage as prescribed. Attendance offers structured treatment including supervised dosing and access to medical specialist and case management support. Takeaway doses are not dispensed routinely at most clinics and treatment is provided at no cost to the client.

The concern is creating and sustaining medically dependent opiate users. Despite attending the clinic daily, the participants indicated that no one has discussed with them the idea of reducing their dosage after some time. Treatment providers are now being paid for the number of people they treat and may not consider transferring clients to other treatment providers, i.e., primary care physicians. Furthermore given the growing rate of opioid-dependent patients seeking psychosocial treatments there is a need to evaluate alternate interventions.

Thematic Findings

Theme 1: Methadone Impact on Participants' Relationships With Others

Study participants talked about how much their addiction has impacted their relationships with others. Several voiced disappointment and guilt about the effect their addiction has had on their families. The women in the study were more expressive of

their guilt feelings than the men. Two female participants talked about feeling guilty about how their addiction forced them to eliminate any contact with their family and friends. These females acknowledged that they chose their opiates over their children and other family members.

Another issue for study participants was trying to reestablish relationships with family and friends that had become strained due to their addiction. Several participants indicated that they have been working on trying to restore themselves with family and friends but that lack of trust interfered with that process. Seven participants indicated that it was important for older addicts to understand that their addiction impacts them and others as well.

Similar to the previous research of Hamilton and Grella (2009), findings from the present study indicate that some older opiate addicts have regret and shame when it comes to their addiction and their relationships with others. Present findings showed some difference between genders in that male and female participants expressed similar feelings about the need to improve or reestablish family and social relationships. The women in the study indicated that they wanted to improve their relationship with their family members, while only two of the men acknowledged the same. Doukas (2011) noted that as addicts age, their immediate support system decreases as their family and friends move away or die. Many older addicts may isolate themselves from others due to their drug use thereby reducing their support system. Developing and keeping a healthy support system is important for anyone who is involved in substance abuse treatment, but this is particularly important for older adults in the present study.

Theme 2: Attitude of Being an Older Methadone User

As reported in Chapter 4, study participants appeared to have mixed feelings about needing methadone at their age. Several of the women had a negative attitude about being on methadone at their age, while the men reflected a positive attitude. The female participants acknowledged trouble dealing with the stigma of being older methadone users. Some identified with issues of health, negative social relationships, and other stigmas associated with aging. Combined with needing methadone for their addiction, the participants reported feeling that society takes a dim view of them still needing support.

One issue that was evident throughout the interviews was the participants' concern about becoming addicted to methadone and having to experience withdrawal if they stopped taking it. Seven participants indicated that they were upset about starting methadone as they now are hooked on it like their opiates. These seven participants all agreed on the need to take methadone to help block and reduce the craving for illicit opiates. When asked what the chances of reducing their dosage were, six participants reported they did not feel they could for fear of physical and psychological withdrawal.

One attitude participants expressed about being placed on methadone was treatment providers failing to inform potential clients of the risks of taking methadone. Two participants expressed concerns and anger about the lack of education provided to them regarding any problems with taking methadone. Four participants stated that they did not realize that they would need to take methadone for as long as they have been taking it. Some participants in the study indicated that methadone programs did not

inform them that opiate addicts would need to take methadone for the rest of their lives and that their options were limited in treating their opiate addiction.

Theme 3: Mental Health Stresses

Mental health stressors and experiences related to being an older methadone user were prevalent in participant comments. Being an older methadone user was described as being stressful most of the time. Study participants could not stress enough the emotional and mental weight and burden that comes with needing methadone to feel safe and secure. Being on methadone at their ages was described as tiresome and, at times, a burden.

Participants who have wanted to maintain a relationship with family members while using methadone needed to address mental health and stressful issues. These participants were not only responsible for maintaining their recovery but also felt a need to assure family members that they could be trusted to take care of finances, to be a good parent, and to ensure the family's safety and welfare. Study participants identified the emotional swings they experienced on an average day. These participants acknowledged they could start their day thinking about getting to the clinic for their daily dosage and then worry about improving their relationships with others and improving their self-esteem.

Two of the women in this study expressed a need for mental health treatment to address past issues that were an impetus for their drug use. These issues were relationship problems, physical abuse, and feelings of rejection. One of the men in the study expressed concern about how the stress and experiences he had to deal with affected

members of his family. He understood that even though he was the addict, his behavior had an impact on his wife and children.

Although already dealing with the stigma of being an IV drug user, of aging, and of being on methadone treatment, many participants faced the stigma of mental illness. Like previous studies such as those made by Connor and Rosen (2008) and Semple, Grant, and Patterson (2005) regarding the stigma of mental illness, present study findings also showed that despite the need to address their mental issues, older methadone users were reluctant to talk to their family and friends about them. As previously stated, participants felt distinct pressure from family members to be perfect and not be affected by stress and life struggles in the same manner as those who are not addicts. Although the participants desired to be viewed as human, there was also pressure to maintain an image of being "healthy and fine." This pressure made it difficult for participants to seek help, as they feared that they would return to their previous drug use behavior if they failed.

Study participants made it clear that mental health treatment is important and a needed part of good self-care if older opiate users are to operate in a healthy manner when facing stressful situations. In talking about what qualities were most desirable in a therapist, participants wanted someone who had experienced addiction, relapse, and cravings. These qualities were approached from multiple perspectives. One participant compared the need for the therapist to understand cravings and other issues associated with being an addict with physicians who should be well educated in patients' medical needs. Two participants commented on the need to know that the advice or guidance they received would be based on the 12-step program. According to Kothari, Hardy, and Rowe

(2010), the therapist's approach for treatment in helping the addict develop a commitment to staying sober and being consistent with their treatment goals is vital to developing a strong alliance.

Theme 4: Attending the Methadone Clinic Daily

Unlike health policies in other countries, the United States does not have a specific policy regarding drug treatment service delivery. Many study participants supported the idea of obtaining their medication without having to attend the clinic on a daily basis. Similar to previous study findings of Treloar, Fraser, and Valentine (2007), participants indicated the benefits to them would be greater convenience, saving money on travel, reducing the possibility of others learning about their involvement, and increasing the ability to work. When starting a methadone treatment program, clients new to the procedure are expected to come to the clinic on a daily basis to secure their medication. One concern acknowledged by present study participants was the difficulty in getting to the clinic on a daily basis. Participants' feelings appear to be supported by previous study findings that programs requiring long-term commitments for daily clinic attendance had difficulty retaining clients in treatment (Bell, Dru, Fisher, Levit, & Safraz, 2002).

Six participants expressed frustration about having to go to the clinic daily. The majority of participants felt that attending the clinic daily reflected a lack of trust in them. When asked about the possibility of relapsing, participants indicated that they would be more than willing to take a drug test to ensure that they are not using illicit drugs such as cocaine or marijuana. One participant noted that she was well aware of the consequences

should she violate her agreement not to use illegal or illicit drugs. It should be noted that urine drug tests will identify methadone as an opiate, but not an increase level of the opiates. Participants' responses regarding service delivery and the clinic environment reflected a strong desire for having flexibility in going to the clinic and receiving their dosage as well as in clinic hours of operation. Their concerns were similar to those in other research regarding methadone treatment (Madden, Lea, Bath, & Winstock, 2008).

Study participants seemed acutely aware of how clinic workers and others perceived their desire not to attend the clinic on a daily basis. Participants expressed concern that they did not always make the best decisions when it came to ensuring their methadone use. Participants shared stories of how some older users who were allowed to take their medication unsupervised did not always comply with the rules thereby forcing the clinic and others to reevaluate the takeaway program. A major theme derived from study participants when it came to not attending the clinic on a daily basis was trying to facilitate a normal lifestyle and generate a sense of trust in society.

Theme 5: Needing Other Treatment Besides Methadone

Needing other treatment besides methadone was an issue many study participants expressed throughout their narratives. Not lost on the participants was the need for additional treatment services not only for them at their age, but also for younger opiate addicts. Several women talked about their depression and its impact on their addiction. These women noted that they needed additional services to combat their depression so they would not seek drugs to treat their former ways of addressing their depression. Another reason for needing additional treatment was to help with the loss that older

opiate users have experienced. Six participants reported not being able to work to support themselves and experiencing some depression due to the loss of friends and associates. Although all of the participants felt that methadone was helping them with their cravings, three participants indicated that eliminating their cravings would help them not overdose like the friends they lost due to their friends' addiction. Present study findings related to other issues besides participants' addiction were similar to previous research related to co-occurring issues. Minkoff and Cline (2006) noted that when treating people with addiction and a mental health disorder, both should be treated at the simultaneously and each one given equal importance.

Participants also discussed needing additional help with medical issues. Research has shown that medical professionals who work with people with addiction need to be trained to work with older opiate users who may be presenting with issues besides addiction (Doukas, 2011; Williamson, Darke, Ross, & Teesson, 2009). All four women in the present study admitted having some physical problems, and two of the women needed assistance for their mobility. These women reported due to their addiction they forfeited nutritional needs, failed to seek medical attention when feeling ill, or utilized prevention services such as flu shots or other vaccination as they were engaging in drug seeking behavior. Two of the men stated that they had experienced some physical problems but had not sought medical attention. All participants noted that it was difficult for them to see a doctor on a regular basis, as all of the primary care physicians in the area limited the number of Medicaid patients they treated.

In the present study, seven participants reported being involved in an NA program. The particapnts' reasons for being involved included the support the participants received from other addicts. Etheridge, Hubbard, Anderson, Craddock, and Flynn (1997) noted that the increase in NA meeting involvement is due in part to others understanding the importance of aftercare programs and a decrease in funding for treatment programs. Despite the 40 years of research on 12-step programs (White at al. (2013) stated treatment providers should not view 12-step programs as a standalone treatment.

One issue in the present study that appeared to be similar to those in other studies was the lack of connecting with a sponsor. Only one participant indicated having a sponsor or someone in a program to talk to. Five participants stated that the reason for not having a sponsor was more about trust than availability. Concerns about confidentiality made it difficult for the participants to seek help as they felt a sponsor would, intentionally or not, share what was said. One participant valued being able to go to therapy in a place where he would not be seen by many people because of the premium he puts on privacy. If participants are involved in a 12-step program, other treatment modalities should also be such as outpatient methadone (OMT) and outpatient drug-free (ODF) programs should be included in their treatment plan.

Another issue participants noted was dealing with some negative experiences at NA or AA meetings. Five participants talked about how some 12-step program participants, especially those in AA, saw people taking methadone as substituting one drug for another. As a result, these participants felt as if they were being punished for

caring for themselves. Although greater 12 step attendance was related to better treatment outcomes after detoxification, patient attendance and involvement in these groups did not lead to better opiate use outcomes. Consequently, an important goal of psychotherapy should be to encourage and maintain NA involvement. However, simply supporting a psychotherapy patient's participation in NA fails to result in a unified treatment approach if the two models of change are not working together in a coordinated manner.

Limitations of the Study

The present study's primary strength was its design. The help-seeking views, attitudes, and barriers for older methadone users are areas that have not received much research attention. This lack of information influenced the decision to use an empirical phenomenological framework to better understand the lived experiences of older methadone users. This form of qualitative research allowed for collecting data through an initial interview. By conducting in-depth interviews, I built rapport with the participants. This rapport was conducive to creating an environment of respect and safety that led to participants sharing deeply personal and revealing information.

Additional study strengths included (a) bracketing of my experiences as growing up in an addictive family, (b) being an addiction therapist, (c) manageable sample size, which allowed for greater depth and broader scope of data retrieval, (d) an even distribution of men and women, which allowed for varying perspectives, (e) the age range of the participants in that they were all close in age and therefore able to identify with some similarities while growing up, (f) the semistructured interview protocol to

minimize researcher bias and allow for participants to explore their experiences as they saw fit, and (g) a comprehensive analysis.

With this said, it is important to note that results from the present study should be weighed against several limitations that are typical of qualitative research. First, the results may not be generalized to larger populations of older methadone users as my focus was only on elucidating and describing the lived experiences of the eight study participants. Second, all participants in the study came from the greater Grand Rapids, Michigan area, and all but one attended the same methadone clinic. Such similarity could impact the study as those attending the same clinic may have similar responses to all of the questions.

Third, the sample was fairly homogeneous in that all of the participants were White despite efforts to recruit African Americans and other minorities who would also identify as being older methadone users. Therefore, the results may not be representative of members of a more diverse ethnic or racial groups. To recruit African Americans and other minorities, Spence and Oltmanns (2011) suggested that the advertisement seeking participants should be very specific as a general announcement may be viewed with skepticism in a minority community. Another way to help recruit minorities for future studies is that older African American should be addressed by their surname until the researcher is given permission to call the potential participant by their first name. Such behavior shows respect and sincerity in the African American community. Fourth, the information gathered for this study was obtained by conducting in-depth interviews and relied on participants' self-reporting. As a result, there were no objective measures to

substantiate their stories or any empirical data as this type of information gathering was beyond the present study's scope. I relied on each participant to be truthful about his or her experience as an older methadone user. Even knowing that they were to receive a small token of appreciation, all participants appeared surprised and appreciative when they received it.

Research Recommendations

Based on the present study's strengths and limitations, some recommendations are proposed for future research. First, additional phenomenological studies should be conducted to examine the lived experiences of older methadone users. As discussed in Chapter 2, there is a significant gap in the qualitative literature about the experiences of older opiate users who depend on methadone for their addiction treatment. At the same time, methadone continues to be the primary treatment for opiate-addicted people, and the number of people needing methadone is on the rise (Bart, 2012; Gossop & Moos, 2008).

Second, while some quantitative studies have been conducted over the past several years on methadone use and addiction, very few phenomenological studies have been conducted to specifically examine older methadone users. Moreover, relatively few qualitative studies have been conducted regarding older methadone users needing to attend the methadone clinic and how not wanting to attend the clinic daily influences their methadone treatment. Generally speaking, more researchers should examine the stigma of being older methadone users and the stigma of having to be supervised while

taking their medication and how the medication impacts their treatment experience (Anstice et al., 2009).

Third, future research on the lived experiences of older methadone users should focus on examining how various mental health diagnoses, family relationships, and legal status correlates with the treatment modality. Researchers should consider different coping strategies older methadone users engage in, including NA meetings, spirituality, and religious involvement. Although all present study participants acknowledged the importance of having a higher power, none indicated being involved in a specific religion. Furthermore, research should be conducted on this population's help-seeking behaviors. Studies conducted over the past several years have shown that older methadone users experience some significant losses and exhibit a high degree of anxiety, low self-esteem, and a feeling of hopelessness (Borelli, Luthar, & Suchman, 2010; Gil-Rivas et al., 2009; Kwiatkowski & Booth, 2003; Wu & Blazer, 2011).

Fourth, research in this area would benefit from a larger study that sampled more participants and reflected a better racial balance. As previously mentioned, efforts were made to include African Americans in the present study, but this was not accomplished. African Americans are reluctant to be in an empirical research due to not trusting research based on past negative experiences (Coker, Huang, & Kashubeck-West, 2009; Katz et al., 2009). Generally speaking, African Americans tend not to trust outsiders as there is a shroud of secrecy regarding the African American culture (Nicolaidis et al., 2010). By expanding this study, the results could be generalized to a larger population of older methadone.

A larger study would potentially allow for more themes under the views domain to be flushed out and explored, which would further impact how clinicians understand and work with older methadone users. A larger study would also allow for further exploration of issues such as confidentiality in the community and in the clinical relationship. Finally, a larger study would also potentially carve a well-rounded depiction of the preferred characteristics of clinicians who work with this population. From a larger study, a treatment model could be developed through a qualitative grounded theory framework. As older methadone users are better understood in their cultural context, a model that addresses and understands older methadone in that context could prove monumental. Older methadone users must deal with the reality of being an opiate addict in the addiction community as well as individuals unable to share their stories with others. This unique intersection requires sensitivity to ethnic, spiritual, and cultural issues. A model in which it were possible to juxtapose these key identity factors for this population would be a model with the power for addressing stigma and making mental treatment more accessible and welcoming to older methadone users.

A study on the impact of good mental health care and wellness in older methadone users and how these factors influence the mental health and emotional wellness of their families, especially their children, would be powerful. Many participants in the present study shared concerns about how their addiction had affected their relationships with family members and how their children have engaged in some drug use themselves or cannot relate well to others. Further examination of relationships with

family members may impact older methadone users' decisions to seek help if they believed that it would impact their family in a positive manner.

Implications for Social Change

Some important implications emanated from the present study's findings related to research methodology, the practice of professional counseling, and engendering positive social change at the micro- and macrosocietal levels. Regarding methodology, results from the present study add to the knowledge base of qualitative research concerning older methadone user. This study was undertaken, in part, because a significant gap existed in the qualitative literature about dosage and the need for daily clinic attendance for older methadone users in the United States. The majority of the research I identified in Chapter 2 was done in Europe or Australia.

To date, few phenomenological studies have been conducted on the lived experiences of older methadone users in general and the lack of ongoing treatment outside of the daily dosage they receive. Moreover, the intrapsychic and sociocultural factors impacting low-income older methadone users have not been closely examined from a hermeneutical phenomenological standpoint. Even community gatekeepers tend to be leery of empirical research endeavors, especially where vulnerable populations are concerned. For instance, before launching this study, I attempted to gain access to two major methadone treatment clinics by visiting and talking about the study to the program directors. Neither was willing to help recruit participants and felt the study was unnecessary. Despite these roadblocks, I forged ahead and employed a mass marketing approach, which proved effective.

Findings from this study further convey implications for professionals working with older methadone users. Professionals involved with addiction treatment, particularly methadone, may use this study's results to develop appropriate treatment interventions for this population. Although much of previous research about methadone maintenance treatment focused on dosing and illegal drug use, it is important for treatment providers to understand how to incorporate various treatment modalities for an older population dependent on various medications. Findings from the present study validated prior research findings indicating that older methadone users will need a variety of services to help ensure they maintain their sobriety and do not return to previous negative behaviors.

In the same vein, findings from the present study can potentially create positive social change for older methadone users who fail to grasp the need for additional services and may fall victim to not engaging in other treatment. Collaboration is needed between treatment providers, funders, and the addiction community so that positive social change for individuals on methadone may help reduce relapses, criminal justice system involvement, and increase medical interventions among older methadone users. On an organizational level, an ongoing working collaboration between treatment programs and the addiction community may result in service delivery improvement and increase knowledge regarding stages of change. Finally, relationships between older methadone users and treatment providers can potentially increase utilization of other services such as employment and education counseling as well as others as a well-informed provider may be more willing to refer clients to nonclinical services.

Conclusion

This hermeneutic phenomenological study's focus was on examining the lives of eight methadone users ages 50–55 years who use methadone to address their dependency on various opiates. These participants shared their private stories and viewpoints for this study and discussed the issues that caused them to need methadone at their age. Findings from this study demonstrated that as this population ages there is a need for collaboration between service providers as older methadone users will need additional services to have a healthy life. Researchers to date have not adequately studied this population's experience in using other treatment modalities besides methadone and the outcomes of those who have. Study findings showed that older methadone users have unique lived experiences as they deal with views, attitudes, and barriers in maintaining their sobriety that need to be further explored and addressed if the field of addiction treatment hopes to provide quality and relevant care to all those who need such care and seek it out. It was my goal to provide a different perspective for service providers by giving a voice to older methadone users.

In spite of life's challenges, study participants have embarked on rebuilding and reinventing themselves as older methadone users. Taking their recovery slowly, the participants are progressively redefining their personal values; participants do not want to review any negative ideas from their past experiences or other people's beliefs of who they are or what they should be. Because of their renewed faith in themselves, study participants have become stronger and more knowledgeable about what methadone will

do for them. From their lived experiences, participants will hopefully take lessons learned with them and try to help others understand methadone's long-term effects.

As agents of social change, counselors and other human service practitioners must find ways to develop culturally relevant interventions to help older methadone users continue to make transformative and meaningful changes in their lives. Hopefully, findings cultivated from the present study will add to the body of knowledge that informs professional counselors in facilitating the process of growth and change for individuals' positive change that radiates to families, organizations, and society as a whole.

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Appendix A: Advertisement for Potential Participants

Advertisement for Potential Participants

Let your voice be heard!

Could you be a potential participant dissertation research study?

Who is conducting the study?

LaMart Hightower, a Ph.D. candidate at Walden University for the completion of his academic work. This facility is not conducting the study and is not responsible for questions asked, the collection of the material, or its dissemination.

What is the purpose of this study?

The purpose of this study is to assess the relationship between methadone maintenance and the life experiences of older opiate users, those 50 to 55 years old.

Who is needed for this study?

- Acknowledge a history of opiate dependency
- Are between 50 and 55 years old
- Are currently on methadone to treat their addiction to opiates
- Have been involved in a license methadone treatment program for the past two years
- Have not relapsed within the past year

In order to CONFIDENTIALLY find out more about this study and possible become a participant, please email me at [redacted] or call me at [redacted] with your contact information and your preferred means of communication and I will contact you with details and further information about the study.

Thank you

Appendix B: Demographic Data Questionnaire

Demographic Data Questionnaire

The title of this study is *A hermeneutic phenomenology examination of methadone treatment and relapse by opiate dependent addicts 50 years and older.*
Please complete each of the following demographic items. Thank you for your participation.

1. Gender (Please check one)

   Male____ Female____

2. Age at last birthday_____

3. Marital Status (Please check one)

   Married____ Divorced____ Widowed____ Single____

4. Please check one

   White_____ Black or African American____ Hispanic_____

   Asian American_____ Other_____ (please specify) _____

5. Highest educational level completed (Please check one)

   Grade School____ High School____ Some College____

   College Graduate____ Graduate or Professional School____

6. As of 2015, how many years have you been on methadone? _____

7. Are you taking methadone to treat an addiction to opiates? Yes_____ No____

8. How long have you been in recovery from opiates? _____

9. Are you taking methadone for pain management? Yes___ No____

10. Have your ever received treatment other than methadone for your addiction?

Yes____ No____

If yes, please identify which treatment (check all that apply)

Residential_____ IOP_____ Outpatient_____ NA/AA_____ Other_____

During the time of your sobriety how much of the time have you had any of the following problems with your work or regular daily activities as a result of your addiction (such as feeling depressed or anxious)?

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
11. Has your health declined in the past five years?	⬭	⬭	⬭	⬭	⬭
12. Accomplished less than you would like	⬭	⬭	⬭	⬭	⬭
13. Did activities decrease	⬭	⬭	⬭	⬭	⬭

14. During the past year to what extent has your addiction interfered with your normal social activities with family, friends, neighbors, or groups?

⬭ Not at all ⬭ Slightly ⬭ Moderately ⬭ Quite a bit ⬭ Extremely

15. Describe your cravings for opiates have you had in the past year?

⬭ None ⬭ Very Mild ⬭ Mild ⬭ Moderate ⬭ Severe ⬭ Very Severe

16. During the past year how much has your addiction interfere with your normal life (including both work outside the home and housework)?

⬭ Not at all ⬭ Slightly ⬭ Moderately ⬭ Quite a bit ⬭ Extremely

These questions are about how you feel and how things have been with you during the past year. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the past year.

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
17. How often has your health affected your treatment?	⬭	⬭	⬭	⬭	⬭
18. Do you have difficulty making appointments?	⬭	⬭	⬭	⬭	⬭
19. Do feel like your friends and family have been supportive of your treatment?	⬭	⬭	⬭	⬭	⬭
20. Have you thought about using another medical assisted treatment other than methadone?	⬭	⬭	⬭	⬭	⬭
21. During the past year how much has your addiction interfered with your social activities (like visiting friends, relatives, etc.)?	⬭	⬭	⬭	⬭	⬭
22. Do you feel like your treatment plan is working for you?	⬭	⬭	⬭	⬭	⬭

Appendix C: Informed Consent

Informed Consent Form

A hermeneutic phenomenological study of methadone treatment by opiate dependent addicts 50 years and older.

Walden University

You are participating in a research study of opiate users who are maintaining their recovery with the use of methadone. You are being asked to participate because you met the inclusion criteria for this study. The inclusion criteria are male or female, between the ages of 50 to 55 who are involved in a methadone clinic; have been taking methadone for at least two years; and reside in one of three counties in the state of Michigan, Kent, Muskegon, and Wayne. Please read this form and ask any questions you may have before signing this consent form.

This study is being conducted by LaMart Hightower (a PhD candidate at Walden University).

Background Information:

This study is important in the field of addiction as it increases the understanding of older opiate users and their lives such as family, medical issues, legal issues, and relationships. This study will help promote changes through improved understanding of methadone use for substance abuse therapists.

Procedure:

If you are interested in being in this study, please complete the attached questionnaire. Completing the questionnaire should take between 5 to 10 minutes. If you

meet the inclusion criteria, you will participate in an open ended interview which will last between 60 to 90 minutes. The interview will be audio taped. The researcher will ask questions regarding your life while using methadone. If you are unsure of the question, you may ask for clarification or indicate your refusal to answer any questions. Once the researcher has completed asking you questions, you will be given an opportunity to ask any questions of your own. If the researcher feels there is a need for follow up questions, he will inform you of this prior to your leaving and decide on the best way to communicate such request. The researcher will thank you for your time and discontinue the recording. It is important to note that you must sign the consent form before the research can begin to ask any questions.

Voluntary Nature of the Study:

Your participation in this study is strictly voluntary. Your decision whether or not to participate will not affect your current or future relationship with anyone. If you initially decide to participate, you are still free to withdraw at any time without affecting those relationships.

Risks and Benefits of Being in the Study:

In the event you begin to experience stress or possible relapse issues, you may terminate your participation at any time. You may also refuse to answer any questions you consider invasive or stressful. In addition, I will provide you with a referral for services in your community if you began to experience undue stress. In Muskegon County this will be a referral to Lakeshore Coordinating Agency, Kent County, this will be a referral to Network 180, and in Wayne County, this will be a referral to Detroit

Wayne Mental Health Authority. These places will offer a free evaluation and referral to appropriate treatment programs.

The benefit of participating in this study is to expand information available regarding opiate dependency, with an emphasis on methadone use among older opiate users.

Compensation:

Those who are interviewed will receive a $20.00 gift card from Walmart.

Confidentiality:

In order to ensure the confidentiality of the participants only the primary researcher will know the identities of each of the participants. Each participant will be given a pseudonym to disguise his or her identity. All paperwork regarding the participants will be stored in a locked file cabinet that only the primary researcher will have access to. The researcher will be sure to describe the sample in detail in the beginning of the study and information pertaining to a particular participant will not have any identifying information attached to it. All direct quotes that will be used will be shown to that participant prior to them being included in the study to ensure that the participant is comfortable with the wording and to give him or her an opportunity to modify the statement to provide them with sufficient anonymity.

Each of the participants in the study will be given pseudonyms (for example Participant #1) to prevent identification in reports or results. The key to the match of pseudonyms and the participant's real names will be kept at the researcher's office in a locked file cabinet. Participants' real names will only be kept while the data is being

collected throughout the study and will be separated from any of the data collected. Likewise, recorded data will be kept in a locked filed cabinet and transcripts will also be kept separate in a locked file cabinet. University regulations also require that the principal investigator keep copies of the participant list separate from transcribed data at his office in a locked file cabinet. The audio recordings of the interviews will be erased from the voice recorder after the transcripts are completed and checked for accuracy. Per Walden University's policy I will maintain all information in a locked file cabinet for five years after the completion of the study.

I also am aware that the researcher is a mandated reported in the state of Michigan and is required to report specific incidents to the appropriate authorities. These incidents include information that may indicate current child abuse or neglect; current abuse of a vulnerable adult; and/or indications that I am at risk of harming myself or others.

Contacts and Questions:

The researcher for this study is LaMart Hightower. The researcher's advisor is Dr. Barbara Benoliel. You may ask any questions you have now. If you have questions at a later date, you may contact LaMart Hightower at [redacted] or email [redacted]. The Research Participant Advocate at Walden University is Dr. Leilani Endicott and you may contact her at [redacted] if you have any questions about your participation in this study.

You may keep a copy of this consent form.

You will receive a copy of this form from the researcher.

Statement of Consent:

I have asked questions and have received the answers. I have read the above information and I agree to participate in the study.

Printed Name of the Participant:

_____ _____

Signature Date

_____ _____

Signature of Investigator Date

Appendix D: Script for Recruitment to Participate in In-Depth Interview

Script for Recruitment to Participate in In-Depth Interview

(This script is to be used when meeting with the participant face to face prior to the interview.

Hello my name is LaMart Hightower. Thank you for your willingness to participate in my dissertation study entitled "A hermeneutic phenomenological study of methadone treatment for opiate dependent addicts 50 to 55 years old."

As you may recall, the purpose of this study is to gain insight into the lives of people 50 to 55 years old who are using methadone to treat their addiction to opiates. The ultimate goal is to expand on existing help-seeking literature by using yours and other participants' experiences and worldviews to shed light on the lived experiences of older methadone users as it relates to treating their addiction, responding to additional needs, and understanding the role methadone plays in their lives.

The format of the individual interview is a conversational manner where you would respond to open-ended questions, describe your experiences, and include your thoughts and opinions concerning methadone use, your history of addiction, seeking other assistance, and other issues regarding your recovery.

Once I have completed all initial individual interviews and analyzed them, you and other participants may be asked to participate in a follow-up interview. The open-ended questions that will guide the follow-up interview will be developed based on yours and other participants' responses from the in-depth interviews.

All the information collected from you is confidential. Your name or any other identifying information will not be used in any analysis or in any reporting of the data. Your participation in this research is completely voluntary. You may decide not to participate, to withdraw at any time during the interview, or not to answer certain questions without prejudice or penalty.

May I answer any questions you have?

Thank the participant.