Counseling Interventions and Buprenorphine

for Treatment of Opioid Use Disorders

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ABSTRACT

Opioid abuse and opioid related deaths continue to affect families and communities across the United States. Medication-assisted treatment shows advantages over other types of interventions for opioid use disorder (OUD) (Bart, 2012). While buprenorphine, an approved medication for the treatment of OUD, has a wide research base to support its efficacy, there is little research or guidance on behavioral interventions to use in conjunction with the medication. Investigating clients' experiences in treatment can provide helpful and necessary information for improving treatment efforts. The following qualitative study used a phenomenological approach to explore the client experience of group therapy with buprenorphine for OUD. Results showed the importance of supportive, genuine relationships in recovery, as well as the need for accountability and a safe space for self-disclosure. This research highlights the importance of the therapeutic alliance, the 11 therapeutic factors of groups, and the necessity of building authentic relationships in treatment.

Keywords: opioid use disorder, medication-assisted treatment, buprenorphine, group therapy

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GENERAL AUDIENCE ABSTRACT

As opioid overdoses continue to rise in the United States, it is essential that we improve addiction treatment. Medication-assisted treatment (MAT) combines the use of medications and counseling to treat the whole person. This type of approach shows advantages over counseling only interventions for opioid use disorder (OUD) (Bart, 2012). While MAT shows promise over counseling only approaches, there is little research or guidance on how to implement counseling with the medication. Investigating clients' experiences in treatment can provide helpful and necessary information for improving counseling in MAT. The following qualitative study used in-depth interviews with participants who are currently in a MAT program to better understand their experiences in treatment. Results showed the importance of supportive, genuine relationships in recovery, as well as the need for accountability and a safe space for sharing. This research helps further knowledge of treatment for OUD to better serve those affected by addiction, as well as adding to the gaps in group therapy and addiction's literature.

Keywords: opioid use disorder, medication-assisted treatment, buprenorphine, group therapy

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CHAPTER ONE: INTRODUCTION

Opioid abuse and opioid related deaths are an increasing problem in the United States (Rose, Aleshire, Zibbell, & Gladden, 2016). The widespread nature and alarming rise in deaths due to drug overdoses have distinguished this problem as an epidemic (Rose et al., 2016). "Since 2000, the rate of deaths from drug overdoses has increased 137%, including a 200% increase in the rate of overdose deaths involving opioids (opioid pain relievers and heroin)" (Rose et al., 2016). The opioid epidemic has received national attention by policymakers and was named as "the biggest crisis facing the agency (FDA)" by Scott Gottlieb, the chief of the U.S. Food and Drug Administration (Edney, A., 2017). In addition, synthetic opioids, such as fentanyl, which is approximately 100 times stronger than morphine (Drug Enforcement Administration, 2017), and carfentanil, a large animal tranquilizer, have been associated with overdose deaths and were noted as a "serious danger to public safety" by the Drug Enforcement Administration (2016).

Policies aimed at stemming the tide of addiction have decreased opioid prescriptions by 2.2 % in 2014 and 6.8% in 2015 (Pezalla, Rosen, Erensen, Haddox, & Mayne, 2017). The decrease in prescriptions, though, has not affected the number of opioid related deaths, which continue to rise (Rose et al., 2016). It is obvious that the need for effective treatment is great.

The counseling field has offered little support and guidance to its practitioners on how to address the epidemic. Most of the current guidance on treating OUD is aimed at psychiatrists and other physicians. It is important for counselors to step up and take part in the research efforts, not only because counseling is half of the medication-assisted treatment equation, but also because we are often the treatment professionals who spend the most time with clients with opiate addiction. A typical psychiatric appointment lasts 15 minutes versus a group or individual

counseling session which runs from 45 minutes to one hour or more. Feedback and insight from counselors is extremely important. Yalom & Leszcz state, "client's reports are a rich and relatively untapped source of information. After all, it is their experience, theirs alone, and the farther we move from the clients' experience, the more inferential are our conclusions" (2005, p. 3). Counselors are in an ideal situation to glean information regarding the client experience, which can advance treatment and research efforts.

Context for the Study

The joys and pains of opium have been recognized for thousands of years, since prehistoric times (Kuhn, Swartzwelder, & Wilson, 1998). In 1821, Thomas de Quincey published *Confessions of an English Opium Eater*. In this work, the English essayist chronicles his use and experiences with opium. Like many others, de Quincey began opiate use for pain, and subsequently became addicted (de Quincey, 2013). De Quincey writes:

> [H]ere was the secret of happiness, about which philosophers had disputed for so many ages, at once discovered: happiness might now be bought for a penny, and carried in the waistcoat pocket: portable ecstasies might be had corked up in a pint bottle; and peace of mind could be sent down in gallons by the mail coach. (2013, p. 38-39)

While de Quincey's language is dated, the experience of opiates remains the same. On a web-forum discussing the opiate high, one participant describes heroin as, "Pleasure in every cell of the body, and pure contentment with one's self and the world. All pain disappears" (Dyingtomorrow, 2009). In their book, *Buzzed*, Kuhn et al. (1998) liken the experience to an orgasm. With this type of pleasure and avoidance of pain, it's easy to see the appeal of the drug. Unfortunately, opiates come with a high price-tag: they are highly addictive and can have deadly consequences (Kuhn et al., 1998).

Given the extraordinary scope of the current epidemic, it may be surprising to some to know that opium's addictive qualities have been recognized for centuries. Concerns regarding opium were recorded as far back as the fifth century BCE (Booth, 1996). In America, large scale issues with addiction to opiates were seen after the Civil War (Kuhn et al., 1998). Until the 1980's, most doctors were hesitant to prescribe opiates because of its known ability to cause addiction (Quinones, 2015). With the release of OxyContin, though, prescribers were assured that the addiction potential was low due to the timed-release feature of the drug (Quinones, 2015). This was only one aspect of many that contributed to the current epidemic.

In 2017, heroin overdoses accounted for 15,482 deaths in the United States (Centers for Disease Control and Prevention [CDC], 2019). According to a report from the CDC, "2,038,000 persons in the U.S. aged 12 years or older had a substance use disorder involving prescription pain relievers" (2017a, p. 13). Heroin use affected 591,000 people (CDC, 2017a). In 2016, 39,166 died from opioid overdoses including heroin, natural and semi-synthetic opioids, methadone, and other synthetic opioids (CDC, 2017b). For comparison, 37,461 people in the U.S. died from traffic accidents in 2016 (National Highway Traffic Safety Administration, 2017).

Drug use is a complicated issue. It affects not only the user, but families, friends, and communities. Addressing the opioid crisis will require a multi-faceted approach including policy, prevention, and treatment. This study focused on treatment of opioid use disorder.

Statement of the Problem

Opioid addiction is a difficult disease to treat. In a study looking at fatal overdoses and treatment for OUD, it was seen that those only receiving psychosocial treatment had double the risk of a fatal overdose as those who were receiving opioid-agonist pharmacotherapy (Pierce et

al., 2015). In a review of the literature, Bart states, "Historical data indicate poor outcome in patients provided only psychosocial interventions" (2012, p.3). Retention in treatment is also an issue. St. Marie, Sahker, and Arndt (2015) compared prescription opioid (PO) admissions to treatment and treatment completions with those of other substances. A large data set from SAMHSA, with a total sample size of 2,909,884 was used. Successful discharges were less frequent in the PO group (n=38.61%) than with other substances (n=46.91%). When researchers looked at successful discharges across all treatment settings, findings remained consistent with the PO group having the least number of successful discharges. The National Institute on Drug Abuse (NIDA) reports that remaining in treatment is an important aspect of recovery (2018), although it is unclear why retention is more of a problem among opioid users.

Medication-assisted treatment (MAT) is the current recommendation for treatment and has a wide research base to support its effectiveness (Bart, 2012). MAT is the combination of medication to treat the physical symptoms of addiction, and counseling to treat the psychological components of addiction (SAMHSA, 2015). Methadone, buprenorphine, and naltrexone are the primary drugs being utilized for treatment of OUD. Methadone is a schedule II drug, meaning it has higher abuse potential, and, as such, can only be prescribed in specialty clinics (SAMHSA, 2018). Naltrexone, with the brand name Vivitrol, is an antagonist and acts as a blocker to deter the use of opiates and can be prescribed by any physician (SAMHSA, 2016a). Buprenorphine, commonly known as Suboxone®, which is the combination of buprenorphine and naloxone, is a Schedule III drug, and can be provided in office-based settings. The focus of this paper will be on treatments including buprenorphine, as it is a relatively new, but promising, drug, with a research base in need of expansion.

Buprenorphine

Buprenorphine was approved for use with opioid addiction in the United States in 2002 by the Food and Drug Administration (FDA) (SAMHSA, 2005). It is seen as a safer option than methadone because of its ceiling effect, which makes it difficult to overdose on (SAMHSA, 2005). Buprenorphine is an opioid partial agonist and works by attaching to the same brain receptors as full agonist opioids, but, as a partial agonist, it does not usually cause a high (America's Addiction to Opioids, 2014). In this way, the drug reduces cravings, but allows the user to function normally (America's Addiction to Opioids, 2014). The most common form of buprenorphine is Suboxone®, which is a combination of buprenorphine and naloxone. The addition of naloxone causes sickness if used intravenously, which is a deterrent for abuse of the drug (SAMHSA, 2005).

As a result of the Drug Addiction Treatment Act (DATA 2000), clients can receive buprenorphine treatment from office-based physicians (SAMHSA, 2005), which is meant to make treatment and care more accessible. In order to prescribe buprenorphine, doctors must receive a waiver from SAMHSA, which requires some brief training in the area of addictions. To prescribe the medication, doctors must also ensure that they can provide or refer clients for counseling (SAMHSA, 2005).

Counseling and Buprenorphine

The literature on types of therapies used in conjunction with buprenorphine is limited. Much of the current research focuses on the combination of cognitive behavioral interventions and buprenorphine (Fiellin et al., 2013; Ling, Hillhouse, Ang, Jenkins, & Fahey, 2013; Moore et al., 2012; Moore et al., 2016). CBT is commonly used for the treatment of mental health and substance use disorders. This type of therapy focuses on changing cognitions or thoughts in order

to alter behavior and emotions (Beck Institute for Cognitive Behavior Therapy, 2016). CBT can

be administered in group or individual sessions. Current MAT research focuses on individual

CBT sessions (Fiellin et al., 2013; Ling et al., 2013; Moore et al., 2012; Moore et al., 2016).

Fiellin et al. (2013) and Moore et al. (2012), both compared outcomes for participants

receiving weekly, individual CBT sessions in addition to physician management (PM) with

buprenorphine, with those only receiving PM. No significant differences were seen between

groups for retention in treatment or abstinence from opioids (Fiellin et al. 2013; Moore et al.,

2012). In the case of Moore et al. (2012), patient satisfaction was also recorded, with no

differences seen between groups.

Similar findings occurred in a 2013 study by Ling et al. Participants received either CBT,

contingency management (CM), CBT and CM, or brief counseling by the physician during the

weekly medication management meeting (Ling et al., 2013). CM incorporates the use of positive

and negative consequences to reinforce different types of behavior in drug and alcohol treatment

(Higgins & Petry, 1999). For example, a food or gas voucher may be given for every negative

urine screen. Several outcomes were measured, including opioid use and other drug use, craving

and withdrawal symptoms, retention, Addiction Severity Index (ASI), and satisfaction (Ling et

al., 2013). Across groups, no significant differences were found in outcomes (Ling et al., 2013).

Another study by Moore et al. (2016), also measured outcomes for participants receiving

buprenorphine with CBT, with the added qualifier of primary opiate of abuse: prescription or

heroin. Moore et al. (2016) hypothesized that there may be differences between prescription

opioid and heroin users that would affect response to treatment. Again, no significant differences

were found between treatment or opioid use groups for retention or urine screens negative for

opioids (Moore et al., 2016). However, the prescription opioid group receiving CBT did have

significantly more negative urine screens for all drugs, which was not the case for the heroin use group (Moore et al., 2016). The researchers also noted that prescription opioid users had fewer experiences in drug treatment and detoxification than heroin users (Moore et al., 2016).

Based on the findings from these research studies, questions could be raised about the effectiveness or necessity of adding counseling treatment with buprenorphine. The addition of CBT to buprenorphine treatment, and CM in the case of Moore et al. (2012), does not show added benefits in contrast to only physician management. It is important to note, though, that opiate use was reduced in all groups (Fiellin et al., 2013; Ling et al., 2013; Moore et al., 2012; Moore et al., 2016), and in studies that looked at participant satisfaction, both groups reported satisfaction with their treatment (Ling et al., 2013; Moore et al., 2012); this suggests that behavioral interventions are acceptable to clients. Knowing that behavioral interventions are acceptable, and that there are few studies assessing the impacts encourages additional research in this area.

Client Perceptions and Experiences

Qualitative studies are useful and complementary sources to the quantitative work in the opioid treatment field. It is especially necessary to understand the client perspective of treatment, as this will help further develop, refine, and pinpoint effective interventions. Two qualitative studies, relevant to this specific topic, discuss barriers and facilitators to buprenorphine treatment (Hewell, Vasquez, & Rivkin, 2017), and identify specific beneficial elements of the treatment process (Fox, Masyukova, & Cunningham, 2016).

In order to better understand barriers and facilitators to buprenorphine treatment, Hewell, Vasquez, and Rivkin (2017) conducted research with 11 participants through focus groups and semi-structured interviews. The necessity for social support was seen as a theme among

participants (Hewell et al., 2017). Social supports included family, friends, peers in treatment, and providers (Hewell et al., 2017). Other themes that emerged included the importance of motivation and self-efficacy (believing in one's abilities) as facilitators of recovery (Hewell et al., 2017). Authors recommended that motivation and self-efficacy be nurtured throughout treatment, especially at the beginning (Hewell et al., 2017). This finding aligns with previous recommendations from a 2007 empirical review of the literature pertaining to implementations of counseling with buprenorphine (Copenhaver, Bruce, & Altice, 2007). Motivation for recovery has been linked to higher retention rates in treatment (Joe, Simpson, & Broome, 1998), and based on this finding, Copenhaver et al. (2007), recommend the use of motivational interviewing as this type of therapy focuses on increasing client motivation for change (Miller & Rollnick, 2013).

A second qualitative study focused on identifying facets of office-based buprenorphine that clients find beneficial or harmful for treatment. "Nearly all participants recognized that in addition to the physical components of withdrawal and craving, treatment needed to address the psychological or 'mental' component of addiction, which required that physicians have counseling skills" (Fox et al., 2016, p. 72). Participants overwhelmingly endorsed the importance of a positive patient-physician relationship, which meant that they valued a relationship in which they felt they could be open and honest (Fox et al., 2016). Conversely, a physician that was seen as judgmental or confrontational was viewed as a deterrent to recovery (Fox et al., 2016). Options for treatment that were tailored to the individual, and client inclusion in goal setting and treatment planning, were seen as valuable and helpful (Fox et al., 2016). Additionally, participants had negative perceptions about mandatory regulations, such as forcing clients to attend therapy to receive medication (Fox et al., 2016). Another key aspect was having a space to

self-disclose, either with a physician or in a group setting, and having peer support (Fox et al., 2016).

From these studies, it is evident that there are several aspects of treatment that cannot be supported by medication alone. Social support, a place to self-disclose, positive physician relationship, openness and honesty, self-efficacy, and motivation (Hewell et al., 2017; Fox et al., 2016) are all factors that point to the need for behavioral interventions. One possibility to address these needs is the utilization of group therapy with buprenorphine treatment.

Group Therapy

Group therapy has long been utilized in addiction treatment. Groups are used in community health centers, private practice, hospitals and inpatient rehabilitation centers. Group therapy provides many benefits, including a space to discuss personal struggles, receive feedback from peers, try out new behaviors, and receive support and encouragement in life changes (Corey, Corey, & Corey, 2018). Group therapy is also seen as a more cost-effective approach as there is generally one or two facilitators for a group of clients. It is necessary to distinguish between support groups, such as Alcoholics and Narcotics Anonymous, and group therapy. Support groups are peer-led, usually by a senior group member, whereas group therapy is facilitated by a mental health professional.

While group therapy is a commonly accepted intervention in addiction treatment, there is little empirical research showing its effectiveness (Weiss, Jaffee, Menil, & Cogley, 2004). A 2004 review by Weiss et al., published in the *Harvard Review of Psychiatry*, found 24 articles regarding group therapy interventions with substance use disorders published between the 1970's to early 2000's. Given the common utilization of group therapy in substance use treatment, it is surprising to find such a dearth of research in this area.

Some studies show promise for group interventions with OUD. A pilot study in China showed significant differences in abstinence rates between heroin users receiving a standard treatment and heroin users receiving relapse prevention group therapy (Min, Xu, Chen, Ding, Yi, & Mingyuang, 2011). At a three-month follow-up 37.2% of the group therapy participants reported no drug use and tested negative as compared to 16.7% of the standard treatment group (Min et al., 2011). A 2005 study by Rosenblum, Magura, Kayman, and Fong, found that attendance at 12-step groups was increased by those who also attended a group therapy intervention for substance use. While this study included those with OUD's, other types of substance use disorders were also incorporated (Rosenblum, et al., 2005). Their findings suggest that the motivational and CBT group counseling affected participation in other substance use interventions (Rosenblum et al., 2005).

Therapeutic group qualities align with factors identified by clients as important to OUD treatment. As noted previously, peer support, a place to self-disclose, openness and honesty, self-efficacy, and motivation are aspects of OUD treatment (Hewell et al., 2017; Fox et al., 2016) that can be addressed through the use of group therapy interventions. Group therapy provides a safe space for self-disclosure with peers, allows for openness and honesty through discussion with others in treatment, fosters self-efficacy and motivation as members try out new behaviors and receive feedback and encouragement from other members (Corey et al., 2018). A need for this research has also been noted in the literature:

> "However, group based counseling has not been evaluated, and for buprenorphine patients requiring high levels of support, alternative care delivery models, such as combining treatment with group-based counseling, appear to be acceptable and may improve outcomes" (Fox et al., 2016, p. 74).

It is important to note that individual counseling also aligns with factors identified by clients in OUD treatment and warrants further study. Group therapy, though, was determined as the focus for several reasons:

1. The current research on counseling interventions and buprenorphine focuses on individual interventions, and group has not yet been looked at.

2. A need for this research is identified in the literature (Fox et al., 2016).

3. Group therapy has the potential to make treatment more available as it accommodates a larger number of clients, which fulfills the prescribing requirement of psychosocial support.

4. Group therapy is also a more cost-effective option, which is an important consideration for policy and organizational decision-making.

Purpose of the Study and Research Questions

Given the scope of the opioid epidemic, it is essential that we better understand treatment options for OUD. The purpose of this study was to explore the client experience of group therapy in MAT with buprenorphine. The research questions were:

1. What is the client experience of group therapy in MAT with buprenorphine?

2. How does attending group affect a person's recovery?

3. How do experiences in group impact perceptions of the treatment?

While buprenorphine has a wide research base to support its efficacy, the addiction field lacks guidance on counseling interventions to use in combination with the medication for effective MAT. CBT, in conjunction with buprenorphine, is currently the most researched form of therapy, but studies do not show advantages for clients receiving counseling versus clients only receiving physician management (Ling et al., 2013; Moore et al., 2013; Moore et al., 2016). Qualitative

measures support the need for treatment to address the mental health aspects of addiction as well as the physical (Fox et al., 2016), which encourages additional research for counseling interventions. Group therapy is one counseling intervention that deserves further research. Group therapy is a viable option for MAT, and could address several client needs such as peer-support, a safe space to self-disclose, and it can also bolster motivation and self-efficacy, which are important factors in the recovery process (Hewell et al., 2017; Fox et al., 2016).

Definitions

Medication-assisted treatment- The combination of medication to treat the physical symptoms of addiction, and counseling to treat the psychological components of addiction (SAMHSA, 2015). MAT is most commonly used for opioid and alcohol use disorders (SAMHSA, 2015).

Buprenorphine- Buprenorphine was approved for use with opioid addiction in the United States in 2002 by the Food and Drug Administration (FDA) (SAMHSA, 2005). Buprenorphine is an opioid partial agonist and works by attaching to the same brain receptors as full agonist opioids, but, as a partial agonist, it does not usually cause a high (America's Addiction to Opioids, 2014). In this way, the drug reduces cravings, but allows the user to function normally (America's Addiction to Opioids, 2014).

Group therapy - For the purposes of this paper a general definition of group therapy is used to refer to a meeting of a small group of peers, generally concerning a specific topic, and is led by one or two mental health professionals. "The broad purposes of a therapeutic group are to increase members' knowledge of themselves and others, to help members clarify the changes they most want to make in their lives, to provide members with the tools they need to make these changes, and to support their changes" (Corey et al., 2018, p. 6). It is important to contrast this definition of group counseling with groups like Alcoholics and Narcotics Anonymous, which are

categorized as self-help groups. Self-help groups are participant-led groups, which do not include a mental health professional.

Opioid use disorder- The Diagnostic and Statistical Manual of Mental Disorders, 5th ed. (DSM-5) characterizes opioid use disorder as a "problematic pattern of opioid use leading to clinically significant impairment or distress" (p. 541, 2013). OUD can include a number of symptoms such as tolerance, craving, and withdrawal; inability to stop use despite having a desire to quit; experiencing issues in relationships, jobs, or school due to opioid use; large amounts of time and energy are spent acquiring or using the drug; continuing use despite risky, dangerous, or negative consequences.

Overview of the Method

The qualitative study utilized a phenomenological approach. A phenomenological approach aims to capture the experience of a phenomenon (Patton, 2015), which is most fitting to the research question. Participants were recruited from an office-based opioid treatment program that utilizes group therapy as the mental health component of MAT with buprenorphine. Semi-structured interviews took place with each participant, and interviews were then transcribed. The selective or highlighting approach, as laid out by Van Manen in *Researching Lived Experience* (2016), was used to analyze and code the data. Cross-case analysis was then applied to look for themes in the transcriptions.

CHAPTER TWO: LITERATURE REVIEW

The purpose of this study was to gain a deeper understanding of the client experience of group therapy in MAT with buprenorphine. Group therapy is frequently employed in different types of substance use treatment, from long-term residential to outpatient treatment. Surprisingly, though, there are currently no studies that assess group therapy in combination with buprenorphine as an acceptable form of treatment for OUD. Furthermore, many of the studies that look at counseling interventions in combination with buprenorphine, utilize quantitative methods (e.g., Fiellin et al., 2013; Ling et al., 2013; Moore et al., 2016). A phenomenological approach can help provide a deeper and more holistic view of the client experience in MAT. With the opioid epidemic continuing to take lives, it is imperative that we gain a more complete understanding of the client experience in order to make informed treatment, policy, and prevention decisions.

Opiates: A Brief History

To better understand the current epidemic, it is important to set the historical backdrop for the drug at the root of our problem. Mankind is no stranger to opiates. The first documented, medicinal uses occurred as far back as 4,000 years ago (Kuhn et al., 1998). They have been used over the centuries by multiple civilizations to treat such things as diarrhea, vertigo, headaches, menstrual pain, melancholy, insomnia, and, of course, pain (Booth, 1996). The Egyptian text, *Therapeutic Papyrus of Thebes*, which is dated 1552 BCE, lists 700 remedies involving opium, including a treatment for peevish children that involves mixing the drug with fly droppings (Booth, 1996). Opium has been used non-medicinally by the Greeks and Romans for religious purposes and in spiritual ceremonies; Romans also saw opium as a means of poison and suicide

(Booth, 1996). Recreational use of opium was seen in India, China, and later in Europe and America (Booth, 1996).

Addiction

Opium's ability to ensnare users was recorded as far back as the fifth century BCE, and then later by a philosopher in the third century BCE, Diagoras of Melos, who "declared it was better to suffer pain than to become dependent upon opium" (Booth, 1996, p. 17). Farmers who grow opium have been known to become addicted due to frequent contact with the plant (Booth, 1996). In the 1600's doctors in several parts of the world noted the negative and habit-forming effects of opium (Booth, 1996).

America and opium. While America's history with opium is relatively short in comparison to other parts of the world, we are still familiar with its positive and negative attributes. The first widespread problem of addiction to opiates was seen in America following the Civil War (Kuhn et al., 1998). Veterans were one of the populations affected (Courtwright, 1978), as doctors prescribed opiates to relieve pain from wounds and alleviate diarrhea (Beck, 1851). Middle and upper-class women accounted for a large portion of the affected demographic as they were treated for "neuralgia, morning sickness, or painful menstruation" (Courtwright, 1978, p. 111). In 1853 the hypodermic syringe was created and this was combined with the potent, purified form of opium, morphine, making the drug effects almost instantaneous (Kuhn et al., 1998). This combination also contributed to the opioid problem, though the size of the effect is debated by historians (Courtwright, 1978).

If we have known about the addictive consequences of the drug, how did we end up here? In his book, *Dreamland: The True Tale of America's Opiate Epidemic* (2015), Sam Quinones documents the contributing factors and backstory leading up to the current crisis: pharmaceutical

companies, the medical field, and black tar heroin. Quinones goes back to the 1950's and 60's, with Arthur Sackler, a psychiatrist turned marketing guru, who owned a marketing firm and eventually purchased Purdue Pharma (then Purdue Frederick) along with his brothers (Quinones, 2015). Sackler is credited with altering the way pharmaceuticals are marketed through inundating doctors and their offices with sales people and ads to push their drugs (Quinones, 2015). At the time, this was innovative ad campaigning that came to influence the aggressive manner in which pharmaceutical companies marketed pain killers (Quinones, 2015).

In the medical field, most doctors were wary of opiates because of their previously noted addictive qualities (Quinones, 2015). There began to be a shift in the 1990's with pain becoming a fifth vital sign, and doctors feeling pressure to please their patients as hospitals emphasized patient satisfaction reports and more holistic approaches to treating pain were not covered by insurance companies (Quinones, 2015). Doctors needed a way to address their patients' concerns. Further bolstering the argument for opiate prescriptions was 'research' in the form of a letter in *The New England Journal of Medicine* and a report of 38 cancer and non-malignant pain patients. The five-sentence letter was by Dr. Hershel Jick and Jane Porter, who, from information in their medical database, noted four patients out of 11,882 becoming addicted (1980); no specifics on dosage or diagnoses were provided; this was no research article, simply a letter noting observations based on numbers from a database. The second article was a report by Russell Portenoy and Kathleen Foley that noted two out of 38 patients developed an addiction to opiates prescribed for pain (1986). These two sources were cited over and over by doctors and pharmaceutical companies as proof that opioids were not addictive (Quinones, 2015).

Payments to physicians by pharmaceutical companies also seems to be an issue. The Physician Payments Sunshine Act, which is a section of the Affordable Care Act, as of 2013,

"requires medical product manufacturers to disclose to the Centers for Medicare and Medicaid Services any payments or other transfers of value made to physicians or teaching hospitals" (Richardson, 2014). This includes speaking fees, meals, travel, education, consulting and research. Reporting potential conflicts of interest in the form of even small payment amounts is important as its been shown that drug companies providing meals to doctors is associated with increased prescribing of the advertised drug (DeJong et al., 2016). The first study analyzing this data found, not including research, payments involving an opioid increased 10.7% from 2014 to 2015, with a total payment amount of over 20 million dollars in 2015 (Hadland, Krieger, & Marshall, 2017). Fentanyl was the top opioid, accounting for 46% of all payments between 2013 to 2015 (Hadland et al., 2017).

A third influencing factor involved increasing supply of black tar heroin coming in from Mexico (Quinones, 2015). Innovative sales tactics, involving the driver meeting the consumer versus requiring the buyer to come to a house, and low costs due to the Mexican supply versus overseas supply, made this heroin desirable and easily obtainable (Quinones, 2015). In addition, the black tar heroin was more potent, making it more lethal than the white powder form that is often cut with other ingredients (Quinones, 2015).

Combined, these three factors made for the perfect storm. The pharmaceutical companies pushed OxyContin, which they falsely touted as non-addictive, to a medical field that was desperate for an answer to patients' pain (Quinones, 2015). Physicians began prescribing opiates in numbers that have significantly increased since the 1990's (America's Addiction to Opioids, 2014). People then became addicted, needing larger and larger amounts of the pills. Heroin was in ready supply for those looking for a cheaper and more potent option. While prescription opioid use has increased worldwide, the United States, as of 2007, "accounted for over 99 per

cent of global consumption of hydrocodone and 83 percent of global consumption of

oxycodone" (International Narcotics Control Board, 2008, p. 20).

Opioid Use Disorder

> Opioid use disorder includes signs and symptoms that reflect compulsive, prolonged self-
>
> administration of opioid substances that are used for no legitimate medical purpose or, if
>
> another medical condition is present that requires opioid treatment, that are used in doses
>
> greatly in excess of the amount needed for that medical condition. (American Psychiatric
>
> Association [APA], 2013, p.542)

As the disorder progresses, activities revolving around obtaining the drug and avoiding

withdrawal become central to the addict's life, which can then cause legal, employment, and

marital problems (APA, 2013). Relapse is a common experience in treatment, and around 20-

30% are able to attain long-term abstinence (APA, 2013). Common co-occurring disorders

include depression, insomnia, and posttraumatic stress disorder (APA, 2013).

A longitudinal study with a sample size of 34,653 participants, found that nonmedical

opioid use is significantly higher for those with mood and anxiety disorders (Martins et al.,

2012). The authors investigated three different associations including opioid use that leads to

mood/anxiety disorders, mood/anxiety disorders that lead to use, or "shared vulnerability," which

indicates another influential factor like environmental stressors or genetics (Martins et al., 2012).

Evidence supporting all three pathways was found (Martins et al., 2012). Interestingly, it was

also seen that those who had used opiates for non-medical reasons were more likely to develop

an anxiety disorder (Martins et al., 2012).

According to the DSM-5, "[t]he 12-month prevalence of opioid use disorder is

approximately 0.37% among adults age 18 years and older in the community population" (2013,

p. 543). It is noted that this number may be underestimated as it does not take into account those

that are incarcerated (APA, 2013). In the U.S., over twelve million people in 2015 misused

prescription opiates (National Center on Health Statistics, 2017), with 33 million people

worldwide using prescription and other opiates (United Nations Office on Drugs and Crime

[UNODC], 2016). The rise in opioid prescriptions has caused an increase and shift in the

demographic of heroin users. Current trends show that those who end up addicted to heroin

typically begin with legally obtained, prescription opiates and then later switch to heroin, as a

stronger and more cost-effective option (Cicero, Ellis, Surratt, & Kurtz, 2014). A mixed-methods

study which analyzed demographic data from 2,797 heroin users seeking treatment, found that

those who began use in the 1960's were predominantly male (Cicero et al., 2014). Over the

decades from 1960 to 2010, the number of men and women using heroin has become almost

equal (Cicero et al., 2014). In the 1960's, there were approximately equal numbers of white and

non-white users, but by 2010, white users accounted for 90.3% of the study population (Cicero et

al., 2014). For those entering treatment for prescription opiates, clients are more likely to be

white and female as compared with those entering treatment for other substances (St. Marie

 et al., 2015). Adolescent females are also noted as more at risk for OUD (APA, 2013).

Those with an OUD are more likely to develop health-related issues such as HIV,

hepatitis C, tuberculosis, and bacterial infections, usually due to the use of contaminated syringes

(APA, 2013). There is a high-risk of overdose due to unknown contaminants such as fentanyl (

SAMHSA, 2014). Babies born with neonatal abstinence syndrome, which is withdrawal from

opioids due to the mother's use during pregnancy, have alarmingly increased from 3.4 per 1,000

births in 2009 to 5.8 per 1,000 births by 2012 (Patrick, Davis, Lehmann, & Cooper, 2015). These

issues alone are obvious calls for attention, but the ripple effects on the children and families of those with an OUD add to the need for effective treatment and prevention.

Treatment

Navigating the treatment process can be very difficult for clients. There are many types of treatment options, but one's options are often dictated by insurance, finances, and local availability. For example, finding treatment in rural settings is much more difficult due to a lack of resources and options. Finding treatment is further complicated by age; adolescent treatment programs are less common than adult programs and, between 2003-2010, there have been decreases in "substance abuse treatment facilities that reported providing specialized programming for adolescents" (Mericle et al., 2015, p.6).

Another difficulty in getting treatment is that addiction can go undetected by physicians as training to recognize and diagnose substance use disorders is a relatively new movement in medical schools (Sheff, 2013). From a SAMHSA data set of 2,909,884 people in treatment for substance use disorders it was seen that self-referrals at 47%, were much more common for prescription opioid users, as compared to 24.91% for other substances (St. Marie et al., 2015). These numbers possibly suggest the lack of recognition of opioid dependence by treating physicians. It is also common for health professionals and treatment programs to treat all substance use disorders the same (Sheff, 2013). As counselors know, there is no one-size-fits-all type of treatment. No matter how similar two clients appear, their treatment needs to be tailored to their own needs and goals. The same is true for treatment of substance use disorders (Sheff, 2013).

While tailoring treatment to the needs of the client is an important aspect of counseling, perceptions of MAT among counselors is a problem. In a study of 725 counselors working in

treatment programs for substance use disorders, researchers found that "20.7% of counselors did not know enough about buprenorphine to provide a rating" regarding the drug's effectiveness (Aletraris, Edmond, Paino, Fields, & Roman, 2016, p.49). In addition, the mean acceptability rating of various psychosocial treatments (CBT, motivational interviewing, contingency management, community reinforcement) for OUD were rated higher than buprenorphine, with methadone having the lowest acceptability rating (Aletraris, 2016). Unsurprisingly, a greater orientation to the 12-step philosophy was negatively correlated with MAT acceptability, and higher levels of education and training were positively correlated with MAT acceptability (Aletraris, 2016). These findings are a clear call for more education and training of counselors given that research has shown the superiority of MAT to that of only psychosocial interventions for OUD (Bart, 2012; Pierce et al., 2015).

This study focused on MAT using buprenorphine. Due to the widespread nature of the opioid crisis and its deadly affects, it is necessary to utilize treatment approaches that are easily accessible. A large part of the appeal of buprenorphine is that it can be prescribed in an office-based setting (Center for Substance Abuse Treatment [CSAT], 2004). Many treatment programs for substance use require a large time commitment on the part of the client who may have to come for counseling several days a week for several hours at a time. Many methadone clinics require clients to come every day to receive their medication. For people with families and jobs or unreliable transportation, the time commitment makes these programs impossible; for these people, office-based treatment can be ideal. Another positive of MAT is that it is a cost-effective measure. Among the Medicaid population in Vermont, those in MAT as compared to those in other therapies for OUD, had reductions in ER visits and hospital admissions (Mohlman,

Tanzman, Finison, Pinette, & Jones, 2016). Another aspect of making treatment more available

is the ability for any physician to apply for a waiver to prescribe buprenorphine.

Buprenorphine Prescribing

To prescribe buprenorphine in an office-based setting, a physician must apply for a

waiver from SAMHSA. There are a few ways to qualify for the waiver; licensed physicians with

a subspecialty in addiction psychiatry or addiction medicine; adequate experience or training in

the treatment of OUD, as determined by the individual's state licensing board; participation "as

an investigator in one or more clinical trials leading to the approval of a narcotic medication in

Schedule III, IV, or V for maintenance and detoxification treatment" (SAMHSA, 2016b);

completion of at least eight hours of training on working with and treating those with OUD

(SAMHSA, 2016b). Section 823 of the Controlled Substances Act (2016 ed.) outlines the

requirements to be included in the eight-hour training:

1. opioid maintenance and detoxification;

2. appropriate clinical use of all drugs approved by the Food and Drug Administration for
   the treatment of opioid use disorder;

3. initial and periodic patient assessments (including substance use monitoring);

4. individualized treatment planning, overdose reversal, and relapse prevention;

5. counseling and recovery support services;

6. staffing roles and considerations;

7. diversion control; and

8. other best practices, as identified by the Secretary.

The physician's training and qualifications are approved by SAMHSA, and then the physician

receives an identification number from the Drug Enforcement Administration (DEA), which is

required on buprenorphine prescriptions (SAMHSA, 2016b). The number of patients that a

physician can treat for OUD is restricted to 30 in the first year, and then can be extended to 100

with an additional application to SAMHSA (SAMHSA, 2016b). Now, due to new legislation,

physicians can prescribe to 275 patients (SAMHSA, 2017a). As of July 22, 2016, it is also

possible, with an additional 24 hours of training, for nurse practitioners and physician assistants

to apply for a SAMHSA waiver (SAMHSA, 2017b).

Drug for a Drug?

One of the common concerns and criticisms of MAT is that one is simply replacing one

drug for another. How can replacing one substance for another be part of recovery? In the case of

buprenorphine, the pharmacokinetic and pharmacodynamics of buprenorphine differ from that of

heroin and other short-acting opioids (Gerra et al., 2009; Bart, 2012). This means that

buprenorphine is metabolized and reacts differently in the body than short-acting opioids like

heroin and oxycodone. It is believed that a part of heroin's addictiveness is the intense,

immediate gratification, which does not occur in buprenorphine when used as prescribed (Gerra

et al., 2009). There is some abuse potential for buprenorphine if used intravenously or mixed

with benzodiazepines (Gerra et al., 2009). However, Suboxone®, the most commonly used form

of buprenorphine, comes in a sublingual film form versus a pill form, which deters crushing to

inject or snort the medication. Suboxone® is also combined with naloxone, an opioid antagonist,

that if used intravenously, can cause withdrawal, as the naloxone attaches to the opioid receptors

and blocks other opiates (Indivior Inc., 2017). Buprenorphine, along with methadone, has been

seen to correct "many of the neurobiological processes contributing to relapse" (Bart, 2012, p.8).

"Regardless of the relation between increased HPA activity and craving for heroin, we have

shown that buprenorphine does normalize the otherwise hyperactive HPA axis in heroin

dependence" (Kakko et al., 2008, p.176). The hypothalamic-pituitary-adrenal (HPA) axis helps

regulate stress hormones that are integral in human responses to hectic or traumatic events

(Stephens & Wand, 2012).

Counseling

Counseling plays a pivotal role in addiction treatment. Long-term residential programs,

detoxification, outpatient counseling, partial hospitalization and intensive outpatient therapy are

some of the many delivery options within addiction treatment. There are several counseling

approaches used for addiction; some of the most common approaches are CBT, motivational

interviewing, dialectical-behavior therapy, mindfulness, contingency management, couples and

family therapy, and group therapy (Sheff, 2013).

As mentioned previously, counseling makes up half of the medication-assisted treatment

approach. In his book, *Clean*, researcher and author, David Sheff describes the complexity of

treating addiction:

Since there are physiological and psychological components to addiction, it isn't enough

to treat the physical dependence or to work with therapists to change patterns; it isn't

enough to put a person in a new environment; it isn't enough to administer medication to

block craving; and it isn't enough to teach addicts how to survive sober. It often requires

all these things. (2013, p. 171)

While the ability to obtain buprenorphine in office-based settings makes the drug more

accessible, it does pose a difficulty in addressing the psychological component.

To prescribe buprenorphine in an outpatient setting, doctors must have the "capacity to

refer addiction patients for appropriate counseling and other nonpharmacological therapies"

(CSAT, 2004, p. 80). In 2015, the American Society of Addiction Medicine (ASAM) also

produced guidelines for prescribing and treating opioid addiction. In their guidelines, the

counseling component is addressed as follows:

> Psychosocial treatment is recommended in conjunction with any/all pharmacological
>
> treatment for opioid use disorder. At a minimum, the psychosocial treatment component
>
> of the overall treatment program should include the following:
>
>> (1) assessment of psychosocial needs;
>>
>> (2) supportive individual and/or group counseling;
>>
>> (3) linkages to existing family support systems; and
>>
>> (4) referrals to community-based services. (ASAM, 2015, p. 38)

While the ASAM guidelines are more comprehensive, they remain guidelines; the CSAT

regulations describe the extent of the doctor's responsibility to include counseling. The

requirement to refer for counseling brings us to the problem researched for this study.

Statement of the Problem

While the vagueness of the counseling requirement allows the client more control in their

treatment options, it has been confusing for providers and researchers who are looking for the

most effective combinations of treatment. Due to the relative newness of buprenorphine, in

comparison to methadone, there is little research to guide the implementation of psychosocial

interventions alongside the drug (Dugosh et al., 2016). A recent survey of buprenorphine

providers (n=346) found that 66% provided counseling services and 31% referred, with 3%

indicating services unavailable (Barry et al., 2016). Those in addiction medicine and psychiatry

were more likely to offer services, while providers in internal and family medicine most often

referred for services (Barry et al., 2016). Individual (51%) and group (41%) were most

commonly offered, then family/couples (31%) and self-help support groups (32%), with

telephone or web (13%) being the least common (Barry et al., 2016). While this study looked at availability of counseling services, it did not assess attendance of sessions or utilization of referrals (Barry et al., 2016).

Many physicians that prescribe buprenorphine are concerned about counseling resources for their patients (Huhn & Dunn, 2017). Lack of counseling or knowledge about counseling interventions is one of the obstacles identified by physicians as a reason they do not take on more patients in need of buprenorphine (Huhn & Dunn, 2017). This obstacle was also noted as one of the reasons why physicians do not obtain the waiver to prescribe buprenorphine (Huhn & Dunn, 2017). Understanding these issues is important as the U.S. does not currently have enough buprenorphine prescribing physicians to address the treatment demand (Jones, Campopiano, Baldwin, & McCance-Katz, 2015). It is possible that as the research base expands, and we gain a clearer picture of effective practices for treatment of OUD, more physicians will apply to receive the SAMHSA waiver, making treatment more available and accessible.

The vague requirement for counseling brings up many questions. What kind of counseling? How much? How often? Do support groups such as AA and NA count? These are just a few of the questions that could be asked regarding counseling for the MAT client. Looking to the research for answers to these questions is difficult as there is little available, and there are areas of contention among the literature that does exist.

Counseling and Medication

As discussed in Chapter One, there is limited support in the quantitative research for the use of counseling in MAT with buprenorphine. The addition of behavioral interventions in the case of Fiellin et al. (2013), Moore et al. (2012) and Ling et al. (2013) showed no significant differences in outcomes, with some evidence by Moore et al. (2016) for benefits among

prescription opioid users. However, Neumann, Blondell, Azadfard, Nathan, and Homish (2013) reported discrepant information. To better understand characteristics associated with consistent treatment attendance for at least six months, the researchers analyzed treatment records in an office-based buprenorphine program for 356 clients. Data analysis determined counseling attendance and past physical trauma/injury as significant predictors for treatment retention at six months (Neumann et al., 2013).

Another study by Fiellin et al. (2006), looked at differences between groups receiving buprenorphine and brief weekly counseling (20 minutes) or extended weekly counseling (45 minutes). Decreases in drug use were seen among all groups, though no significant differences were seen for drug use or treatment retention between groups (Fiellin et al., 2006). It is curious to note that instead of using counselors or psychologists for the counseling component, primary care nurses, "with no previous experience treating addiction and limited concurrent responsibilities" (Fiellin et al., 2006, p.366) provided the medication management and counseling. Sessions were audiotaped and reviewed for fidelity to the counseling approach, and the nurses met weekly with a physician and psychologist "to review the counseling" (Fiellin et al., 2006, p.367).

A large study (n=653) focusing on prescription opioid users assessed treatment outcomes for those receiving standard medication management (SMM) with buprenorphine-naloxone and those receiving SMM and individual drug counseling (Weiss & Rao, 2017). Again, no significant differences in outcomes were seen between groups. Researchers did find a significant interaction between counseling attendance and previous heroin (as opposed to prescription opiate) use (Weiss & Rao, 2017). Those in the counseling group, who had used heroin, and had attended 60% or more of sessions offered, had significantly better outcomes than the standard treatment

group (Weiss & Rao, 2017). Researchers recommend the need for individualized treatment with

the OUD population as additional counseling seems to benefit some, but not others (Weiss &

Rao, 2017).

A 2015 study by Saunders et al., looked at the combination of MAT and two specific

types of behavioral interventions for those with co-occurring PTSD and OUD. At six months,

"MAT patients receiving ICBT (Integrated Cognitive Behavioral Therapy) had only a 5%

probability of a positive drug screen" (Saunders et al., 2015, p.729). This is in contrast to a 30-

50% probability among the other treatment conditions, which included standard care of intensive

outpatient treatment (individual and group counseling at differing levels depending on severity

and program site) and standard care plus manual-guided Individual Addiction Counseling.

Interestingly, the treatment to see the most significant decrease in PTSD symptoms was the

ICBT with no medication group; the mean score, at six months, for this group on the Clinician

Administered PTSD scale was 28.13 (a score of 44 indicates PTSD diagnosis, with increasing

severity the higher the score); all other groups had scores over 50 (Saunders et al., 2015). The

possible cause for this difference is unknown, although the authors suggest it may be due to

numbing effects of the medications, so the non-MAT group was more able to process and cope

with the trauma (Saunders et al., 2015). This is an interesting suggestion, although the two other

non-MAT treatments did not see the same reduction in scores. It is also important to point out the

small sample size which was 13 for the non-MAT ICBT treatment group.

There are several limitations to consider for these studies. In all studies except Saunders

et al. (2015), counseling treatment was given in individual sessions; group or family treatment

was not provided. It is also unclear whether there were any long-term benefits to receiving

behavioral interventions, as two studies gathered data for three months (Moore et al., 2013;

Moore et al., 2016), three at six months (Fiellin et al., 2013; Fiellin et al., 2006; Saunders et al.,

2015), and one did a last follow-up at 52 weeks (Ling et al., 2013). The only study to do a long-

term follow-up was Weiss and Rao (2017), which did interviews at 18, 30, and 42 months. It is

also interesting to note that in the Fiellin et al. (2013) and Moore et al. (2016) studies, exclusion

criteria included anyone with "untreated major depression" (Fiellin et al., 2013, p. 74) and Fiellin

et al. (2006) excluded those with major depression. The Ling et al. (2013) study required

participants to be in "good general and psychiatric health" (p. 1790). It is unclear, to what

degree, those with co-occurring mental health disorders were excluded from these studies as both

statements are vague. This does reduce the generalizability of findings, though, as those with

OUD and other mental health diagnoses may respond to treatment differently. Those with

additional diagnoses may also need more out of treatment than those with only an OUD, which

might explain why the additional counseling did not show significant differences in the measured

outcomes. Another consideration is the therapeutic approaches, which were CBT and CM

(Fiellin et al., 2013; Fiellin et al., 2006; Moore et al., 2013; Ling et al., 2013; Moore et al., 2016),

ICBT and Individual Addiction Counseling (manual guided with 12-step influences) (Saunders

et al., 2015), and manual based opioid drug counseling (Weiss & Rao, 2017); these obviously do

not encompass the variety of approaches used in substance use counseling. While there were

measures to ensure fidelity to the counseling approach, therapeutic alliance was not measured in

any of the studies. Therapeutic alliance has been shown to be an integral factor in positive

outcomes for therapy (Horvath & Luborsky, 1993), and would be an interesting factor to look at

in future research.

The Client Perspective

While studies have assessed client satisfaction with MAT (Ling et al., 2013; Moore et al., 2012), this provides only a small glimpse of the client's perceptions of treatment. In order to better understand treatment of OUDs it is imperative that the client's perspective be fully explored. Qualitative data are generally most helpful in this area as it provides an in-depth view of a particular phenomenon or experience, and also allows for a variety of answers, as opposed to the limited selection of a survey or likert-scale type questions.

The importance of relationships in recovery is addressed by several studies (Hewell et al., 2017; Fox et al., 2016; Brekke, Lien, & Biong, 2017). As discussed in Chapter One, social support, a place to self-disclose, positive physician relationship, openness and honesty, self-efficacy, and motivation (Hewell et al., 2017; Fox et al., 2016) are all important aspects of recovery. Further bolstering these claims is a study by Brekke et al. (2017), which explored the experiences of those with co-occurring mental health and substance use disorders and their views of helpful and harmful behaviors of professional helpers. Trust was found to be a main theme across interviews (Brekke et al., 2017). Attributes that influenced trust were professional helpers who expressed hopefulness and loving concern, commitment, direct honesty and expectation, and action and courage (Brekke et al., 2017). Behaviors or attributes that negatively influenced trust were condescending or arrogant attitudes, acting more as a friend versus professional, lack of direct and honest feedback, unfamiliarity with substance use issues, and lack of commitment and belief in the client (Brekke et al., 2017).

Another qualitative study looked at experiences in MAT from clients in Sweden, which included those on methadone and buprenorphine (Lindgren, Eklund, Melin, & Granheim, 2016). An overarching theme that was expressed was that participants felt MAT allowed them to take

back control of their lives (Lindgren et al., 2016). The following participant quote from Lindgren et al. (2016) describes the life shift that MAT allowed:

> But then, from having started to feel better, from thinking about suicide as a form of relief, to actually wanting to live, to no longer thinking about killing myself, as I had done every day before…for I don't know how many years. I no longer think like that, so it's like going from a dark autumn storm to a sunny summer's day... it's absolutely enormous. (IP #9) (p.966)

Other important findings related to treatment include: "the opportunity to talk about everyday life and to get advice and help" (p. 966), "talking about the past was experienced as a healing process" (p. 966), a "need to deal with traumatic experiences" (p. 967), and the need for staff support and resources.

Based on the available research, it is difficult to draw solid conclusions on the impact of counseling in MAT. Some studies show no additional benefits to receiving counseling (Fiellin et al., 2013; Fiellin et al., 2006; Moore et al., 2012; Ling et al., 2013), while another shows benefit for prescription opioid users (Moore et al., 2016) and another for heroin users (Weiss & Rao, 2017). For those with co-occurring PTSD and OUD differences were seen for those receiving ICBT along with MAT (Saunders et al., 2015). From the qualitative perspective, it is clear that medication alone is not enough to sustain recovery: addressing the "psychological or 'mental' component of addiction" (Fox et al., 2016, p.72) is important to clients, and "all participants discussed feeling that MAT alone was not enough and should be paired with support or treatment" (Hewell et al., 2017, p. 5). Developing trusting relationships that allow the client to be honest, self-disclose, and receive support are valuable in treatment.

Group therapy

Over its history, group therapy has evolved from a place of questioned effectiveness to taking the front lines as a go-to intervention for certain issues (DeLucia-Waack, 2004). One of the most well-known researcher and practitioners in the group therapy field is Irvin Yalom. The 11 therapeutic factors of groups are one of the great contributions of Yalom (DeLucia-Waack, 2004). While previous researchers had been working with the therapeutic factors, Yalom gave much in the way of defining and researching these factors (DeLucia-Waack, 2004). The goal of his efforts was to better understand how groups work. The therapeutic factors will now be discussed and defined.

Therapeutic factors. The 11 factors identified by Yalom and Leszcz in *The Theory and Practice of Group Psychotherapy* (2005) are:

1. Instillation of hope

2. Universality

3. Imparting information

4. Altruism

5. The corrective recapitulation of the primary family group

6. Development of socializing techniques

7. Imitative behavior

8. Interpersonal learning

9. Group cohesiveness

10. Catharsis

11. Existential factors

It is important to note that these factors "are interdependent and neither occur nor function separately" (Yalom & Leszcz, 2005, p. 2). As in most therapy, people differ in what is most beneficial for their growth, which is the same with the factors; different people find different factors more or less impactful (Yalom & Leszcz, 2005). It is also interesting to note, that therapists and clients from the same group can have divergent views of what factors are most important (Bloch & Reibstein, 1980).

Instillation of hope has to do with beliefs and expectations for treatment. "Not only is hope required to keep the client in therapy so that other therapeutic factors may take effect, but faith in a treatment mode can in itself be therapeutically effective" (Yalom & Leszcz, 2005, p. 4). Counselors can help instill hope at the outset of group through education about the group and potential benefits (Yalom & Leszcz, 2005). Hope is provided through interaction with members in the process of seeing others progress and cope with struggles (Yalom & Leszcz, 2005). Support and encouragement provided by the group also lends to a sense of hope.

Universality encompasses the member experience of connecting with others and realizing one is not alone in the struggle (Yalom & Leszcz, 2005). Being physically isolated and feeling emotionally alone are common human experiences that can exacerbate physical and mental illnesses. The group format provides an avenue for folks to share their stories, listen, and interact with others, realizing they are not alone in their struggles.

Imparting information includes a variety of modes; psychoeducation and feedback from the therapist, as well as suggestions and other help provided by members. Members benefit from learning about their specific problem and acquiring coping skills (Yalom & Leszcz, 2005). There is also power in the act of giving and receiving suggestions or advice as this is often an expression of empathy and caring (Yalom & Leszcz, 2005).

Altruism is the notion that giving to others feels good. Being able to give to others results in a sense of usefulness and empowerment; for an individual who has struggled with the meaning of their sufferings, being able to provide help or guidance to others in similar situations can give a sense of purpose. Groups provide a format for altruism to occur, as members connect, share, and reach out to each other.

The corrective recapitulation of the primary family group, is a fancy way of saying resolving family issues. Early experiences in the family can be defining and debilitating for people; a difficult parental relationship can have effects that play out for several generations of a family system. Group therapy can provide an outlet for people to express these issues and also have appropriate or desired responses modeled or acted out in role plays. This may result in the person actually discussing the problem with their family, but often the group experience is healing in itself.

Development of socializing techniques describes the process of learning and testing out new and healthy ways of interaction. This can be gleaned from feedback from other group members on behaviors that are problematic. The group can also provide a safe space for members to practice new ways of interacting with others (Yalom & Leszcz, 2005).

Imitative behavior is similar to socializing techniques as it has to do with social interactions. "Group members learn from watching one another tackle problems" (Yalom & Leszcz, 2005, p.18). The facilitator also acts as a model of healthy communication, new ways of thinking, and encourages beneficial interactions among group members.

Interpersonal learning has to do with becoming aware of and understanding one's beliefs about the self. How do we think about and talk to ourselves and how does this affect our interactions with others? In providing a space for social interaction, groups provide a stage to

display problem behaviors, receive feedback, and learn to change. Interpersonal learning is a complex factor that Yalom and Leszcz devote a whole chapter to, but for this study's purposes the brief explanation is sufficient.

Group cohesiveness refers to the relationship of the group as a whole. A sense of trust, belonging, and comfort are all important in building group cohesiveness (Yalom & Leszcz, 2005). "It is a precondition for other therapeutic factors to function optimally" (Yalom & Leszcz, 2005, p.55). Group cohesiveness is distinctly part of group therapy, as individual therapy cannot provide the sense of acceptance or belonging that a group dynamic offers.

Catharsis is the expression of emotions or feelings that often results in a feeling of release. In groups catharsis can lead to greater cohesion as members relate to one another, express empathy and understanding (Yalom & Leszcz, 2005). Feeling that others accept, listen, and empathize is also powerful for the person expressing emotion.

Lastly are existential factors. Existential factors refer to questions of purpose, death, and the meaning of life. Groups can offer a place for members to explore these questions and learn from others.

Therapeutic Factors and MAT

In looking at the themes and needs from previously mentioned qualitative studies, many align with the therapeutic factors of groups. Table 1 illustrates the intersection between therapeutic factors and MAT needs as identified through qualitative research.

Table 1

Intersection of MAT needs and Therapeutic Factors

	Instillation of hope	Universality	Impart Information	Altruism	Corrective Recapitulation	Socializing techniques	Imitative behavior	Interpersonal Learning	Group cohesiveness	Catharsis	Existential factors
Hopefulness•	X			X					X		X
Loving concern•			X	X					X		
Commitment•	X	X							X		
Direct honesty•	X				X	X	X			X	
Expectation•		X			X	X			X	X	X
Safe place for self-disclosure□						X		X			
Attitudes›	X	X					X			X	X
Support›			X	X		X			X		
Resources›			X	X					X		
Advice*			X	X							
Need for dialogue*								X		X	
Talking about past*					X			X		X	
Trauma*					X			X		X	
Stigma*	X	X									
Storytelling*		X						X		X	

•Brekke et al., 2017
□ Fox et al., 2016
›Hewell et al., 2017
* Lindgren et al., 2016

The table does not display a certainty that needs and factors will always align, but shows the possibilities. The intersection of some needs and factors, of course, depend on the particular experiences of the individual. For example, if a client has past issues from childhood, corrective recapitulation of the primary family group may be an important factor in their group experience. In terms of the relational aspect of treatment, many of the therapeutic factors are relevant: group cohesiveness, universality, imparting information, and instillation of hope. Group can provide a safe space for self-disclosure, open and honest feedback, supportive relationships, and a place to ask questions about treatment and resources. Groups can also help in coping with stigma, as participants meet others going through similar struggles and receive support and encouragement from each other.

Motivation and Retention

An additional facet of recovery, not previously discussed, is client motivation for treatment. Joe, Simpson, and Broome (1998) found that treatment readiness was a significant predictor of retention at 90 days in long-term residential treatment, and at 360 days in outpatient methadone programs. Since successful discharges are less common for PO users (St. Marie et al., 2015), and we know that treatment readiness is a significant predictor in retention (Joe, Simpson & Broome, 1998), it makes sense to target and encourage motivation for PO users entering treatment. This, again, is an area that can be addressed through group therapy. Instillation of hope, universality, impart information, and group cohesiveness are some of the factors that can influence motivation.

For example, a client who enters treatment with low motivation may be mandated, have concerns about his own ability to change, or may worry about the effectiveness of the program. Through group, this person may witness similar stories and feelings he can relate to, which are

aspects of universality and group cohesiveness. This can help assuage fears about personal abilities and the program. Hearing others' stories of success can instill hope, and influence desires to change. Imparting information can also be a helpful aspect for new group members, as veteran members or the counselor share about what to expect, possible gains, and other information relevant to treatment. Groups can be additionally helpful for those with low motivation, as active participation is not necessary to make initial gains. Simply through listening and being in group, one's motivation can be affected as others share and participate.

Summary

The identified treatment needs and desires of MAT clients and their alignment with therapeutic factors support group therapy as a viable option for those receiving treatment for OUD with buprenorphine. In order to gain a better understanding of the MAT client experience in group therapy was explored. This research helps to fill gaps on several levels. There is currently not enough evidence to draw conclusions about the efficacy or added benefits of counseling in MAT. Exploring experiences of the client in MAT can help further our understanding of treatment for OUD. Also, group therapy in combination with buprenorphine has not been researched as yet. There is support in the literature for further investigation of group therapy, as evidenced by the following quote:

> Most participants also had positive experiences with past group-based counseling and believed that groups could be used as part of buprenorphine treatment to provide psychosocial support and treat the psychological dimension of addiction. (Fox et al., 2016, p. 73)

Additionally, the research adds to the field of addictions and group therapy by furthering

knowledge of the client experience in group. Lastly, it assists in our understanding of treatment

for OUD, and helps focus future research efforts in this area, which are desperately needed.

CHAPTER THREE: METHODS

The purpose of this study was to explore the client experience of group therapy in MAT with buprenorphine. As the main purpose of the study has to do with the essence of a phenomenon, phenomenology was chosen as the research approach. Phenomenology aims to uncover the actual, in the moment, experience of a phenomenon (Patton, 2015). It is, of course, impossible to uncover the essence as it is being experienced, as one needs to reflect to explain, which immediately takes the person out of the moment of experience (Patton, 2015). The closest way to get to this experience is through reflections and descriptions of the phenomenon, as related by the experiencer.

Descriptions and language are integral aspects of phenomenology (Patton, 2015; Van Manen, 2016). How one puts into words the experience is important as it reflects the process of meaning making for the individual and helps illuminate the individual's worldview (Patton, 2015). The experience of the phenomenon and the meaning that individuals give to the experience were the main factors of inquiry: What is the client experience of group therapy in MAT with buprenorphine?

"So phenomenological research has, as its ultimate aim, the fulfillment of our human nature: to become more fully who we are" (Van Manen, 2016, p. 12). This statement parallels with what is often an integral piece of addiction treatment, which is for people to discover who they are outside of the addiction. The disease of addiction often warps behavior and morals to fit the needs of the addiction; this is all at the expense of the person. Previously held values, morals, and beliefs about who one is, are shattered by the addiction. Treatment is often a discovery of who the person is when addiction is not a driving force, which is why this statement further represents the appropriateness of phenomenology for research in addiction treatment.

Role of the Researcher

"To truly question something is to interrogate something from the heart of our existence, from the center of our being" (Van Manen, 2016, p. 43). This quote struck me as it represents the commitment I feel to my research. "To truly question something" goes beyond mere curiosity; truly questioning is a deep desire to know, a driving force that motivates inquiry.

Due to the intimate nature of the relationship between the research and researcher, it is necessary that I acknowledge my own background experiences, values, biases, and cultural lens in order to more clearly conduct the research. In qualitative research,

> [r]eflexivity reminds the qualitative inquirer to be attentive to and conscious of the
> cultural, political, social, linguistic, and economic origins of one's own perspective and
> voice as well as the perspective and voices of those one interviews and those to whom
> one reports. (Patton, 2015, p. 70)

I identify as a White woman from an upper-middle class family. Most of my childhood and adult years have been spent in Southwest Virginia. Professionally, I have worked as a counselor and supervisor in community mental health settings, in a school, and have also worked in private practice.

My interest in opioid treatment began when I was facilitating groups and individual counseling for a MAT program, which used Suboxone®. I was struck by the stories, struggles, resilience, and humor of the folks I worked with. My knowledge of OUD and MAT was limited at the time, so this became a subject of interest and study for me. I was surprised at the dearth of information and guidance I found. While I have not worked at that facility for over two years, I still feel a strong sense of connection to the people I worked with and hope that they are continuing in recovery, which is a driving factor for this dissertation. I hope, in some way, to

help the people I worked with and others who struggle with the same disease. The recruitment site for this study was not the one I previously worked at, and I have no affiliation with, or work experience at the study site.

I should also say that I grew up in a family that was affected by addiction. This may be why I became particularly connected to my work in the MAT program. Having experienced addiction from a family member perspective made this topic especially salient for me. In training to become a counselor, I was challenged to face my own preconceived notions of addiction; this led to a process of shedding these notions and embracing a more holistic and empathic understanding of those who struggle with addiction.

Phenomenology fits with my role as the researcher because it requires me to examine my background and motivations in doing this research. Clearly, I am connected and passionate about the research. While my own experiences have influenced my motivation, I utilized resources to ensure they did not have undue influence on the data, which is further discussed in the *Credibility and Trustworthiness* section.

Participants

Ten participants were interviewed for this study from an office-based opioid treatment program for adults in southwest Virginia. This number aligns with similar qualitative studies, which examined experiences of group interventions (Laberg, Törkvist, & Andersson, 2001; MacMahon et al., 2015). An office-based opioid treatment program operates similarly to an outpatient physician's office. Office-based settings are generally more flexible and convenient for patients, as they require less of a time commitment. Office-based settings run differently depending on the physician's preference and office capability. For example, some offices offer counseling on-site, while others refer out.

This particular program had on-site counseling, which consisted of weekly group therapy. The main facilitator for groups was the prescribing psychiatrist. Co-facilitators often included a medical resident and a social worker. Groups were open, meaning that new members were allowed and clients had the option of attending a group that best fits their schedule. Groups were provided on weekdays at several different times. At the outset of treatment, clients were required to attend weekly group therapy meetings, and as their recovery progresses they may be allowed to attend every other week and, eventually, monthly. Clients received prescriptions at their group meetings. Weekly urine screens were also required and reviewed at group therapy sessions.

The program accepted private and public insurance as well as self-pay clients. Attending on-site counseling was required, with rare exception. If a client was already receiving counseling services, which are deemed appropriate for the client level of need, the requirement to attend on-site groups was sometimes waived. In the case of a client attending outside counseling, the program made sure to collaborate with the service provider about the client's treatment.

Table 2 describes characteristics of the study sample. Four of the ten identified as being male, with the remaining identifying as female. The age range was 28 to 64, with a mean of 39.7. Eight participants identified as white, with the remaining two identifying as Native American, both from the same tribe. Primary drug of abuse was split with half as heroin and half as prescription opiates. The length of treatment ranged from one to eighteen months, with previous substance use treatments ranging from zero to ten. A majority of participants were not receiving other types of mental health services or support, with one receiving individual counseling and psychiatry, a second receiving individual and attending self-help groups and spiritual services integral to treatment, and two others utilizing online support groups.

Table 2

Participant Characteristics

Participant	Age	Gender	Race/Ethnicity	Primary Drug	Length in Tx	Approx. Group Sessions	Previous Tx	Other Services
Jerome	64	M	W	Heroin	10 mo.	40	2	Individual, self-help group, church service
Vivian	32	F	NA	RX	18 mo.	80	3	Individual, psychiatrist
Nina	34	F	W	RX	12 mo.	36	0	online
Cameron	32	M	W	Heroin	9 mo.	36	1	none
Lee	34	M	W	Heroin	12 mo.	40	1	none
Meredith	33	F	W	RX	1 mo.	4	4	none
Joanne	43	F	W	RX	2.5 mo.	10	4	none
Lena	57	F	W	RX	12 mo.	46	0	none
Noelle	28	F	NA	Heroin	2 mo.	7	10	Narc.Anon.-online
Moe	40	M	W	Heroin	15 mo.	80	1	none

* W= White, NA= Native American

Recruitment from one site, versus multiple sites, was a strength as clients were all receiving the same form of group therapy. The therapeutic model of the program was described as supportive group therapy, meaning a person-centered approach. Groups focused on the concerns of the clients and were more process-oriented versus psycho-educational or structured such as CBT. A process-oriented group lent itself well to the study purpose, as data from other more structured approaches may be focused on specific interventions or topics of the group. A process-oriented group also relies more heavily on the therapeutic factors of group that support this study, versus interventions specific to a particular group approach or group structure.

Sampling Procedures

Purposeful sampling was used as it "is aimed at insight about the phenomenon" (Patton, 2015, p. 46). With group therapy in MAT as the phenomenon, it was necessary for participants to be currently involved in MAT with buprenorphine and engaged in group therapy. Additional inclusion criteria required that participants have attended at least three group sessions; this ensured that participants have multiple experiences in group sessions. For the purposes of this study, it was not deemed necessary that participants have extensive group therapy experience, as perspectives of newer group members were equally valuable to the research question as those who have been in treatment longer.

Recruitment

Participant recruitment took place at the treatment site where the researcher was present at the beginning of each group session for one week. The researcher briefly explained the research purpose, the amount of time required, interview format, and monetary compensation. A recruitment flyer with brief explanations of the procedures and informed consent was left with group members, so they had additional time to review and consider participation. To protect confidentiality, each member was given a card to indicate their participation desire, which was handed back in to the researcher. Contact information for the researcher was on the recruitment flyer, if anyone wished to contact the researcher after group to participate. The researcher contacted each volunteer to schedule an interview time per the participant's convenience. Interviews took place in a private room at the treatment location. A separate location on the hospital campus, outside of the treatment location, was offered for meeting if confidentiality was a concern.

Data Collection

After the recruitment took place, the researcher met with participants individually. All participants chose to meet in a room at the treatment location, after their group sessions as this was most convenient for their schedules. Given the intimacy of phenomenological interviews, it is important that participants are in a space that "feels comfortable and secure" (Seidman, 2013, p. 53), and that is also quiet and confidential (Seidman, 2013).

Once the interviews were scheduled, the researcher met with each participant individually. Consent forms were explained, which included the research purpose, confidentiality, and voluntary participation. To bolster confidentiality, written consent was not required, so there was no identifying information gathered. Two audio recording devices were used to tape the interviews, so that there was a backup in case one malfunctions. The researcher also had a notebook and pen to make notes on visual observations and other reflections that were helpful in the analysis stage. At the conclusion of the interview, participants were given a brief demographic form to fill out. Digital recordings were stored on the researcher's computer in an encrypted folder. As a backup, recordings were also added to an external hard drive, which was kept in a locked file cabinet at the researcher's office. Observation notes, and demographic forms were also stored in a locked file cabinet. When data collection was finished, a professional transcription service was used to transcribe interviews.

Interview Guide

Participants were interviewed once, with the possibility of a follow-up call for clarification of ideas. Interviews were semi-structured, and lasted approximately 45-60 minutes. The semi-structured nature of the interviews consisted of nine questions, and allowed for exploration on topics of importance as they arose. This allowed the researcher to further explore important issues related to the client experience.

"[T]he term 'essence' may be understood as a linguistic construction, a description of a

phenomenon" (Van Manen, 2016, p. 39). The overarching purpose of the interview guide was to

design and ask questions that evoked descriptions of the essence of group therapy. The interview

guide consisted of nine prompts related to the client experience of group therapy:

1.   In your own words, what do you think is the purpose of group therapy?

2.   How does group therapy impact your recovery?

     a. How would your recovery be different without group therapy?

3.   Describe a time when group was particularly meaningful for you.

4.   Describe a time when you were upset or uncomfortable as a result of group.

5.   Have you experienced or made changes in your life as a result of group?

6.   What are some downfalls or things you don't like about group therapy?

7.   Are there certain issues that are best addressed by group therapy?

8.   How does group therapy compare to other types of therapy or counseling you

      have experienced?

9.   If you were giving another person advice about how to get the most out of group,

      what would you say?

Data Analysis

Making something of a text or of a lived experience by interpreting its meaning is more

accurately a process of insightful invention, discovery or disclosure—grasping and

formulating a thematic understanding is not a rule-bound process but a free act of

'seeing' meaning. (Van Manen, 2016, p. 79)

The quote from Van Manen represents the heart of phenomenological analysis, which is

to illuminate meaning in the experience. This quote also describes the ambiguous nature of

phenomenological data analysis; it "is not a rule-bound process," that can be described step-by-step. It is necessary, though, for the beginning researcher to work within some type of framework, or to follow premeditated steps for data analysis.

Toward the goal of uncovering themes, Van Manen (2016) describes three approaches:

1. The wholistic or sententious approach;

2. The selective or highlighting approach;

3. The detailed or line-by-line approach (pp. 92-93)

The selective or highlighting approach was used to look for themes in the transcriptions. This approach required multiple readings of the transcript. The focusing question that the researcher kept in mind during the readings was: "What statement(s) or phrase(s) seem particularly essential or revealing about the phenomenon or experience being described?" (Van Manen, 2016, p. 93). The researcher marked these statements or phrases in the text.

When the selective or highlighting approach was done for each transcript, cross-case analysis was used to look for thematic commonalities across transcripts. Cross-case analysis assisted in identifying threads or patterns that were common to the phenomenon of study (Patton, 2015). This was important as phenomenological research does not simply look for individual meaning and experience, but meaning of the phenomenon itself as it transcends the individual (Van Manen, 2016).

Credibility and Trustworthiness

To add to the credibility and trustworthiness of the study findings, reflexive journals, collaborative analysis, and reporting negative evidence was used. Reflexivity is a necessary aspect of qualitative inquiry; it bolsters credibility and trustworthiness as it requires a level of transparency on the part of the researcher (Patton, 2015; Creswell & Poth, 2018). I kept a

reflexive journal to document and process my experiences, observations, reactions, and ideas throughout the study. This helped me to be aware of how my own culture and experiences affect aspects of the study, such as my interpretation of the interviews and patterns and themes that emerge. Integrity was further enhanced through allowing colleagues to read the reflexive journals, and provide comments and feedback about their own interpretations.

Collaborative analysis can take place in several different forms such as involving participants in developing themes or asking the assistance of other professionals in analysis (Van Manen, 2016). For this study, professional colleagues were asked to provide their perspectives on reflexive journals and transcripts. Two colleagues were asked to review three transcripts each, using the selective or highlighting approach, and the reflexive journal pertaining to the transcript. Conversations with each included potential themes and patterns that peer auditors recognized. In both cases themes and patterns coincided with my previous analysis of the data. These conversations assisted me in further refining my codes and organizing my data. The auditors were also asked to review the reflexive journal for the transcript in order to gain an understanding of my experience of the interviews and to check any biases that may have influenced my analysis of the data. No concerns were shared in either case.

During data analysis and reporting, special attention was paid to negative or disconfirming evidence (Patton, 2015). Paying attention to disconfirming evidence requires researchers to look outside the patterns and themes they have collected for divergent experiences (Patton, 2015). Reporting on the exceptions provides "a realistic assessment of the phenomenon under study" (Creswell & Poth, 2018, p. 261).

Additionally, trustworthiness was upheld through observance of Virginia Tech and treatment program specific IRB guidelines and ethical guidelines as set by the American

Counseling Association (2014). Research was conducted in an ethical manner through maintaining confidentiality, explaining and obtaining informed consent, secure storage of data and notes, and treating participants with warmth and respect.

Summary

"Phenomenology is not concerned primarily with the nomological or factual aspects of some state of affairs; rather, it always asks, what is the nature of the phenomenon as meaningfully experienced?" (Van Manen, 2016, p. 41). The previous chapter outlined the means to illuminate the meaningful experience of the phenomenon of group therapy in MAT with buprenorphine. The means for participant recruitment, data collection, and data analysis were identified. Ethical behavior and research was addressed to protect participants and the credibility of the study. Reflexivity was also discussed through exposition of my own experiences and cultural lens.

CHAPTER FOUR: RESULTS

Results are categorized into three main sections according to research question. Eight themes total emerged during the analysis stage. Research question one includes the themes of: (1) Support (2) Safe Space (3) Enjoy. Research question two includes two themes: (1) Accountability (2) Receiving Help and Feedback. Lastly, research question three includes three themes: (1) Genuine Caring (2) Flexibility (3) Called Out.

Research Question One

Research question one encompasses the main goal of the study: What is the client experience of group therapy in MAT with buprenorphine? In many ways, this question serves as an umbrella for all other questions in the study. Protocol questions directly tied to the client experience include: (1) In your own words, what do you think is the purpose or goal of group therapy? (2) I'd like you to think about a particular session or time when group was especially meaningful for you. Please describe that time. (3) Now, think about a session or time when you were upset or uncomfortable in group. Please describe that time. Using the selective or highlighting approach (Van Manen, 2016), three themes emerged relating to the experience: (1) support, (2) safe space, and (3) enjoy.

Theme One: Support

One of the most common experiences noted by all participants was feeling a sense of camaraderie and support from the group. Being around other folks struggling with addiction was seen as comforting in that they are not alone in the process. Lee shared, "I was talking earlier and a girl started getting teary-eyed and stuff. It's real supportive. I wish we had more than one day a week, for real. I think it helps out a lot." About half of the participants described the group as a family. Lena stated, "I enjoy going to hear the stories and the knowledge that actually, everybody

goes through the same thing. We're like a family in there. It's very supportive." Vivian provided

a specific example in which she was having a difficult time and described the group as being

helpful in getting her through:

> I just felt like I had a group of people behind me that have my back, and that's just – you
>
> know, that's always nice. And I managed to pull myself up out of it and I'm sure that had
>
> something to do with it.

In addition to noting the importance of the support of the group members, a few participants

discussed the importance of supportive staff. Cameron discussed the stigma associated with

addiction and the negative judgment he has felt in other treatment programs. He contrasted this

with the level of comfort he feels in the current program, which he attributes to the respect and

care he receives from the staff.

> …but I feel some people look at you bad, especially if they know you're in an addiction
>
> group. I don't know, I've had that feeling –you're just a piece of crap. So, I guess when you
>
> – it feels good to come in and check-in and feel comfortable. Then get called back and you
>
> go back to somebody, it seems like a family type, everybody cares about everybody.

Theme Two: Safe Space

Related to feeling support, was the theme of experiencing group as a safe space for self-

disclosure. Jerome used the words "safe haven" to describe the trust and confidentiality he felt

within the group. Meredith further describes the level of trust in group and how this relates to

sharing, "[S]o you can actually talk about things without feeling like it's gonna leave the room or

other people are gonna talk about it outside. And you feel like you can be more honest and more

open." In exploring what helped Meredith to be able to speak freely, she stated, "Because you

know that there's people around you that know what you're talking about and know where

you're coming from." Being able to speak freely is, of course, important in counseling. Joanne

discussed how it was to share in group, and, as a newer member, considered the process of

building trust.

> Like today I shared some, and it felt good to be able to do that. I felt comfortable with the
>
> people in there. And I'm feeling comfortable with them. So I think I'll be able to open up
>
> more as we go along.

Conversely, Nina shared that she is able to be more open in her online support group. She

described having a hard time being in group when some members are not committed to

treatment: "It's very frustrating for people who are really trying, to see the people you can just

tell don't care." She experiences the online group as "actually committed to recovery," and

described a deeper level of intimacy as a result.

Theme Three: Enjoy

Over half of participants described group as something they enjoy and look forward too.

There is a special bond that is created in group between members and facilitators because of the

shared experiences and intimate sharing. Being able to experience this kind of care and openness

was a bright spot in their week. Joanne referred to group as her "me time," and discussed how

she went from being apprehensive and not wanting to go to group at first, to now enjoying it. She

shared, "Just knowing that somebody cares, I mean, it gives you something to look forward too.

You know, you don't have to feel alone." In response to the question about a particular session

that was meaningful, Cameron stated, "No, I enjoy coming to every one. I look forward to

coming to group." Meredith shared about being able to openly discuss relapse, which contributes

to why she looks forward to group:

To be able to speak freely and talk, and not – because you might, to someone else…you

might lie and say you're not doing anything. But when I'm here I feel like I could – if I did

do something, I can say I did.

In examining research question one, it was evident how interconnected these three

themes were. Being around other folks with similar substance use issues contributed to a sense of

feeling understood and supported. Feeling support and understanding from the members

contributed to experiencing the group as a safe space to talk and share. In looking at quotations

from theme three, looking forward to group is influenced by support ("knowing that somebody

cares") and having a safe space for self-disclosure.

<div align="center">**Research Question Two**</div>

Research question two encompassed the impacts of group on recovery. Interview

questions pertaining to recovery included: (1) How does group therapy impact your recovery?

(2) Have you experienced or made changes in your life as a result of group? (3) If you were

giving another person advice about how to get the most out of group, what would you say?

Theme One: Accountability

Accountability was mentioned by all but three participants as an impact of group on their

recovery. Specifically, accountability was experienced as helpful in abstaining from drug use.

Having to come to weekly group, participate in drug screening, and knowing the screenings

would be part of the group discussion all contributed to accountability. Noelle shared, "And see,

this group keeps people from not using too. Knowing they have to come every week and do a

drug screening does help. That's another reason the groups are important." In addition, there was

a relational aspect of the group that contributed to accountability. Cameron describes this in how

he feels a responsibility to be clean as he is looked up too in group and often asked for advice or feedback:

> Yeah, it does, because you want everybody to be proud of you also. Especially, the doctors…because I don't want to be the one that comes in dirty this week…because [facilitator's name] comes to me and asks me what I think of this and what I think of that…and I think it's just a pride kind of thing. It makes you feel good to be clean.

Vivian shared similar sentiments, and how accountability has impacted her recovery:

> I don't think I'd be as far along as I am and I'm not as far along as I should be, but if I didn't have that accountability, if I didn't know that I had to come every week and if I'm dirty, I have to explain why, you know, I don't think I would have done as well. I think I'd be further back, much further back.

In discussing accountability, most participants shared about the aspects of group that were helpful. In contrast, Nina talked about a desire for increased accountability. In her group, there is an individual that continually has positive drug screens, which, she says, "makes you feel like even if you were to use you wouldn't be held accountable." She then provided suggestions for increased accountability: "I think people that are failing the test all the time, they should get pill counts. They should call them in for random screens."

Theme Two: Receiving Help

A second major impact on recovery was the help and feedback that participants received in group. All participants commented on this aspect of group. No specific commonalities in terms of type of feedback or areas for help were uncovered, rather the opportunity and experience of receiving help was noted as beneficial. Noelle, who is newer to the program, discussed comfort in having people she can turn to for help:

> Just meeting new people here that are going through recovery and stuff like that too is a
>
> good thing. Yeah, so you can have people to fall back on if you run into something and
>
> you need some answers or some help with it.

Similarly, Joanne described her own process of sharing with the group and receiving feedback:
"Just like today, I had some stuff I talked about, and the feedback was pretty good. So I'm gonna
try it and then next week I'll relay how it worked or how it didn't work."

Interestingly, the group aspect was integral to help and feedback as it allows for multiple
perspectives. Cameron explained:

> We all comment on everybody's struggles. Everybody does, and it's – like I said that's
>
> what makes it, I think, the best. Hearing everybody's side, not only medical side, but
>
> everybody else's opinion. They might have went through the same thing, and they tell
>
> you what they did or the best – what they think the best way to do it is or they help you
>
> try to find a job or something like that maybe. It just depends on what day it is.

Receiving feedback from folks that have been through similar situations, as Cameron and Noelle
described, is a benefit unique to group on which participants commented.

Research Question Three

Research question three was: How do experiences in group impact perceptions of the
treatment? The goal of this question was to gain an understanding of how participant's feel about
their treatment and the role of group therapy in shaping perspectives. Interview prompts
pertaining to this question included: (1) What are some downfalls or things you don't like about
group therapy? (2) How does group therapy compare to other types of therapy or counseling you
have experienced? (3) Are there certain issues that are best addressed by group therapy?

There were particular experiences or aspects of group that were essential to a positive view of treatment. Aspects essential to a positive view were centered around relationships with group members and staff. Having meaningful connections, and experiencing genuine caring in particular, was noted by all participants. The lack of caring greatly influenced negative perceptions of treatment, as well as too much flexibility in rules, and being called out in group.

Theme One: Genuine Caring

Genuine caring, related to the previous theme of support, as the sense of intention behind the supportive action. Participants relayed that it was not merely the actions of others, but the sense that the person is acting out of concern and compassion, and not from any ulterior motives. An example comes from Vivian in reference to the program staff: "But you start to see how genuine they are. They mean it, when somebody who wants to help you just because you need help, not because of anything they want."

As discussed in Research Question One, having a safe space to self-disclose is important. Feeling that you are heard by group members and facilitators is integral to developing a safe space, and is an experience that lead to feeling genuine caring from others. Stories of sharing with the group and feeling understood and accepted were common. For example, Joanne said, "I think just because it's really the first time I've really talked, and the feedback was really good. I felt like they genuinely cared. So it felt good."

Empathy also contributed to genuine caring. Empathy was discussed in terms of being able to tell that others in the group could relate to or understand on a deeper level. Lee describes this in his interview: "Just, I mean, the people in group, I've gotten real close to. It's just like they can feel what I'm feeling." Knowing that others cared about him was particularly touching for Lee, and is one of the most important factors in his continuing treatment through several

relapses. Lee went on to share that he leaves group "happier." Explaining his improved mood he said, "I feel the warmth coming from the other group members…I feel wanted with the group members, but not by the doctor." In Lee's case, he described having a contentious relationship with the facilitator. Despite disagreements with the facilitator, Lee still had a positive view of the treatment saying early in the interview that without the group, "I'd probably be dead." Vivian also shared that her relationship with group members was more important to her experience than the relationship with the facilitator. Others though, like Jerome and Moe said that having good relationships with the facilitator and group members was equally important.

In explaining genuine caring, participants also discussed acts of kindness. These were stories that described staff or group members going above and beyond what was expected. Moe shared about his initial experience with the facilitator in helping him get into treatment: "Yeah, he didn't have to meet me at 6:00 at night, and then have me here first thing the next morning. I think if the pharmacy would've been open, you know, he would've gotten me on Suboxone that night." Moe, who had been in previous treatment programs, said that he knew this one was the "right choice" from his first day because of the acts of kindness he received, not only from the facilitator but the group members who helped alleviate his anxiety during his first session.

Lack of Caring. On the other hand, a perceived lack of caring was the biggest contributor to negative views of treatment. For example, half of participants shared negative views of previous treatment programs they had attended. Programs that provided little accountability, generic counseling not tailored to the group members (i.e. worksheets and psycho-education focused groups), and emphasis on money were main contributors in participants feeling that staff did not care about their treatment. About his previous experience, Cameron shared,

Because I – the only reason why it helped me is because I wanted to be clean at the time

and I think that's the reason it didn't last is because there was nobody there to help or tell

you anything. No support whatsoever. It was just a money pit, that's all they wanted was

money.

Meredith discussed the lack of accountability at her previous program, "They would say, 'Come

to group,' but they didn't really – they didn't care if you did." Meredith shared that this

contributed to her continued drug use while on Suboxone in her previous treatment program.

Vivian discussed her frustration with generic group counseling saying, "now I've had other group

therapy that was shit. Sorry. Generalized bullshit. You know, those stupid worksheets." She went

on to explain why she likes the current program: "The fact that it's not a generic group. We get to

– the group gets to help each other out in a real-world kind of way."

Theme Two: Flexibility

Flexibility, in terms of rules and consequences was discussed by the majority of

participants. Interestingly, views were split on flexibility being a positive or negative thing.

Those that saw flexibility as a negative, shared personal experiences or seeing others receive

different treatment for similar or same offenses. This usually included differences in dosing due

to a positive drug screen. Lena shared a story where her dosage was cut back due to a positive

drug screen, and in another session the dosage was raised for a client who had a positive drug

screen. "I got very upset over that. The next week, I didn't even come to class," Lena stated.

Lena did eventually go back to group and the issue was discussed, though she does not

understand the reasoning behind the different treatment. She feels that the staff "need to learn to

treat their patients equal." Lee shared similar sentiments and further clarified that, "treatments

should be different for everybody, but the rules and regulations should be the same." For Lee,

treatments included medication dosages and counseling requirements, and rules and regulations were more of consequences for being on time to group and for positive drug screens.

Conversely, others saw the flexibility as a positive. Vivian shared, "There's some flexibility. I mean, not too much because then people would walk all over, right, but there is some. Enough for you to work with. And I think that saves a lot of lives. I really do." Vivian discussed how the facilitators involve the group in decision-making regarding issues that come up, for instance with folks who have positive urine screens. This is important, she explained, because the group members often have a better idea of the experience of a particular person, which puts them in a better position to offer helpful insight, ideas, or helpful consequences. Moe also had similar views:

> He's (the group facilitator) not quick to just throw you out the group and get rid of you. Like, a lot of programs have three strikes you're out—I've seen people mess up time and time again and, you know, eventually, he'll put them in in-house or something like that, but he won't get rid of you. He won't give up on you. And that's comfortable to know.

Theme Three: Called Out

Several participants commented on drug testing and the experience of being "called out" in a group setting. In this program, urine screens are reviewed at the beginning of every group session. Those with positive drug screens are given the opportunity to share about what happened that led to drug use and may also receive feedback from the group and facilitator. Meredith explained,

> But to be honest, I think it should be more, yeah, not in a group setting, talk about your urine screens. Because it – not that it embarrasses you or anything, or makes you feel – it just kinda makes you feel like you've failed to other people.

Jerome described this as being on the "hot seat… where everyone was focusing on my behavior." This was one of the "worst times" for Jerome, and he considered not coming back to group. Though he thought about not returning, his desire to continue recovery acted as a protective factor as he saw the alternative as falling back into drug use. Interestingly, this negative experience did not continue to color his perceptions of treatment as he later stated that "this group is what's really saved me, it really has."

> Noelle also shared that being called out is uncomfortable, but for different reasons:
> There's been once or twice, just how they talk about your drug tests in front of everyone and stuff like that. And then also using the words, like specific words of the drugs sorta can … it can send you into a whirlwind.

For her, hearing specific drug terms was triggering and produced cravings and anxiety. She further elaborated that the specific terms are what she finds problematic, and if drug use is discussed in general terms it is not an issue.

While participants discussed negative experiences or downfalls of group, the only factor that emerged as being able to completely color the perception of treatment as negative was a perceived lack of caring. The experiences of being called out and frustration around flexibility were more of stand-alone experiences that did not affect the overall perception of the treatment program. The presence of genuine caring to perception was as important as the lack of it. Experiencing genuine caring was discussed in all cases as important in their treatment.

Summary

In analyzing the data for the three research questions eight themes emerged. Though distinct themes, many are interrelated. For example, feeling support contributes to having a safe space, which both influence looking forward to group. Support and having a safe space are also

part of accountability in that accountability requires honesty and being open, which is difficult if one does not feel supported or have a safe space for disclosing issues or relapses.

In looking at the interrelatedness of the themes, it becomes apparent that almost all the themes have to do with relationships and connecting with others. Flexibility is the only theme to emerge that had more to do with procedural aspects of group, rather than relational aspects. Even the experience of being called out was relationally connected, as the main discomfort arose from being confronted by another person in front of other people. The emergence of such a strong connection to relationships is unsurprising if we look back at Yalom's therapeutic factors, which will be discussed in the following chapter.

CHAPTER FIVE: DISCUSSION

"[C]lient's reports are a rich and relatively untapped source of information. After all, it is their experience, theirs alone, and the farther we move from the clients' experience, the more inferential are our conclusions" (Yalom & Leszcz, 2005, p. 3). I wanted to start the last chapter with this quote as it is a reminder of where I began, which was a desire to hear from the clients. I started with the very basic question of, 'What do clients think about their treatment?' This question led me to a qualitative design and a phenomenological approach in order to focus on the clients' experiences. Having answered the research questions, we now look at what to do with this information.

Research Question One

The first research question encompasses the main focus of the study, which is the client experience of group therapy. The most common experiences were of group as a supportive environment and a safe space to self-disclose. Group was also experienced as enjoyable and something that participants looked forward to.

The group was often described as a family, which shows the close bond that members develop. In looking back to the therapeutic factors, Support directly relates to universality and group cohesiveness. Instillation of hope and socializing techniques are also relevant to Support. Table 3 on page 68 visually represents the relationship between the themes and therapeutic factors. Universality relates to feeling connected to other members and realizing one is not alone (Yalom & Leszcz, 2005). Addiction is an isolating disease, which participants expressed, and finding out that you are not alone in your feelings and experiences was one of the powerful things about group. Similarly, group cohesiveness refers to the bond of the group and the members feeling trust and belonging within the group (Yalom & Leszcz, 2005). Yalom and

Leszcz (2005, p. 55) describe group cohesion as "a precondition for other therapeutic factors to function optimally." It makes sense then, in having support, that members would also experience group as a safe space. Support was also integral in the instillation of hope, which kept members coming back week-to-week and looking forward to group. Lastly, Support relates to socializing techniques as new members come in, experience the support and then are able to provide that to others.

Safe Space is a combination of the therapeutic factors of group cohesiveness and catharsis. In participant descriptions, Safe Space was linked with self-disclosure or the ability to share about personal issues or experiences. Having a safe space for self-disclosure was also noted in Fox et al. (2016) as important in recovery.

Enjoy was one theme that was unique to this study. This is not necessarily surprising, though, as this study focuses on experiences of group, whereas previous research explored different aspects such as experiences of professional helpers (Brekke et al., 2017) and barriers and facilitators to treatment (Hewell et al., 2017). In terms of the therapeutic factors, Enjoy can relate to instillation of hope. Instillation of hope has to do with beliefs in the treatment, which is important to remaining in treatment (Yalom & Leszcz, 2005). Enjoyment of group indicates a belief in the treatment, and hope and enjoyment are both positive, future-oriented stances.

Research Question Two

The second research question looked at how group therapy impacts recovery. Two main themes emerged related to recovery: (1) Accountability (2) Receiving Help. Accountability was mentioned as helpful in abstaining from drug use and was influenced by mandatory group sessions, drug screening, and group discussion of screenings. Receiving Help, although not

directly related to a certain aspect of recovery, was overwhelmingly endorsed as important to recovery.

Accountability was an interesting finding in that it included multiple components. Mandatory group, drug screenings, and the discussion of the screenings within group were all necessary parts of accountability. The relational aspect of accountability was most influential for some in that they did not want to let down the group by using or be the center of discussion due to a positive urine screen. Accountability encompasses elements of several therapeutic factors: (1) imparting information (2) imitative behavior (3) interpersonal learning. Imparting information includes benefits members receive from learning about their problem and acquiring coping skills (Yalom & Leszcz, 2005). In having to discuss positive urine screens with the group, the participant has to confront their problem and then receives feedback from the group. Imitative behavior, where "members learn from watching one another tackle problems" (Yalom & Leszcz, 2005, p. 18) is relevant as members can observe and learn from each other's successes and failures with drug use. Interpersonal learning relates to self-awareness, and is part of accountability as members reflect on their drug use through discussions with group.

Receiving Help most obviously connects to the factor of imparting information. Yalom and Leszcz (2005) indicated that information can come from group members or facilitators, which participants also echoed. For some, the perspectives of the members was most valuable as they had been through similar situations or struggles. For others, getting insight from the facilitators was beneficial, especially when it came to education about the biological effects of addiction. Other factors that relate to this theme are instillation of hope, altruism, socializing techniques, and interpersonal learning (Yalom & Leszcz, 2005). Instillation of hope is relevant as participants described group as a place they could go for help, which brings a sense of hope

versus the isolation of addiction that was experienced before coming to treatment. Altruism

speaks to the position of help giver as opposed to the receiver. Providing help feels good and

strengthens the sense of connection between members. Socializing techniques are relevant to

receiving help, as through observing as well as the direct experience, members see that it is okay

to ask for help. Receiving help can also assist in learning healthy boundaries as the facilitator or

other members provide structure around the help and feedback provided. Lastly is interpersonal

learning, which occurs as members internalize and sort through the help or feedback.

Research Question Three

The third research question focused on how experiences impacted perceptions of

treatment. This question was meant to help explore and provide information on specific types of

experiences that encourage positive views or more engagement in treatment and aspects that

contribute to negative views and less engagement in treatment. Genuine Caring, Flexibility, and

being Called Out were all main contributors in shaping negative or positive views.

Genuine Caring, similar to Support, was related to the factors of universality, group

cohesiveness, instillation of hope, and socializing techniques. Perceiving that someone genuinely

cares contributes to the formation of trust and the bond developed in group that all participants

noted; this further contributes to a sense of hope and belief in the group and also sets a

foundation for caring behavior in group. Lack of Caring was the biggest contributor to negative

views of treatment, which in all cases that were shared, resulted in discontinuation of the

treatment. Connecting back to the work of Yalom and Leszcz, this makes sense as group

cohesiveness "is a precondition for other therapeutic factors to function optimally" (2005, p.55).

If genuine caring is not present then forming trust in the group is nearly impossible, which

affects Safe Space making self-disclosure difficult, which affects Accountability and so on. It is
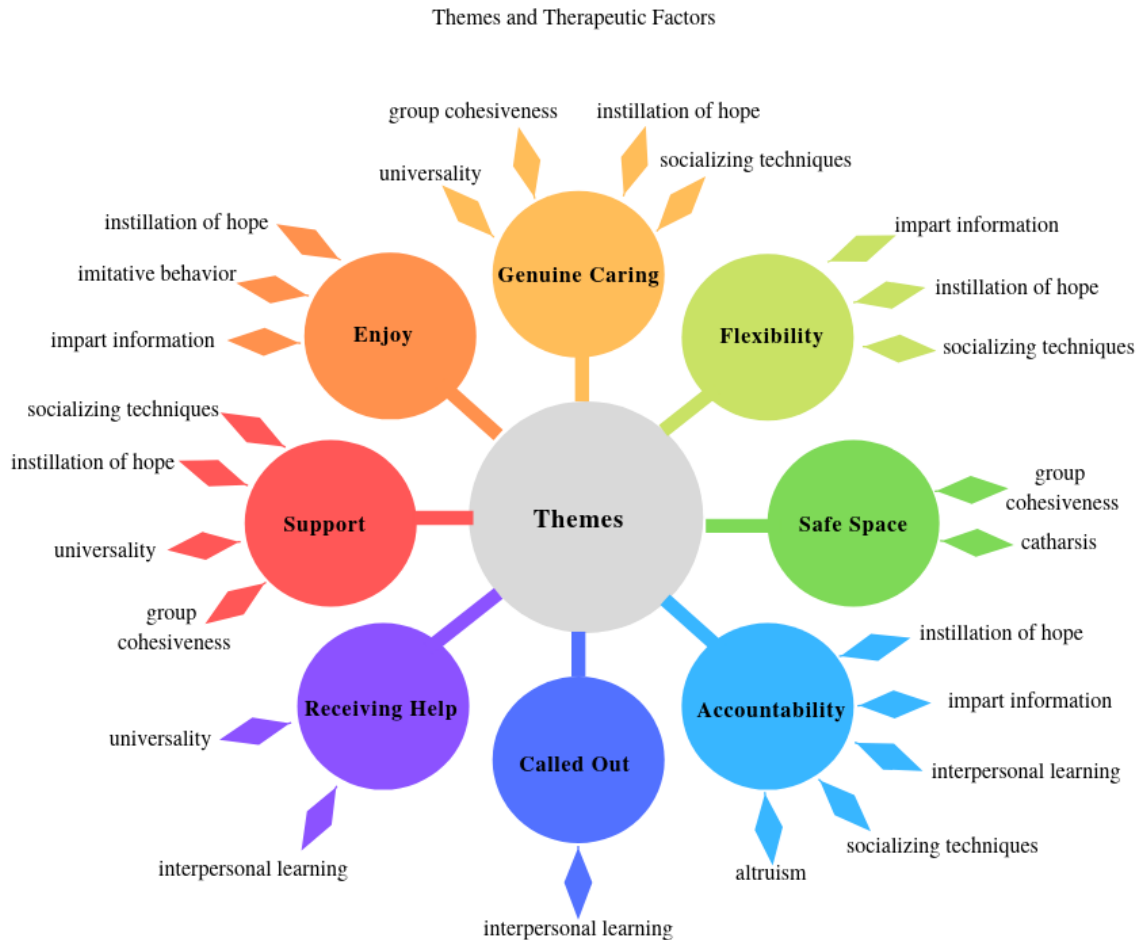
therefore easy to see the difficulties in engaging in a treatment program that is perceived as uncaring.

Flexibility, like caring, was both positive and negative. Flexibility related to the instillation of hope. In the cases where flexibility was viewed negatively, a sense of unfairness or inequality was experienced due to different treatment. Instillation of hope is relevant as beliefs about group being a fair or just environment are affected, which can then affect how hopeful one is about treatment. Those that viewed flexibility as a positive, saw the different treatment as individualized, and appreciated a flexible approach that was not "three strikes you're out." In these cases, hope was encouraged, as they viewed treatment as a place where they would be given help if they were struggling or relapsed.

Lastly, is the theme of being Called Out. Being Called Out was the experience of your behavior as the focus of discussion in group. Three factors relate to this theme: (1) impart information (2) socializing techniques (3) interpersonal learning (Yalom & Leszcz, 2005). While being the focus of attention in group was generally viewed as a negative experience, it did not have the power of Lack of Caring to color one's whole perception of treatment. For instance, being called out was viewed as uncomfortable and, in some cases, seen as more appropriate in an individual setting, but was not a precursor to discontinuing treatment. In fact, this experience could lead to positive changes in behavior. Impart information and socializing techniques are relevant here as being called out is a relational experience where individuals receive direct feedback on their problem behavior. Interpersonal learning can then take place as individuals reflect on this experience and learn how to move forward.

Table 3

Themes and Therapeutic Factors

Themes and Therapeutic Factors

group cohesiveness   instillation of hope

universality   socializing techniques

instillation of hope

imitative behavior

impart information

Genuine Caring

Enjoy

Flexibility

impart information

instillation of hope

socializing techniques

socializing techniques

instillation of hope

Support

Themes

Safe Space

group cohesiveness

catharsis

universality

group
cohesiveness

Accountability

instillation of hope

impart information

Receiving Help

universality

Called Out

interpersonal learning

socializing techniques

interpersonal learning

altruism

interpersonal learning

Implications

There are several implications for counselors, other treatment providers, and counselor educators. As discussed in Chapters One and Two, the need for improved treatment for OUD is evident. Exploring the client experience of treatment is a stepping stone, in many ways, to identifying how to improve treatment efforts and even what questions to be asking in research. Seeing treatment from the client's perspective helps us to understand how interventions are interpreted, what is most beneficial, and what is most harmful.

A Viable Option

At the most basic level, results support the use of group therapy with clients in MAT. The majority of participants had positive views of group which is supported by the theme Enjoy, where clients identified that they enjoyed and looked forward to group each week. Accountability and Receiving Help were positive impacts that group had on recovery. Accountability was noted as helpful in abstaining from drug use, and Receiving Help was important as group was a place that participants could go to for resources and feedback. As lack of counseling resources are a barrier to physicians taking on more patients (Huhn & Dunn, 2017), an emphasis on group therapy as an appropriate treatment could be useful. With group therapy, as opposed to individual, more clients are able to be seen and treated in a shorter period of time. This can be especially beneficial in areas that have high demand for treatment and limited counseling resources, such as rural areas.

Relationship

Findings overwhelmingly indicated the importance of relationships in treatment; this included relationships with other clients, the facilitators, doctors, and other treatment staff. Group was described as a "family," a place where participants realized they were not alone in their addiction, a safe outlet for sharing struggles and receiving help, and a place where they were treated with dignity by staff. A perceived lack of caring from providers was a main contributor to negative views of treatment.

Counselors and Treatment Providers. As retention is a particular problem with this population (St. Marie et al., 2015), the importance of relationships can be used by counselors and treatment providers to improve experiences of treatment, which can affect retention. As discussed in Chapter Two, treatment readiness is a predictor in retention (Joe et al., 1998).

Treatment readiness can be encouraged through experiences in group as study results showed that group was experienced as something clients looked forward too, which was affected by the supportive, safe environment. This information is important for counselors as a reminder to focus heavily on building rapport and trust as soon as a client enters treatment. The importance of building rapport is also encouragement for training for other staff involved in treatment. Providing training on relationship building skills such as active listening techniques, can be helpful for doctors, nurses, and administrative staff that interact with clients; as noted in participant responses, interactions with all treatment staff impacted how participants felt about, and perceived the program. The importance of relationships is also seen in the sub-theme Lack of Caring, which caused participants to have negative views of treatment. Contributors to lack of caring included generic counseling not targeted to the audience, a focus on money, and lack of accountability for counseling attendance and positive drug screens. These types of negative experiences can affect retention and engagement in treatment.

Group Facilitation. Study results largely supported the therapeutic factors of group, which we already knew to be integral to the group approach. Group facilitators can focus on group dynamics and building trust and rapport within the group. While psychoeducation is an important part of addictions treatment, group facilitators should first focus on enhancing support among members. Study results also showed that help and feedback received from group members was just as meaningful, in some cases more meaningful, than feedback from the facilitator; this further bolsters the importance of building relationships within the group to support interaction among members. In addition, Accountability and Safe Space are particularly salient for addictions treatment as relapse is part of the process. Building support and trust

among members is a precursor to having a safe space for productive conversations around accountability and relapse.

Burn-out

Study results support the need to combat burn-out for treatment providers. Burn-out directly affects work with clients as it decreases a worker's desire to be around others and increases negative views of clients (Maslach & Jackson, 1981), which are relevant to themes of Support and Genuine Caring. In addition, Lack of Caring was the biggest contributor to negative views of treatment. Not providing clients with genuine concern and interest could be detrimental to the client's treatment as it exacerbates the negative stigma this population already faces, and causes them to be less invested and engaged in their treatment. Self-care is important in combatting burn-out, as well as clinical supervision, which has been seen to play an important role in protecting against factors of burn-out (Knudsen, Ducharme & Roman, 2008).

Counselor Educators

Implications for educators parallel those of practice. The importance of relationships in recovery, seen in this study and addressed by previous research (Hewell et al., 2017; Fox et al., 2016; Brekke et al., 2017), further supports the importance of the therapeutic alliance and the necessity for counselors to be able to build rapport and trust with clients. Emphasis on foundational counseling skills that begin with a person-centered approach, active listening and providing unconditional positive regard are essential. Due to the stigma that continues to surround addiction, educators need to make extra steps to address personal biases surrounding addiction that counselors-in-training may have. Information on the neuroscience of addiction and systemic factors affecting addiction can help counselors-in-training build understanding and empathy for this population.

In addition to building skills and empathy, education needs to be coupled with an emphasis on self-care and burn-out. There are several elements that make addictions work difficult and emotionally draining; relapse, overdose deaths, mandated clients, and navigating multiple barriers to treatment and recovery such as transportation, finances, and securing employment, are just a few of the complexities of addictions work. Preparing students to cope with the emotional stress that accompanies addictions work is essential.

Limitations

There are several limitations to this study. The recruitment site terms their approach as supportive group therapy. This is translated to mean a person-centered approach to therapy in which group sessions have little structure and are focused on the concerns of the members. Group therapy can be implemented through the lens of different therapeutic modalities and in a variety of ways. Since participants are experiencing one approach, findings cannot be generalized to include all forms of group therapy.

Another limitation is that data is based on self-report. Self-report may be limited by the self-awareness of the individual. A person's ability to be introspective about their experiences influences the quality of the data. In addition, all interviews took place directly after a group session. While the timing was out of convenience for participants, as things like transportation and child-care were concerns in some cases, it is possible that the recent experience of a group session could have influenced answers and reactions to interview questions.

A last limitation is myself as the researcher and interviewer. A researcher's ability to develop rapport, address the differences in power, and be empathic are all things that affect the interviewee's openness in answering questions (Hays & Singh, 2012). My ability as a competent interviewer may have affected participants' openness

Future Research

Looking at the experiences of clients in group therapy with buprenorphine is foundational to better understanding MAT for opioid use disorder. Gaining an understanding of clients' experiences has shed light on treatment factors that are most meaningful to clients such as receiving support and accountability. Looking at treatment through the client lens guides future research in several ways.

The majority of prominent, quantitative studies on counseling in MAT have used individual counseling (Fiellin et al., 2006**;** Fiellin et al., 2013; Moore et al., 2012; Ling et al., 2013; Moore et al., 2016; Weiss & Rao, 2017). As group therapy is commonly used in addictions treatment and was viewed as positive and helpful by study participants, it should be utilized in future research on counseling in MAT. In addition, measuring the perceived quality of relationships with other group members as well as treatment providers would be an essential factor to add in looking at treatment outcomes as therapeutic alliance has been shown to be an integral factor in positive outcomes for therapy (Horvath & Luborsky, 1993). Measuring the therapeutic alliance through tools such as the California Psychotherapy Alliance Scales (CALPAS) would be a helpful addition to quantitative studies looking at counseling in MAT and treatment outcomes. The CALPAS also has group forms for looking at alliance within the group and with facilitators (Gaston & Marmar, 1994). Integrating these types of measures can provide a more holistic view of the benefits, or lack thereof, of counseling in comparison to just medication management.

To complement this study, which sampled those in treatment, another future study that would be helpful would be a qualitative study with people who have recently dropped out of a MAT program. To improve treatment, it is necessary to understand factors affecting retention

and why individuals have stopped participation. Qualitative inquiry would provide a platform to explore this issue in depth to better realize the complexities contributing to dropout. Understanding issues affecting retention can help target more affective interventions.

Conclusion

With the opioid epidemic continuing to take lives, it is important that we gain a more complete understanding of the client experience in order to make informed treatment, policy, and prevention decisions. This study, in giving voice to clients, adds depth to the burgeoning research on treatment of OUD with medication-assisted therapies. Results displayed group therapy as an experience of relationships and support, a safe space to share and receive feedback, and a place to experience genuine caring. Group can also be a place of discomfort as flaws are exposed and offered up for discussion, and frustration arises from differing consequences. Overall, participants expressed that group was an important element in their recovery, providing support for its use in MAT and evidence for future research in this area.

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Appendix A

VIRGINIA POLYTECHNIC INSTITUTE AND STATE UNIVERSITY
Informed Consent for Participants
in Research Projects Involving Human Subjects

TITLE:	Counseling Interventions and Buprenorphine for Treatment of Opioid Use Disorders
PROTOCOL NO.:	18-241 WIRB® Protocol #20181262
SPONSOR:	Virginia Tech
INVESTIGATOR:	Laura E. Welfare, PhD 1750 Kraft Drive Suite 2001 Mail Code 0302 Blacksburg, Virginia 24060 United States
STUDY-RELATED PHONE NUMBER(S):	Laura Welfare 540-231-8194 welfare@vt.edu Dana Ripley 540-525-0498 dmripley@vt.edu
SUB-INVESTIGATOR(S):	Dana Ripley

I. Purpose of this Research Project

I am conducting a school research project to understand the client's experience of group therapy in medication-assisted treatment with buprenorphine. Participants who are currently enrolled as patients in the opioid treatment program at Carilion, are taking buprenorphine or buprenorphine/naloxone (Suboxone) and have attended at least three group therapy sessions are invited to participate in this study. The study will include approximately 10 participants. Findings will be included in Dana Ripley's research project and may also be used for publication

and education purposes.

II. Procedures
Participation includes one, audio-recorded interview that will last approximately 60 minutes. A follow-up phone call, also audio-recorded and approximately 15 minutes in length, may be needed to clarify your ideas. Interview questions will focus on your personal experiences in group therapy. The interview will take place in a private room on the Carilion Campus.

III. Risks
This research project poses minimal or no risk to participants. Foreseeable risks may include discomfort discussing feelings about group therapy experiences. Please note you have the right to stop the interview at any time, to choose what you disclose, or to opt out of the study at any time during or after the interview.

IV. Benefits
Benefits may include improved awareness and understanding about experiences of group therapy. As a participant in this research, you are also helping to further understandings of treatment for opioid use disorder, which can help improve addiction treatment.

No promise or guarantee of benefits has been made to encourage you to participate.

V. Alternatives

This is not a treatment study. Your alternative is to not be in this study.

VI. Extent of Anonymity and Confidentiality
The investigators will not share any identifying information. The information collected will be kept private and every possible effort will be made to mask identities. At no time will the researcher release identifiable results of the study without your written consent. The summary of themes across interviews, used in the findings, will not identify individual participants.

No Protected Health Information or patient identifying information will be requested from or provided by Carilion. We are merely permitted in the facility to invite participation and distribute directions for participation. Allowing the option to meet in the Carilion facility is for your convenience and does not suggest participation is a Carilion service.

The Virginia Tech (VT) Institutional Review Board (IRB) and/or the Western Institutional Review Board (WIRB) may view the study's data for auditing purposes. The IRB is responsible for the oversight of the protection of human subjects involved in research.

VII. Compensation
Participants will be compensated for their time with a choice of a $20 gift card to either Kohl's, Subway, or Papa John's, which will be indicated when the interview is scheduled. The gift card will be presented at the beginning of the interview.

VIII. Freedom to Withdraw

Your participation in this study is voluntary. You may decide not to participate without any penalty or loss of benefits to which you are entitled.

It is important for you to know that you are free to withdraw from this study at any time without penalty or loss of benefits to which you are entitled. You are free not to answer any questions that you choose or respond to what is being asked of you without penalty. Should you withdraw or otherwise discontinue participation, you may keep the gift card provided at the beginning of the interview.

IX. Questions or Concerns

Should you have any questions, concerns, or complaints about this study, you may contact one of the research investigators whose contact information is included at the beginning of this document.

This research is being overseen by an Institutional Review Board ("IRB"). An IRB is a group of people who perform independent review of research studies. You may talk to them at (800) 562-4789, help@wirb.com if:

- You have questions, concerns, or complaints that are not being answered by the research team.
- You are not getting answers from the research team.
- You cannot reach the research team.
- You want to talk to someone else about the research.
- You have questions about your rights as a research subject.

X. Subject's Consent

This information is provided for your review. To protect your anonymity, no written consent is requested.

Appendix B

Interview Recruitment Flyer
Counseling Interventions and Buprenorphine for Treatment of Opioid Use Disorders

Purpose
I am a doctoral student at Virginia Tech and we are conducting research to understand the client's experience of group therapy in a Suboxone® program for treatment of opiate addiction. To participate in the study there are three requirements. You must:
- be a current client in the opioid treatment program at Carilion Clinic
- be taking buprenorphine or buprenorphine/naloxone (Suboxone)
- have attended at least *three* group therapy sessions in this program

Procedures
Participation includes an interview, approximately 60 minutes long, focusing on your experiences in group therapy. A 15-minute follow-up call may be needed to clarify ideas from the interview. I will personally conduct all interviews. Meetings will take place in a private room on the Carilion Campus. Results from this study will be used in my school research project and may also be used in publications and for educational purposes.

To ask further questions or schedule an interview please contact me using the information below.

Confidentiality
The interviews are for research purposes and will not be used for your treatment at the clinic, nor will any clinic personnel have access to your interview. The audio recordings will be kept on a password protected device and no additional identifying information will be collected. The summary of themes across interviews, used in the findings, will not identify individual participants.

Compensation
You will be compensated for your time in the amount of a $20 gift card to your choice of Kohl's, Subway, or Papa John's. The gift card will be presented to you at the beginning of the interview.

Thank you for your consideration.

Respectfully,
Dana Ripley
Virginia Tech
540-525-0498
dmripley@vt.edu

Appendix C

Interview Protocol
Counseling Interventions and Buprenorphine for Treatment of Opioid Use Disorders

Pre-Session Activities
- Before recording and beginning the session, participants will be provided another copy of the consent information form to keep for their own records. Participants will also be given their gift card for compensation.

Questions and Probes

1. I'd like to start with what you see as the purpose of group therapy. In your own words, what do you think is the purpose or goal of group therapy?

2. Now let's talk about your own recovery. How does group therapy impact your recovery?
   - *Follow-up: How might your recovery be different without group therapy?*
3. I'd like you to think about a particular session or time when group was especially meaningful for you. Please describe that time.

4. Now, think about a session or time when you were upset or uncomfortable in group. Please describe that time.

5. Have you experienced or made changes in your life as a result of group?
   - *Probe: Provide examples of learning something new or receiving advice or support from another member.*
6. What are some downfalls or things you don't like about group therapy?

7. Are there certain issues that are best addressed by group therapy?
   - *Probe: Are there things that are easier or more difficult to talk about in a group setting?*
8. How does group therapy compare to other types of therapy or counseling you have experienced?

9. My last question is, if you were giving another person advice about how to get the most out of group, what would you say?

Closing:
- Before ending, provide participant with demographic survey to fill out or assist participant with filling out the form.
- Thank participant for their time and remind them of how to contact you should they have any follow-up questions or concerns.

Appendix D

Demographic Survey
Counseling Interventions and Buprenorphine for Treatment of Opioid Use Disorders

1. Age:_____

2. Gender:_____

3. Race/Ethnicity:_____

4. Please check here if your primary opioid of abuse was a prescription drug ☐

5. What other drugs did you frequently use?

    _____

6. How long have you been in this treatment program?

    _____

7. How many group sessions have you attended?

    _____

8. How many times, before this time, have you been in drug treatment?

    _____

9. What other types of mental health support do you receive? (examples: Narcotics or

    Alcoholics Anonymous, individual counseling, case management, in-home therapy)

    _____