THE LIVED EXPERIENCE OF CLIENTS TREATED WITH BUPRENORPHINE FOR OPIOID WITHDRAWAL PROTRACTED DEPRESSION

by

Samuel L. Marcel

STEVEN SCHENIDER, PhD, Faculty Mentor and Chair

JOSEPH DAMIANI, PhD, Committee Member

BRAD SCHATZMAN, PhD, Committee Member

Curtis R. Brant, PhD, Dean

Harold Abel School of Social and Behavioral Sciences

A Dissertation Presented in Partial Fulfillment

Of the Requirements for the Degree

Doctor of Philosophy

Capella University

November 2013

ProQuest LLC.
789 East Eisenhower Parkway
P.O. Box 1346
Ann Arbor, MI 48106 - 1346

Abstract

Opioid users detoxifying from opioid drugs are at risk of developing a substance-induced mood disorder that meets the symptomatic and duration criteria for dysthymic disorder or major depression. An opioid induced mood disorder such as depression may develop during the intoxication or the withdrawal state. During the withdrawal state, the depressed symptoms can be relatively protracted (Diagnostic and Statistical Manual of Mental Disorders Fourth Edition-Text Revised (APA, 2000). One of the major problems in treating the opiate user with protracted depression is the lack of knowledge concerning the views of the opiate user while in aftercare. Buprenorphine, a semi-synthetic opioid derivate (a partial mu receptor agonist and kappa receptor antagonist), has the potential to act as an anti-depressive agent to help treat patients with opiate withdrawal symptoms such as protracted withdrawal depression (Kintz and Marquet, 2002). A purposeful sampling strategy, criterion sampling (studying participants who have a similar experience as related to the research question) was utilized to recruit and select participants for this research study (Patton, 2002; Marshall & Rossman, 2006)**.**

The sample for this study was seven former aftercare participants, four males and three females between the ages of 20 to50 years old, treated with buprenorphine for opiate withdrawal protracted depression. A qualitative study was used to explore and develop a psychological structure of the lived experience of former aftercare participants treated with buprenorphine for protracted depression related to opiate withdrawal. The qualitative approach selected to analyze this study was guided by the descriptive phenomenological method based on Giorgi's model (Giorgi, 2009). Constituents that

emerged from this study included feeling rejuvenated with a renewed outlook on life, buprenorphine viewed as a “miracle drug” that allowed the participants to refocus on family and social obligation, developing a positive attitude toward participation in aftercare, and abstains from opiates without the desire or craving to use.

The understanding of the participants’ lived experiences in aftercare can serve as a guideline for healthcare and addiction providers who are interested in developing a foundation for an integration program that will meet the needs of opiate users.

Dedication

To my wife Ana

My Children

Octivia

Jonathan

And

Samuel

For their patience and emotional support during this doctoral journey

Acknowledgments

Special thanks to my mentor and friend Steven Schenider, Ph.D. for his unconditional dedication and commitment toward guiding me through this journal of obtain my doctorate degree at Capella University.

Table of Contents

CHAPTER 1. INTRODUCTION

Individuals addicted to opiate drugs are at risk of developing non-life threatening withdrawal symptoms when they attempt to abandon the use of opiate drugs. The withdrawal symptoms experienced by opiate users can be physical as well as psychological. The symptoms of withdrawal may include: feelings of depression, anxiety, flu-like illness, insomnia, diarrhea, muscle aches, pain and drug craving. To help alleviate these symptoms, the user becomes discouraged from abandoning their use of opioids and may relapse back to opioid use. Users have to routinely increase their opiate use to avoid withdrawal symptoms with continued usage (Sadock & Sadock, 2007).

Opioid users detoxifying from opioid drugs are at risk of developing a substance-induced mood disorder that meets the symptomatic and duration criteria for dysthymic disorder or for major depression. Depression experienced by the opiate user may be related to an opioid induced mood disorder or from a preexisting depressive disorder. An opioid induced mood disorder such as depression may develop during the intoxication or the withdrawal state. During the withdrawal state, the depression symptoms can be relatively protracted. The opiate user may experience the feelings of depression between 10-30 days after the cessation of opiate use (Diagnostic and Statistical Manual of Mental Disorders Fourth Edition-Text Revised (APA, 2000).

The high incidence of relapse back to the use of illicit and non-medical use of opioids is a major problem for detoxification, rehabilitation, and aftercare programs. In

order for a substance abuse treatment and aftercare program to be effective both conditions, opioid dependency and depressive disorders, must be treated concurrently. Opioid dependency and depressive disorders left untreated or inadequately treated or targeting only one condition can interfere with the effective treatment of opioid addiction (Julien, 2001).

Developing an effective maintenance program for opiate users suffering from protracted withdrawal depression may be complicated by the difficulty of keeping the user in treatment, the user poor adherence to the treatment modality, as well as not completing the treatment program (Daley & Moss, 2002). The use of antidepressant medications, such as monoamine oxidase inhibitors (MAOIs), to treat opiate users suffering from depression related to protracted withdrawal from opiates, are usually not effective toward relieving protracted depression from opiate withdrawals and may create unwanted side effects. Benzodiazepines and tranquilizers may prove harmful for opiates users by creating dependency or abuse of these medications, requiring the user to substitute one addiction for another (Twerski &Nakken 1997; Muser, Noordsy, Drake, & Fox, 2003).

Muser et., al. (2003) acknowledge that one of the most important factors toward creating an effective chemical dependency and aftercare program for individuals, addicted to opiate drugs, suffering from protracted withdrawal depression would be to develop an effective protocol or program that would treat the underlying protracted withdrawal depression associated with chemical dependency (which is often not addressed in an ineffective sequential treatment program which excludes opiates users with dual disorders from treatment until the mood disorder has been stabilized or the

opiate user has completed a detoxification program, while in a parallel treatment program opiate users suffering from a dual disorder are treated concurrently in different agencies by different healthcare providers). One area of interest, to healthcare and addiction professionals treating opiate users, would be the development and implementation of a psychopharmacological treatment protocol as part of an integrated treatment modality to treat chemical dependency as well as underlying mood disorders, such as depression, to help increase adherence to aftercare and decrease the incidence of relapse in opiate users (McNeece & DiNitto, 2005).

Buprenorphine, a semi synthetic opioid derivate (a partial mu receptor agonist and kappa receptor antagonist), is currently being used as a treatment modality to help decrease severe withdrawal symptom during detoxification from opiate use and prevent relapse during the maintenance phase. Buprenorphine also has the potential to act as an anti-depressive agent to help treat patients with opiate withdrawal symptoms such as protracted withdrawal depression (Kintz and Marquet, 2002).

Before the mid-1950s, opiate medication such as morphine was the drug of choice for treating opiate addiction and depression. Due to the high potential for abuse and the introduction of tricyclic anti-depression medications, opiate medication was replaced as a medical modality for the treatment of depression (Nyhuis & Gastpar, 2005). The use of opiate medications such as Methadone, a synthetic mu-agonist, was introduced to the medical community in 1965 and approved by the US Food and Drug Administration (FDA) in 1972 as a treatment modality for opiate dependency and suppressing withdrawal symptoms, since than Methadone has been viewed as the principal treatment modality for the prevention of abstinence symptoms (Julien, 2001). In the mid-1990s a

clinical trial was conducted with buprenorphine for the treatment of refractory depression, the results revealed that four out of ten participants treated for refractory depression in the trial achieved complete remission from refractory depression and two participant showed mild improvement (Strosser, 2007). In another study, conducted by Caldiero, Parran, Adelman, and Piche (2006), the results revealed that buprenorphine was effective for engaging and retaining opiate users in outpatient chemical dependency programs.

Buprenorphine was approved by the Food and Drug Administration (FDA) under the Drug Addiction Treatment Act of 2000 (DATA 2000), to treat opiate dependency and may prove to be an effective modality in relieving protracted withdrawal depression during the recovery stage of treatment (Kintz & Marquet, 2002). Researching and exploring the experience of participants treated with buprenorphine, for protracted withdrawal depression, may be helpful to health care and addiction professionals to create an integrated treatment approach to treat opiate users suffering from protracted withdrawal depression.

Background of the Problem (Introduction)

Opiate addiction has become a major problem in the United States with the increased use of heroin and non-medical use of opioids such as: codeine, fentanyl, hydromorphone, morphine, methadone, and oxycodone (OxyContin, Percocet). Approximately 2.5 million people have abused prescription opiates once in their lifetime, approximately three million have used heroin once in their lifetime, and 750,000 to one million individuals in the United States are addicted to heroin (HRSACareAction, 2004; Society for Neuroscience, 2006).

Individuals addicted to opiate drugs without access to a chemical dependency treatment or aftercare program will likely face many physical, psychological, social, and economic obstacles in their lives. Untreated opiate addiction has led to issues such as overdose, infectious disease such as human immunodeficiency virus (HIV) and hepatitis C virus (HCV), criminal activity, family violence, loss of jobs, and death(HRSACare Action, 2004). The social and economic price of untreated opiate addiction is enormous (NAOMI, 2006), costing American society an estimated $180 billion a year related to health care costs, decrease in job productivity, and crime (Society for Neuroscience, 2006).

Bio-psychosocial factors combined with easy access to illicit and prescription opiate drugs may lead to comorbidity issues such as chemical dependency and depression Daley & Moss, 2002). Comorbidity issues such as depression and chemical dependency have raised concerns (related to the effectiveness of treatment and not completing the treatment program) among addiction and mental health professionals (Der-Avakian, 2006). Depression combined with ineffective treatment modalities, lack of motivation in treatment, inability to benefit from treatment, and an increase in treatment and aftercare dropout rates are some of the major issues that must be addressed with individuals addicted to opiate drugs (Moore, 2002).

Individuals dependent on opiate drugs are faced with the daunting challenge of staying in treatment, seeking a comprehensive treatment or aftercare program, and adhering to a treatment regimen (HRSACareAction, 2004). The challenges of providing care to individuals suffering from opiate withdrawals have created frustration among addiction and healthcare professionals, because of the ineffective treatment modalities

and the segregation of chemical dependency programs from primary care facilities (HRSACareAction, 2004).

Chemical dependency and psychological disorders occur in three ways: (a) disorders may exist independent of each other, (b) psychological disorder may place an individual at greater risk for induced substance abuse disorders (i.e. depression, anxiety, PTSD), (c) drug abuse, intoxication, or withdrawal may result in temporary psychological disorders syndromes (National Association of State Mental Health Program Directors and National Association of State Alcohol and Drug Abuse Directors, 1999). Creating an effective treatment modality to treat individual, addicted to opiate drugs, struggling with protracted withdrawal depression would be a tremendous step toward erasing the negative stigma of heroin and opiate addiction, as an undesired social problem to be handled only through the criminal justice system, to changing the global community's view of heroin as a bio-psychosocial illness to be treated with elements consisting of biological, behavioral, and social components (Leshner, 1997; McNeece & DiNitto, 2005).

The use of opioids as a form of a treatment modality to treat opiate and heroin addiction has been unavailable in the United States since the early 1900s (Substance Abuse and Mental Health Service Administration -TIP #40). The practice of morphine and heroin-assisted therapy was abandoned after 1923 by the United States government as the treatment of choice to treat opiate addiction. The introduction of Methadone Maintenance Therapy (MMT) (clinic based treatment program) took place in the 1960s as a treatment modality to treat heroin addiction (NAOMI, 2006). Thus far, methadone has proven to be a successful treatment modality to help alleviate opiate withdrawals and

craving, as well as helping to reduce risky lifestyle behaviors, self harm, social problems, criminal activities, and healthcare costs commonly associated with untreated opiate addiction (Sadock & Sadock, 2007). The government's regulations and limited availability to methadone treatment clinic have proven to be ineffective for individuals suffering from protracted depression, due to the difficulty of being unable to get into a methadone program (NAOMI, 2006).

Buprenorphine, a schedule III drug, was approved by the Drug Addiction Treatment Act of 2000, as an office-based treatment modality for easier access to treatment for opiate withdrawals and as a maintenance program for individuals addicted to heroin and opiate medication (Leshner, 2003). Buprenorphine, a partial mu receptor agonist, has shown to have lesser risk for overdose, less sedation and euphoria affect than a full mu opioid agonist such as methadone and morphine, but is effective enough to decrease cravings and prevent opiate withdrawals. Buprenorphine has also shown to have an effect on the antagonist kappa receptors in the brain, which may result in buprenorphine having some mild antidepressant properties, which could be used as part of a treatment modality to treat individual suffering from protracted withdrawal depression related to opiate withdrawals (Srivastava & Kahan, 2006).

In an open label study conducted by Nyhuis and Gastpar (2005) three patients suffering from major depression were treated with buprenorphine (0.8-2mg/d) or oxycodon (20mg/d) as a single treatment modality for Treatment Resistant Depression (TRD), after unsuccessfully responding to antidepressants as well as up to 14 sessions of Electroconvulsive Therapy (ECT). Approximately one week into treatment, Hamilton Scale for Depression (HAMD) scores dropped from an average of 24.0 (before

buprenorphine treatment) to 4.3 (with buprenorphine). The participants' depression scores on the Beck Depression Inventory (BDI) dropped from average 27.3 to 10.3.

In a second study conducted by Nyhuis, Specka, and Gastpar (2006), 11 participants suffering from severe depression were treated with buprenorphine (0.8mg-2.0mg) once daily for Treatment Resistant Depression, after unsuccessfully responding to several different combinations of antidepressants such as SSRI's tricyclic, tranylcypromine and venlafaxine. Approximately one week after the start of the buprenorphine treatment, seven of the participants' scores on the HAMD and BDI dropped at least 50 percent. Five of the participants who responded successfully to the buprenorphine treatment had cortisol levels that were completely suppressed; and two of the participants' cortisol levels were in the ranges between 1.3 and 1.6ug/dl. Four of the 11 participants who did not fair well with the buprenorphine treatment had cortisol levels in the ranges of 10, 2.0, 2.1 and 3.ug/dl (2006). The implication of this study suggests that the antidepressant effect of buprenorphine (approved by the FDA for the treatment of opiate addiction, not depression) on the endogenous opioid system may help alleviate protracted depression in individuals detoxifying from opiate drugs (Nyhuis, Specka, & Gastpar, 2006).

Tan, Eiger, and Roth, 2007 administrated buprenorphine (16mg/d) to a 50-year-old man with a history of suicidal ideation, alcohol abuse, and Treatment resistance Depression as part of the participant's treatment modality treated. The participant reported an improvement in his condition such as decreased depression, without cravings for alcohol, benzodiazepines, opioids, or euphoric effects from the buprenorphine within one week of starting the buprenorphine treatment. Episodes of depression had decreased

in terms frequency of occurrence within six months while the participants was on the buprenorphine protocol. The above studies were able to demonstrate buprenorphine antidepressant efficacy to treat individual with Treatment-Resistant Depression as well as individual unresponsive to ECT, the results of these studies were limited and the samples were too small to generalized buprenorhine effectiveness to treat depression. Further studies may help support the argument for the use of buprenorhine due to its potential antidepressant properties to aid in the treatment of individuals suffering from protracted withdrawal depression related to opiate withdrawal.

Statement of the Problem

According to the Diagnostic and Statistical Manual of Mental Disorders Fourth Edition-Text Edition DSM-IV-TR, (APA, 2000, p. 405), depression related to protracted withdrawal from opiates can persist for months after the cessation from opiate use. Kintz and Marquet (2002) acknowledge that protracted depression related to opiate withdrawal is common in aftercare participants and is associated with a 50 percent drop out rate from opiate aftercare programs. This study investigated the lived experiences of aftercare participants, treated with buprenorphine. Identifying and matching opiate users suffering from protracted depression related to protracted opiate withdrawals, with an appropriate treatment modality to help reduce relapse and drop out rate in opioid aftercare programs should be of paramount importance to health care and addiction professionals. Assessing the lived experience of opiate users treated with buprenorphine, as part of an integrated approach during aftercare, can be useful in developing awareness of protracted depression and the use of buprenorphine as a treatment modality for opiate users (Gastfriend, 2003).

Purpose of the Study

The purpose of this descriptive phenomenological psychological study was to explore and develop a psychological structure of the subjective lived experience of former aftercare participants treated with buprenorphine for protracted depression related to opiate withdrawal. This study allowed former aftercare participants treated with buprenorphine for protracted depression the opportunity to openly express their unique experience in their own words. The goal for this study was to generate, among healthcare and addiction professionals, a better understanding of the lived experience of aftercare participants treated with buprenorphine for protracted depression related to opiate withdrawals.

Significance of the Study

A six month outpatient dose reduction schedule clinical study, conducted by Bickel, Amass, Higgins, Badger, and Esch (1997), to evaluated the efficacy of buprenorphine to treat opioid withdrawal, revealed that participants remained free of opiate use for approximately eight weeks and were two to three times more likely to remain in an outpatient maintenance program when treated with buprenorphine. An uncontrolled evaluation conducted by Becker, Strain, Bigelow, Stitzer, and Johnson (2001) revealed that participants had low levels of self-reported withdrawal when buprenorphine was gradually reduced over a period of 28-days. The scarcity of rigorous research assessing the lived experience of aftercare participants (McNeece & DiNitto, 2005) treated with buprenorphine for depression related to protracted opiate withdrawal while in aftercare, is an area that needs further investigation (Johnson, Strain & Amass, 2003). The target

professional audiences for this study will include addiction and other health care professionals.

Research Question

This phenomenological research study investigated the following question over the course of the study: What is the lived experience of aftercare for clients treated with buprenorphine for opioid withdrawal protracted depression? Interview questions are provided in Appendix B.

Assumptions and Limitations

This study was conducted based upon the following assumptions:

1. The participants selected in this study represent a small sample of individuals throughout the country with similar experience of protracted depression related to opioid withdrawal.
2. The participants selected (based on self-admission and clinical diagnosis) in this study will have a history of opiate dependence as well as treated with buprenorphine for protracted depression related to withdrawal from opiate use.
3. The participants selected for this study will answer all questions truthfully.
4. The answers provided by the participants during the interview process will be authentic and represent their actual lived experience.

The following limitations applied to the study being conducted:

1. The methodology approach for this study focus on the lived experience of former aftercare participants treated with buprenorphine for protracted depression related to opiate withdrawal.

2. External factors related to opiate addiction such as family, financial, and legal issues that could affect the outcome of this study was not addressed or accounted for as a cause of the participant's depressed mood.

3. The researcher as a novice qualitative/phenomenological researcher may unintentionally omit important information that may be significant to the participant and this study as well as lead participants to a specific theme or focus in the study.

4. All data for this study was collected and analyzed using Giorgi's descriptive phenomenological approach. This approach may limit or decrease the researcher's capacity to interpret the data using meaning units.

5. The sample size for this qualitative study is generally smaller than that of a quantitative study. The data is not quantitative but was based on the unique experience of a small number of participants that may not be a true representation of a larger population.

Definition of Terms

. *Buprenorphine* will be defined as a semi-synthetic opiate medication with partial agonist and antagonist properties approved by the Food and Drug Administration (FDA), under the Drug Addiction Treatment Act (DATA) of 2000, for the treatment of opiate withdrawals as well as an outpatient maintenance modality to prevent relapse back to opiate use (Kintz & Marquet, 2002).

Former aftercare participants will be defined as participants who have completed a 90 day post detoxification, an intensive treatment, or halfway house, outpatient follow-up program for opiate addiction. Aftercare programs are designed to provide

the participants with outpatient counseling and support services to deal with issues such as remaining drug free, dealing with depression, building social relationships as well as providing self-help and educational programs to help the participants in developing positive self concept and self esteem (McNeece & DiNitto, 2005).

Lived experience will be defined as the participants reflecting on their conscious perceptions, thoughts, feeling and behaviors just as they experienced it in their everyday life (Seidman, 2006). Participants will be reflecting on their experience of completing an aftercare program, sustaining abstinence, maintaining employment, and performing activities of daily living (caring for self) (Giorgi, 1985), related to being treated with buprenorphine to overcome depression.

Protracted depression will be described as, a depressed mood that is judged to be due to the direct psychological effect of opiate use, lasting up to approximately four weeks or longer after the cessation of opiate use DSM-IV-TR (APA, 2000).

1. Participants experienced a lack of or a diminished interest or pleasure in all or most all daily activities and responsibilities
2. Participants experienced irritable or decrease in energy related to opiate withdrawals.
3. The evidence will be based on self-admission or the result of clinical laboratory report suggesting that the participant's depressed mood is evidence of opiate use or withdrawal.
4. The participant's symptoms of depression occurred within one week of opiate withdrawal.

5. The clinical diagnosis from a psychiatrist, psychologist, or licensed professional counselor confirming that participant's symptoms of depression did not precede the use of opiates, evidence that the symptoms occurred and persist for up to a month after the cessation of acute withdrawal from opiates.
6. The participant's symptoms of depression had a major impact on their social, occupational, school or family obligations DSM-IV-TR (APA, 2000).

Opiate withdrawal will be defined as the presence of a substance-specific syndrome that is developed after the cessation of opiate use that has be heavy or prolonged. The opiate withdrawal syndrome may have caused clinically significant emotional, physical, social, or occupation distress (Sadock and Sadock, 2007). Participants will be able to reflect on their experience related to depression and diminished interest or pleasure due the cessation of opiate use.

CHAPTER 2. LITERATURE REVIEW

Introduction to the Literature Review

This study was designed to bridge the gap between research literatures as it relates to the experience of opiate users, seeking treatment for protracted depression related to opiate withdrawal, while in aftercare. In reviewing the vast amount of literature, relating to the effects of opiate addiction and medication management to treat opiate addiction, unfortunately there is a paucity of studies examining the lived experience of opiate users protracted depression post detoxification phase of treatment. One of the major problems in treating the opiate user protracted depression would be the lack of knowledge concerning the views of the opiate user while in aftercare. Reviewing of the literature revealed that the majority of studies conducted, concerning opiate addiction and medication management to treat opiate addiction, were designed using a quantitative methodology. This study was conducted using a qualitative methodology to address the research question for this study. The qualitative approach selected to answer the research question for this study, "What is the lived experience of aftercare for clients treated with buprenorphine for opioid withdrawal protracted depression," was a phenomenological inquiry based on Giorgi's (2009) model. Using the descriptive phenomenological inquiry is appropriate for this study because the approach is designed to allow the individual to describe their experiences, in their own words, as it relates to the phenomenon in this study (Giorgi & Giorgi 2009).

Opiate addiction

Throughout history the drug of choice to help relieve pain and depression were opiate drugs, synthetic as well as natural, because of the pain and anti-depressive reduction properties (Dodgen & Shea, 2000). A major criterion to be considered in the manifestation of opiate addiction is the unmanageable control over the use of an opiate substance (prescribed or illicit), as a result of excessive and continuous use in the presence of physical or psychological consequences DSM-IV-TR (APA, 2000). Information obtained from Khantzian (2003) self-medication hypothesis (SMH) revealed that the compulsion to use drugs such as opiates is an opiate user method of alleviating distressful affects and developing comfort from an unmanageable psychological state of mind. The SMH suggests that a major reason for the continuous use of drugs such as opiates is that it interacts with the individual inner states of psychological pain and personality organization (Khantzian, 1997, 2003). Addiction to opiates is a compulsion to use opiate drugs even when there is no medical reasoning for the use of opiate analgesic. An opiate user may continue to use opiate pain killers despite first hand knowledge or experience of the adverse psychological or physical side effect intensified by opiate use (Miller, 2006).

Easy access and availability as well as a misperception about the use and danger of prescription drugs have created a major healthcare concern in the United States (Zany et al., 2003). The addiction and abuse of prescription pain analgesics (among young adults eighteen to twenty years of age) are usually experienced or used later after the use of other gateway drugs such as alcohol, marijuana, and cigarettes (SAMHSA, 2006a). According to Compton, Darakjian, & Miotto (1998), the experimentation and abuse of

opiate drugs is manifested with the non-medical /recreational use of prescription pain analgesics before the use of illicit street drugs such as heroin and cocaine. With the increase use and demand for the use of prescription opiate analgesics, the United States have seem opiate pain killers out valued and have become as available on the street similar to heroin and cocaine. The U. S. has seen a high rise in the abuse and overdose of prescription analgesics. This increase in opiate abuse have tripled, in record numbers, emergences rooms visits, and admission to healthcare and detoxification facilities related to individuals seeking treatment for opiate addiction (U.S. Substance Abuse and Mental Health Services Administration [TEDS] 2005).

In a study conducted by Bagagett, Hwang, O'Connell, Porneala, Stringfellow, Orav, Singer, and Rigotti (2013), that examines the cause of death among the homeless population in the city of Boston. The result of the study revealed that overdose from opiate drugs at 81 percent was the leading cause of death with heroin at 13 percent and opioid analgesic at 31 percent.

Protracted depression

According to the DSM-IV-TR (APA, 2000), the onset of substance-induced mood disorder is manifested by the intoxication or withdrawal states. During the withdrawal state, individuals may experience intense protracted depression symptoms that can last up to approximately four weeks after the cessation of opiate use. The intensity of the depression may create significant distress or impairment in several phases of the opiate user's life such as poor social interaction, lack of family obligation and commitments, lack of pleasure and interest, and occupational problems.

In a case study conducted by Fishman, Wu, and Woody (2011), a 28 year old female described as Ms. B was able to overcome her years of addiction opiate pain killers and depressive mood, related to the use and withdrawal of opiate analgesic pain killers, once she was placed on buprenorphine/naloxone and participate in an aftercare support. The authors revealed that Ms. B had little to no improvement in her depression with the use of anti-depressant. Ms. B. abrupt discontinuation of buprenorphine, led her to relapse back to her drug of choice as well as the recurrence of her depressed mood. Ms. B once again found relief and was able to refrain from opiate use for approximate six month with the use of buprenorphine and participation in an aftercare support group.

Two similar cases were highlighted in a research study conducted by Mendelson, Flower, Pletcher, and Galloway (2008), which demonstrated how two individuals (suffering from prescription opiate analgesic abuse and depression) were able to refrain from opiate use as well as gaining relief from depression once they started treatment with buprenorphine while in aftercare.

Buprenorphine

Approximately 50 percent of the opiate users in aftercare program will experience depression after the cessation of opiate use. This high level of depression is usually associated with a poor treatment prognosis (Kintz & Marquet, 2002).

The Harrison Act of 1914 hindered the medical community efforts toward the use of opiate medication in the United States to treat opiate addiction. Although the Harrison Act did not directly prohibit the use of opiate medication to treat opiate dependency, the medical community, under the pressure of the Treasury Department and including the American Medical Association in 1920, was ultimately deterred from engaging in the

practice of using opiate as a treatment modality to treat individual suffering from opiate addiction. The attitude of the American medical society, against the use of opiate medication to treat opiate dependency, changed with the closing of morphine clinics in 1923 and introduction of methadone maintenance clinics 1964 (Jaffe & O'Keeffe, 2003).

Buprenorphine a semi-synthetic opioid derived from thebaine, an alcaloid of the poppy Papaver somniferum, was developed by the Reckitt and Colman Products in the early 1970s.The development of buprenorphine was due to the search for an alternative analgesic to morphine that had a low abuse potential and reduced toxicity properties, (Hull, UK). Buprenorphine was later synthesized in the United States in 1973 by Alan Cowan and John Lewis for medication management to treat opiate addiction (Marquet, 2002). Buprenorphine became available for the treatment of opiate dependency with the implementation of The Drug Abuse Treatment Act of 2000 (DATA 2000). The DATA 2000 allowed certified physicians, with notification to the Secretary of Health and Human Service with the intent to treat under DATA 2000, to treat up to 30 opiate users at a time in a clinical setting.

The use of buprenorphine as a treatment modality during the maintenance phase and aftercare has been met with societal ambivalence. The healthcare community advocated for the use of buprenorphine due to its acceptability over methadone as well as its effectiveness to help reduce drop out rate in treatment, the reduction of high-risk behaviors associate with obtaining and relapsing back to opiates, and the decrease or cessation of illicit or prescription opiate medication. Proponents against the use of opiate medication as a treatment modality argues that a "drug free" approach or abstinence and reduction of opiate use should be the main focus of treatment. Advocates for medication

management in the healthcare community agree that this approach may be effective for some but for most the drug free or abstinence approach may cause needless physical and psychological suffering (Wesson, 2004).

The apostolic duty of the healthcare provider is to help to alleviate or reduce the suffering of an opiate users seeking medical assistance. With the modernization of medication such as buprenorphine, healthcare providers are now able to employ a comprehensive approach to treat opiate addiction (Johnson, 2007). Increasing the availability, implementation, and creating a standardized protocol for the use of buprenorphine as part of the treatment modality to treat opiate dependency, would be crucial in assisting the opiate user to regain a sense of normalcy in their life (NIDA, 2013).

Approximately 54 percent (out of the 99 participants in the study) of opiate users were able to maintain their sobriety for six months once they started treatment with buprenorphine, for opiate dependency and alleviating withdrawals symptoms (Mintzer et al., 2007). Caldiero reveals that opiates users were more likely to seek and remain in outpatient treatment with the continuation of buprenorphine as part of their treatment modality (Caldiero, Parran, Adelllman, Piche, 2006). Comments obtain, from participants during an evaluation of United States buprenorphine waiver program, revealed that 40 percent of the participants stated that they were pleased with using buprenorphine as part of their treatment modality as well as the increased access to healthcare providers certified to prescribe buprenorphine to treat opiate addiction (Mendelson, et al., 2008).

Aftercare treatment

Detoxification to treat opiate dependency should service as a gateway, not the end to the beginning, to rehabilitation and aftercare services that should consist of medication management combined with psychological support (counseling and 12 step program), to help treat opiate dependency (Johnson, 2007).

The treatment of choice for starting an opiate user on buprenorphine in the office setting and while in aftercare would be a combination of buprenorphine/naloxone. The rationale for the buprenorphine/naloxone combination would be to prevent the misuse of the medication by an opiate user attempting to crush the medication and use it intravenously (Kintz & Marquet, 2002).

The use of buprenorphine usually provides the user with relief from depression and other withdrawal symptoms within 30 to 60 minutes after taking the medication. This time frame also allows the healthcare provider to assess the outcome of the medication and adjust the medication as needed to help the individual receive the desired relief. Healthcare providers are encouraged to be involved with the opiate user weekly, biweekly, or monthly until the opiate users symptoms are alleviated or stabilized. Health care provider should titrate, buprenorphine down, to a therapeutic dosage as needed to help opiate users remain symptom free or maintain stability (DeMaria & Patkar, 2008).

During the treatment process, rapid or aggressive titration of buprenorphine would be unadvisable (DeMaria & Patkar, 2008). The opiate user may experience mild opiate withdrawal symptoms if buprenorphine is titrated aggressively or discontinued abruptly. Opiate withdrawal symptoms may begin within three to four days once

buprenorphine is titrated below a therapeutic dosage or abruptly discontinued (Johnson et al., 2003).

An acceptable standardized protocol among the medical community to address the duration concerning the time frame of maintaining or terminating the treatment with buprenorphine to treat opiate addiction needs to be established (Mendelson, et al., 2008).

CHAPTER 3. METHODOLOGY

Purpose of the Study

The purpose of this descriptive phenomenological psychological study was to explore and develop a psychological structure of the subjective lived experience of former aftercare participants, treated with buprenorphine for protracted depression related to opiate withdrawal. This study allowed former aftercare participants, treated with buprenorphine for protracted depression, the opportunity to openly express their unique experience in their own words. The goal for this study was to generate, among health care and addiction professionals, a better understanding of the lived experience of aftercare participants treated with buprenorphine for protracted depression related to opiate withdrawals.

Research Design

The qualitative approach selected to answer the research question for this study was a phenomenological inquiry based on Giorgi's model (Giorgi, 2009). A phenomenological inquiry was appropriate for this study because it focuses on describing the individual's experiences as it relates to the phenomenon in this study (Giorgi, 2009; Creswell, 2007). This research study focus on the lived experience of former aftercare participants, treated with buprenorphine for protracted depression related to opiate withdrawals.

The sample for this qualitative study was five to seven former aftercare participants, between the ages of 20-to 50-years old, who have been diagnosed with opiate dependent and depression related to opiate withdrawal, by a psychiatrist, psychologist or licensed professional counselor, and treated by a psychiatrist or physician with buprenorphine to alleviate severe physical symptoms related to opiate withdrawals.

Purposeful sampling was used to recruit participants to investigate the lived experience of former aftercare participants treated with buprenorphine for protracted depression related to opiate withdrawals. Purposeful sampling is the most appropriate method when collecting data from all participants who have experienced a similar phenomenon (Creswell, 2007).

Data was gathered through the use of interviews of selected participants. The focus of the interviews was to allow each participant the opportunity to provide a detail description of their experience of the phenomenon (Giorgi, 2009). The interviews was audio-taped and transcribed verbatim (Marshall and Rossman, 2006; Creswell, 2007).

The transcription was reduced by delineating psychological meaning units and analyzed using free imaginative variation method for describing the psychological structure of the experience (Giorgi, 2009).

Target Population and Participant Selection

The population of interest for this qualitative study was opiate users treated with buprenorphine to alleviate protracted depression related to opiate withdrawals. A phone script was utilized to determine if client meet the criterion to participate in this study. The sample for this study was seven former aftercare participants treated with buprenorphine for opiate withdrawal protracted depression or until there is a redundancy or saturation of information (Creswell, 2007and Seidman, 2006). The researcher continued to recruit and collect data for this study until redundancy or saturation of information (no collection of new information) had occurred after the 7th interview (Creswell, 2007). The sample size for this study was consistent with similar phenomenology studies such as Cater, Machtmaes and Fox (2013) study of six youth, in a

qualitative study “A Phenomenological Examination of Context on Adolescent Ownership and Engagement Rationale” as well as Woodman and Radzyminski (2009), study of the lived experience of nine women who has breast reduction surgery.

Procedures

The researcher obtained approval from Capella University Institutional Review Board (IRB) to conduct this research study. Once approval has been granted the researcher placed an ad in the El Paso Times newspaper (section D classifieds), which has an average weekday circulation of approximately 64,141 and Sunday circulation of approximately 83,769, for fourteen days as well as creating and passing out 300 flyers on the streets to potential participants. Once the researcher was unable to recruit seven participants in the fourteen day time period, the ads were renewed for another fourteen days. The ads and flyers included general information concerning the nature of the research study, the amount of participation required, how the data will be collected (e.g. interviews), the researcher’s email address, and telephone number to his private practice office, for those subjects interested in participating in this research study (Seidman,2006).

This researcher was seeking to obtain (from a small number of participants) a thick rich description of the lived experience of aftercare participants treated with buprenorphine for opiate withdrawal protracted depression. Therefore a purposeful sampling strategy, criterion sampling (studying participants who have a similar experience as related to the research question) was utilized to recruit and select participants for this research study (Patton, 2002; Marshall & Rossman, 2006)**.** A phone script was utilized to screen each caller who responds to the flyers and newspaper ads to participate in this study. The purpose of the phone script was to help develop a positive

rapport with each potential participant, as well as assessing the appropriateness of each participant for this study. The major determination for appropriateness was whether the participant's experience meets the criterion for this study (Seidman, 2006). The participants were asked the following question to determine if they meet the criterion for this study: 1) Have you participated in an aftercare program after a detoxification treatment for opiate addiction? 2) Have you been diagnosed by a physician or psychiatrist, or psychologist with depression relate to opiate withdrawal? 3) Do you have a diagnosis of depression not related to opiate withdrawal? 4) Do you have a diagnosis of opioid dependency? 5) Were you treated with buprenorphine to alleviate opiate withdrawal within the past one year? 6) Are you currently free of an illicit drugs or alcohol use? 7) Are you currently on probation?

Individuals currently on probation or placed on probation during this study were excluded from participating in this research study. Selected participant was required provide a discharge or diagnostic summary from a healthcare provider, detoxification and or aftercare program to confirm their criterion to participate in this study. Any former client of this researcher was not recruited and was not considered to participate in this study. This researcher recruited only individuals who were former aftercare participants. Anyone who was in treatment for psychological disorders, medical ills, on probation, or actively using buprenorphine was excluded from participating in this study.

Once appropriateness had been determine the researcher provided the participants information concerning the nature of the study, signing the consent form, the criteria for participation in this study, risk to the participant, the use of tape records and note taking during the interview process, compensation for their participation, as well as establishing

an appropriate meeting place and time comfortable to the participant. A contact visit was scheduled (with the first 10 caller who met the criterion for this study) to conduct a face to face interview to record the lived experience of the 10 aftercare participants (until there a saturation of information) (Creswell, 2007), treated with buprenorphine for opiate withdrawal protracted depression.

Instruments

Giorgi's descriptive phenomenological psychology method was utilized as a guide this study. During the interview process the researcher asked open-ended questions to obtain the lived experience of the phenomenon. The interview was tape-recorded. After the interview process, any notable activities or participant's body language that was observed by the researcher was document. The recorded description of the participant's experience as well as the notes taken by this researcher became the raw data for this research study. The recorded information was transcribed verbatim for reduction, analysis, and presentation (Giorgi, 2009).

Research Questions

What is the lived experience of aftercare for clients treated with buprenorphine for opioid withdrawal protracted depression?

Data Analysis

The transcribed data was processed and analyzed according to Giorgi's Descriptive Phenomenological Psychological model, which consisted of description (the interview), reduction (delineating), interpretation (free imaginative variation), and presentation of meaning units (Giorgi, 2009). The phenomenological reduction of the participants' description of the phenomenon, allowed the researcher to bracket his past experiences

and knowledge about the phenomena while discarding irrelevant and redundant meaning units, by searching for relevancy and emergent themes (Merriam, 2002). The advantage of using meaning units helped to interpret what was significant and determined which direction the meaningful experiences was leading toward (Auerbach & Silverstein, 2003).

Once the verbal data was collected it was transcribed, read, reduced to psychological meaning units and described as a psychological structure of the experience by the researcher. The researcher had to carefully re-read the transcribed data several times, and began the process of reduction by delineating psychological meaning by searching for and extracting key statements, phrases, and words (also omitting non-key statements and phases) that are significant to each participant's experience, related to being treated with buprenorphine for opiate withdrawal protracted depression.

Extracting key statements and phases was the result of the researcher going line by line over each transcript looking for similarities, differences or inconsistencies in the participants' experiences. The participant's expressions generated from the key statements, words and phases was developed into expressions that help to discover and illuminate the participant's psychological meaning of the experience, using the process of free imaginative variation and rendering implicit factors explicit. Finally the participant's transformed meanings unit expressions were used to create a psychological structure of the participants' experience (Giorgi, 2009).

Ethical Considerations

Obtaining informed consent from participants agreeing to participate and be interviewed for this study was paramount toward protecting the participants against vulnerability (Seidman, 2006). An informed consent application was developed and

submitted to Capella IRB committee for approval. Once the informed consent was reviewed and approval by the IRB committee, participant was given the opportunity to read and discuss with this researcher any concerns they were uncomfortable with before signing and participating in the research process. All participants was asked to sign the consent once they felt comfort with the information covered in the informed consent application as well as with the explanations given by the researcher related to the research process.

Expected Findings

The expected findings for this qualitative study, using the descriptive phenomenological psychological model is presented as a discussion based on the interpretation and comprehensive structure description of the lived experience of former aftercare participants, treated with buprenorphine for protracted depression relate to opiate withdrawal Giorgi, 2009). The interpretation and description of the lived experience of the participants of the phenomenon may be helpful in creating interest or awareness among health care and addiction professionals to conduct further research on the effectiveness of buprenorphine as a treatment modality for aftercare participants suffering from protracted depression related opiate withdrawal, to help increase adherence to aftercare treatment.

CHAPTER 4. DATA COLLECTION AND ANALYSIS

Introduction

This research study explored the lived experience of former aftercare participants treated with buprenorphine, related to protracted depression, while participating in an aftercare program. The participants in this study were allowed to express their experience in their own words. A qualitative research method using Giorgi's descriptive phenomenological psychological design was utilized for this study. In following with Giorgi's design this researcher first interviewed seven participants, four males and three females from various socio-economic backgrounds, between the ages of 20 and 50 years old who admitted to experiencing protracted depression during the aftercare phase of their treatment post detoxifying from opiate drugs.

The interviews took place in several different locations based on the preference of the participants. The interviews were audio taped using two digital tape recorders. The researcher transcribed the taped interviews verbatim. The researcher re-read the transcribed interviews several times, then was able to create 288 psychological meaning units from the collected raw data. Using free imaginative variation the researcher transformed each meaning units of the raw data into explicit psychological meanings units of the participants experience as well as changing the raw data from first person expression to third person expression by using the letter P to represent the participants. Changing the raw data to third person expression using the letter P will clarify to the

reader that the researcher is analyzing another person experience (Giorgi, 2007). One psychological structure of the participants lived experience was created from the transformed psychological meaning units. During the post-structural analyses the researcher was able to create 24 constituents from the psychological structures along with the raw data provided by each participant.

Details of the Analysis and the Results

Selected Constituents of the Structure with Empirical Variations Provided by the Participants

Introduction

The purpose of establishing constituents of the structure, using imaginative variation, is to allow the readers to develop an understanding of the variations discovered within the psychological structural based on the participant's experience of the phenomena (Giorgi, 2009).

Question #1

Constituent: Feeling of misery with lack of motivation

P1.
Probability the worst depression you can ever have.
I would fake it at work and I was miserable I was just a walking shell of myself to put it in a nut shell.
I wasn't me it was just to keep up the facade./
The depression lasted about two to three week when I went cold turkey.
You don't want to get out of bed./
I used to be total sleeping for 24 hour or I would be awake and have insomnia for 24 hour a day. I go through cycles, the first three day would be nothing but sleeping, the next three days I would be awake, you can't move, you just want to lay there even though you are awake, that lasted about two weeks when I went cold turkey the first time./

P2.
No motivation, no drive, it was hard to get up and go to work. I just didn't want to do anything. No drive, I kept telling my wife. I couldn't get going, a lot of lying around doing nothing, a lot of sleeping./ The depression lasted for quite a while. It lasted for about three months.

Even though the urges wasn't there, the lack of motivation kept me down, there was no motivation, there was no motivation./ I don't think it was the depression at that point so much. It's hard to tell the different between the depression and lack of motivation.
I don't have much to say, but I think if it was the depression, the depression is what kept me from going and lack of motivation./
If not, it was from the drug and not having the Suboxone, but it was definitely there./

P3.
It was pretty severe. I didn't want to get out of bed. I felt overwhelm and sadness. I had the physical pain, I was…. just didn't want to do anything, just all the symptom of depression. I just didn't want to get out of bed and not wanting to start the day. Not wanting to get up and get dress, go out, or see anyone, talk to anyone./

P4.
Immediately when I got sick I couldn't move I couldn't get out of bed. I just basically laid there for a couple of days.

P5.
Other than the fact I felt like I was going to kill myself. It was horrible. It lasted until I felt fine or until I could get a hold of something./
I felt horrible, horrible, horrible, and I wouldn't have gone to a doctor. So if it wasn't for the Suboxone I would have probably overdosed on the pills. It was getting bad./

P6.
At my worst, I was suicidal. I attempted suicide a number of times. Wounded up in hospitals because of it, it was intense. So probably about a month I was in depression. I just lock myself in my house and just got sick all over the place. And I'll do just about anything not to go through it again, anything./ It was horrible, horrible. It was so scary I don't ever want to go through it again. It was only a couple of week before they put me on the methadone.

P7.
I suffered severe depression after I stopped using buprenorphine and went back to my living environment where they said people, places, and things.
For me I can't really think of it as a time period, it just came and went over time. The main period of depression was about six months after the use of buprenorphine.

Constituent: No Desire to participate in aftercare

P1.
I didn't go to the aftercare program as for as counseling and that. I went the first time I was on Subutex while in A.Z. in 2007./
I didn't try to participate because I really didn't have the motivation to participate in meetings, counseling or aftercare program./
My biggest thing was looking to relieve my withdrawal symptom which would be to go back on my opiates. I had no motivation for an aftercare program. I never ever was in a program until I got on Suboxone./
When I was taken off not by choice, the only think in my mind was how I was going to get something to get me high or how I was going to get some Suboxone again, so there was no motivation for participation. My participation was how I was going to get the drugs./

P2.
I didn't really have much of an aftercare program, it was far away. They gave me the medicine and told me to take it./ But when I had to be there I was there as far as attendance went. I guess it was ok. I try to do what I'm supposed to do. It was extremely difficult to go

P4.
I didn't go to any aftercare program. I overdosed and I was thinking I had to do something before I'm dead.
I didn't want to go to NA, didn't want to go to AA, I just wanted everyone to leave me along./

P5.
It hurt and I didn't want to do it, I was scared so I didn't. I didn't do the program./ Someone told me where I could get the Suboxone so I just took them./ I wasn't going to do that (aftercare program).

P6.
I didn't want to go. I didn't want to participate in aftercare. If I'm depressed I don't want of go and sit in front of a bunch of people and tell them about my life. I just wanted to stay home and eat cookies and watch tv./
I just didn't go to aftercare. I feel like aftercare was there for a good reason but if I wasn't feeling well I didn't want to get in the car and drive 40 miles, I lived out in the country. I just didn't want to get in the car and drive all that way to talk to people if I wasn't feeling well.

P7.
I felt like the one thing that helped my depression was going to the NA meetings, but NA is only one hour to two a day. You can only go to so many meeting a day to try to distracted yourself from being out of your mind about using or something like that./ I felt withdrawn and wasn't as interested in it and kind of sided tracked,

my mind might have been in other places than where it should have been with participating in NA or AA meetings or home group or anything like that.

Constituent: No sense of commitment to family and daily obligations

P2

Other than going to work, I didn't maintain much of a relationship with anybody other than my wife that I see daily. Everyone else that I would see daily, weekly, or monthly, I just dropped off from seeing them. I sort of dropped off the face of the earth for awhile./ People were wondering if I was alright. When they would call I didn't have much to say to them. It affect it a lot, I kind of wanted to disappear./ I really didn't talk to anybody, for a short answer. I just shut away from everybody./

P3.

I wasn't able to commit to anyone without it./ When I didn't have it I was physically ill. When I was on it I was able to function and work on a daily bases, but without it I couldn't get anything accomplish./

P4.

I was pretty emotional, I would get angry quickly. When I was taking it, it took a lot to make me angry. When I got off of it I would get piss off about anything. I would fight pretty much about anything./
I had more agitation and shaky after stop using the medication. I also became more emotional for a while./ That was my side effect./ I just wanted everybody to leave me along. I wanted everybody to get away from me.

P6.

I don't know, I didn't keep my obligations. I do now but before I didn't. I didn't maintain my commitments. I just didn't. My family suffered, my friends suffered, I didn't maintain any commitments. I was pretty much shut off, I went into a shell./

P7.

I didn't have a lot of ambition and couldn't do a lot of the things that I loved. I was withdrawn from a lot of my family and friends where I wanted to be along by myself and not around company and stuff like that.
It was very hard to maintain commitments with family or friends or people from the meetings and stuff like that. I didn't have a lot of energy, lack of sleep, didn't have a good appetite. I founded it very hard to keep commitments or go out and be social with family or friends./
But my attitude, I always tried to stay positive about the aftercare program.

Constituent: The intense compulsion to use drugs

P1.

It was very difficult to stay free of opiate use without Suboxone, it was almost impossible./

I have used twice over the four- five years that I've been on and off Suboxone /Subutex, I have used when I have run out of the medication.

Well, when you are on opiate the way I was and for as long as I was you get intense cravings as well as psychological and physical craving, when your body is physically craving the drug and so is your mind and so you get peaks and valleys./ When you have a valley I go look to use and when I was on a peak I was ok for a little while until the drug wore off than I would get withdrawals again. Than I would go out looking for drugs and this is why I was start on Subutex or Suboxone./

I did what ever it took just to get through the day so I wouldn't lose my job (further on I talk about how I lost my family and homeless for ten months but we can get into that later)./

I was a heroin and mostly a pain killer person. I would take up to 30 to 35 pain killers a day so I was a hardcore pain killer user. I would go to heroin when I couldn't use pain killers./

P2.

I started using, it stayed around until than.

I was able to not use opiate for awhile. I don't know if it was peer pressure or the need to get started, I started using again.

P3.

It was very difficult very difficult to stay clean. I would relapse without the medication. I would try the methadone clinic, to try something new.

P4.

I didn't stay clean at all. I just start back doing it and someone turn me back on to the stop signs (buprenorphine). I would drink and drink and drink, than someone gave me two of those stop signs.

P5.

It's really hard to get off opiates. It's hard, it's really hard./ The friends around so I would use it so it was hard. I like to get high, it's probably the highest high I ever had so it's really hard.

P6.

I was only free of opiate use for only a few weeks. It was difficult, very difficult.

P7.
Of course in the back of your mind you think about taking the easy way out and stop dealing with the program, you don't want to deal with it anymore or deal with the people weather it's from dealing with the people or too much pressure. But it was definitely hard it wasn't any fun. It was very difficult, very, very difficult to take clean in aftercare. Without the Suboxone I felt like it was nearly in possible but I also felt like it might have been me, that's my personal thing, but it was very difficult./

Constituent: Feeling a sense of shame and disappointment

P1.
I got in trouble in A.K., I did a year in jail. I did a year in prison for forging prescriptions. I hired a top dollar lawyer. I sat in jail for eight months they let me out after a year, a year which was eight months. I had no probation or parole which was great because they want to put me on five years probation which they didn't do so I got out. What the drugs did to me was that it made me….I forged prescriptions. Calling the doctors, I would call in prescriptions over the phone like I was a doctor./ I had like ten different doctors DEA number from Texas./ It was pretty ease to do for about six months until they did a sting on me./
The last time I was off my med was last year June of 2011. I went completely off my meds leaving a crazy addictive life. I got kick out of my house and I was homeless for 10 months. I didn't work I didn't do nothing.

P2.
There was a lot of shame involved with the situation. The shame was that I got myself in this situation in the first place and needed treatment to deal with it. It carried through the whole situation.

P3.
If I had the medication for depression and support group it would be the best./ I felted disappointed in myself, I just felt disappointed in myself.

P4.
I get depressed because I'm on the streets. The drugs are what put me on the streets./ Now I'm just trying to get my life back together, it's depressing because I realize how badly I screwed myself. I'm separated. Nobody wants to talk to me. I'm trying to get my life back together./
The question you ask me a while ago, I dropped a few tears on that one (commitment to family). I was thinking about my daughter. That's one of the side-effect./ It made me lose my family after I stop taking the medication.
I haven't been with my family in all most 7 years. It kills me./
I had a really nice job, but now I'm flying a sign on the street to make money./

P5.
My father (having to tell father she was on drugs and medication), having to tell him would kill him, so I wasn't going to do that. I was going to take care it myself (my problem)./
I met my husband and start hanging with all the friends right after the death of my mother so it was kind of like I didn't care anymore I start doing whatever it took to cope. I use the pills to take away the emotional pain but it almost took away my life./

P7.
I felt like I was outcaste from a lot of my friends if they were using and I was trying to stay clean. I was looked at differently.
People looked at you funny or you kind of outcaste from the people depending on your clean time.

Question #2

Constituent: A euphoric feeling of a renewed life

P1.
It like this cloud was lifted off you and you get a renewed life./ It's hard to describe, it like you are high but you're not high it feels like you're on the opiate but you're not, you feel like you on it, your body doesn't crave it your body doesn't crave it, you are happy not feeling depressed at all, don't have any craving./
I had everything there like I was high, energy, motivation – all the things that goes with being high but you are not actually high because it a partial opiate blocker so it doesn't let you get the thrill high but it let you function like you were high (does that make any sense?)./
It's a miracle drug. I mean, to me when I'm on my Suboxone.
The benefits are it completely take away the withdrawal symptoms and when you first take it, like I said, it like this cloud is lifted you feel like a new human being physically and mentally./

P2.
With the medication everything was fine,
It allows you to function but I didn't want to function./
The commitment was lacking still, I did what I had to but I didn't do a whole lot of extra./

P3.
The medication made me feel normal. I can do my daily task with no problems./
The benefits were that I felt normal and I was able to do my daily functions with no problems./
I didn't have much feeling of depression until I stop taking it./

P4.
It made me slow down and think; instead of trying to get more dope. I'm ok. I made my mind up about doing what I was doing./

P5.
It was a lot better. I didn't feel like that.
I highly, highly recommend that if you are going through depression (or withdrawal) to take them./ I'm kind of mean when I'm coming off the drugs, I'm not very friendly. But I'm fine when I use the Suboxone.
The other benefits are you are able to function without drugs. I can actually function without it (prescription drugs). Get out of bed, without the subs I can't with function the withdrawals./ Now I'm fine without the medication./
The benefits are it gets rid of the anxiety and the feeling like you are going to have a heart attack and going to die.

P6.
I was thinking this is going to be like Darvocet you know. This isn't going to help me, but it did a lot. It helped me right away. My mood was thankful and happy./

P7.
It was a miracle drug for me in partial, it totally changed my mood. I felt better physically and mentally.
The benefit was that I felt like I was really back to normal like before I was using. I felt like I was back to my old self. I felt like I could go out into the world and do what I wanted to do, the craving wasn't there./

Constituent: A lost of desire or compulsion to use opiates

P1.
I don't need to use I don't have the desire to use./
I don't think about using. I have energy, it like someone had zapped me with a drug that didn't actually give me the high I was looking for but I didn't really need it./
I don't use when I'm taking the buprenorphine.
The biggest thing….if you can feel good there is no desire to go back out on the street to use. This drug (buprenorphine) help me to do that and when I'm on it I'm a different human being even my family says that, they push the Suboxone because it works./
This is my third attempt at sobriety with Suboxone./ The third time I was on it for nine months. I followed protocols, I been sober, I been following up with Dr. V. every 6 weeks./ My U/As have been clean and no feeling of depression or nothing./

P2
It worked great. It worked great for staying off the opioids./
I'm highly motivated, but I wasn't, but the carving was gone.

I didn't use. I stayed true to the program. I really wanted to stay away from the opiates. I didn't like the dependency of it.
I would say use the medication, it works very well for taking the addiction away or relieving the symptoms and helping you get past that./
It's been a long time since I've been sober, I'm now 26 and I'm glad to say I'm headed in the right path now./

P3
I didn't think about opiates. It took my mind away from opiates. I don't understand how but it did/. It does work for me as like methadone, methadone works better for me but buprenorphine does work./

P4
I had used them before about a couple of years ago. It made me more level headed, it slowed me down instead of wanting to go strong (using opiates)./
The craving was gone. I think it helped./
It's the way to go really, it's better than sucking down another drug./

P5
Honest if it wasn't for the Suboxone I wouldn't have gotten off the drugs (prescription pills)./
Now I'm better. I rather be sober than to be on drugs, thank god for the subs (Suboxone)./
You can't take the Suboxone and use because you will get sick so you just don't use./
So, it took away urges to do that because, it made me sick./
It did get rid of the urges./
If it wasn't the subs I wouldn't have gotten off the Oxys./
Now that my body knows what it feels like to be sober, I'm ok with it./ For a long time if it wasn't the marijuana it was the pill but I'm ok now./

P7.
I didn't have cravings and I didn't have body aches, things that would trigger me started going away.
I started using the medication in detox for seven days and when I got out I went to see the doctor and I use the medication for nine months./

Constituent: Regaining a renewed commitment to family and obligation

P6
My family was happy, I kept all my obligations, I was just another person. I was able to work./
My business started doing well again./ I bought a new car over a six month period of time. And I also go a job grooming dogs at a local grooming place. I had people come from out of state looking at my puppies and selling them, I did very well./

P7.
I felt like being with my friends and family./
I wanted to be with people and go different places and do some of the things I like to do before my addiction. Some of the things I like to do when I was on the buprenorphine was, I like playing sports, go out to the movies, I like music that's a big part of my life. I'm really into art, so being able to sit down and concentrate and draw and paint was a big thing for me./

Question #3

Constituent: Facing the reality of financial challenges and hardships with addiction treatment

P1.
The second time it was financially.
I was between jobs so we were living off what I had made for the last three months and we couldn't afford the medication it very expensive./
The cost was a big kicker. It's very, very expensive we had to re-budget, even though I make very good money in construction, it cost about $300.00 a month. So when you at the higher dose it very expensive we had to re-budget out family budget in order to get my medication. So it took a little hit out of our budget. The 8mg is like $10.00 a pill, so if thirty of those and that is just 8mg a day which is median dosage or median/moderate/high dosage and 30 pills times ten that's $300.00 for moderate dosage, if you're on 60 pills which is a high dosage that's $600.00 a month and you're going to have to spend that out of your pocket a month. Than in the mean time we would try to re-budget the money, we would do anything we could so I could get my meds./ My family was a 100% behind me …/
P2.
I started making too much money, and I couldn't afford it any more./ When they stop paying for it I quite taking it. They stop paying for it./ It was about eight dollars a strip, something like that. It was way too much./

P4.
I stop using the medication when I got out because I didn't have enough money for it./

P6.
I believe it was very high priced. But I was willing, for how it made me feel, I was willing to put up the money and pay for it. I was thinking about back in the day how I would spend money on drugs, so it was minimum./

P7.
The main challenge was financially because it was very, very expensive.

The first doctor I saw…the first visit was about $300 dollars and every month it was about $150 dollars and that was not including the medication. That was just for the visits./ So the cost does affect it./

Constituent: Feeling of disparity and dejection related to lack of Insurance

P1.
The cost of the drug is real important for people who is walking into the office thinking I'm going to get on Suboxone, I heard it was a wonder drug./ If you don't have insurance or a way to buy it, you can get put in a corner real quickly taking the 8mg dosage.

P2.
There was no cost. I had state covered insurance and it paid for it so there was no cost./
But I know what it cost and I probably wouldn't have paid for it if I didn't have the insurance./
There was cheaper ways to not be sick, I would have probably kept using opioids./

P3.
Mainly insurance for me, I couldn't afford insurance./
I thought it was a little expensive, it was expensive and it makes it a little hard and it did effect my attitude as to other opiates are cheaper for me, I kind of thought of it that way./ Because the Suboxone is expensive if you don't have insurance, which I don't have insurance. It was a $130 for 30 days./

P4.
I use to have insurance, but now I have nothing./
Try to get insurance because it is expensive. When I was getting it in MI, while in treatment, I could afford it./ It was doctors everywhere.

P6.
I didn't understand why my insurance wouldn't pay for it. It paid for everything else.

P7.
The insurance companies….the insurance companies didn't accept a co pay or anything like that so it was all cash payments./

Constituent: The feeling of desperation and seeking alternative measures

P1.
You can become so depressed that you can become suicidal./
So I had to tell him I was out of medication, I was back using, but I was sober for three days so I was going through hard core withdrawals and they saw me the next day./

You looking for all these ways trying to explain to them that you need to get in, you need to get in.
I would doctor shop and when I would run out of doctors…. /
Texas has computers that is tied in to all the pharmacies that are tied together so they can check and see when you got the prescription for opiate or hard pain killers, they won't refill it if the time has not elapsed (you know what I'm saying) so they would deny you, if you just filled it a week ago./
So if it said renew in 21 days that would be three weeks, I would go out of state I would go to New Mexico get it refilled if I had to.

P6.
Although I did ok on methadone, I was there for about five or six years I started drinking./
I went right on methadone./There was something missing. So I started drinking to fill the hole that I think people like me have. They have this big hole in them and I think methadone was only filling it three quarters, where buprenorphine was feeling it a 100%.
The methadone was only filling it 75% and I had to throw in some alcohol to fill it. Which wasn't too good, because alcohol is a depressant and you go through the whole thing of a hang over and than feel good and hand over./

P7.
From an addict stand point it a lot easy to go day by day using drugs went it about $20 dollars to get fix or get well than trying to save money to see a doctor.

Constituent: Overcoming increase challenges and limited access

P1.
The first two time I was on it for four months, another time for eight months./ The reason I stop was I was working in A.K. I got sent up to A.K. to work and the medication was not available when I went on to my ship. I was out on the Bering Sea working./ We were doing oil ridge work, I was a surveyor and I couldn't get the drug./ I had to go cold turkey.
I don't know too many people in El P. that can afford $600 a month on medication especially if they are a user coming off the street who didn't have a job to begin with, its a vicious cycle./ People who are coming in are people who are coming off of heroin or pain killers who have probably lost their job already and there family./
A person off the street coming from the Opportunity Center who been using heroin and all of a sudden he want to get clean, they send you upstairs to the clinic and they will send you to a methadone clinic which not to many left in El P. But they will put you on methadone or refer you and than you find out about the three doctor in El P. that prescribes./

P2.
At the time it was not heard of, a lot of people didn't know what I was talking about. Not many people knew about it, I had to research it myself, and talk to other doctors about it. It was new, not many people knew about it, I had to ask my doctor about it./
It was very difficult. I had to go over a 100 miles to get to a doctor who prescribed Suboxone. From up in the mountains of N.M. to the plains it was over a 100 to 120 miles to get to a doctor. That was the closes one, the only one I was able to find. It took awhile./
It took almost a month to two months before I could get in there./

P3.
Finding a doctor certified to prescribe buprenorphine was a problem. The nearest doctor was about 2 hour from me.
It was about a 140 miles I think./
They had it every Thursday, you could go in every Thursday and do the intake and on Fridays you would see the doctors, so about two day on the waiting list./

P4.I wouldn't have anyone to prescribe them to now any way and I wouldn't have to money to buy them.

P6.
I moved to Hawaii, and they put me back on methadone, they didn't have the medication. The buprenorphine haven't come out in pills yet.

P7.
I travel cross the city in Philly to get to my doctor's office which was about a half hour to 45 min drive for each appointment.
So it was difficult calling these doctors to see where I could go and which would be the least expensive and the closest so. It was about 30-40 miles away./

Constituent: Self-medicating via an accessible black market

P1.
There is a black market on the street, normally it a person who is sober, they go in and say they are coming off what ever and they get a prescription for a large amount like 60 of the 8mg pill and that's a lot and that person who have a third person which is a median which take that person to buy the drug at a premium price and than sell it on the market to people who is kicking heroin or kicking pain killers./
Acting as a street doctor and they sell those pills for $20 a piece and people buy them because it works, they know the drug works./
I sold out once that was a long time ago because I was cutting down on my dose, so I sold some pills, but there is a big black market out there for Suboxone on the street in this town./

People who can't afford the full prescription might buy a portion of it, that is what I did the first I got my $500 prescription, I bought enough for ten days, that's ten day that I know that I'm going to be ok./
I would buy pills off the street which is real expensive and when that didn't happen I would go to heroin which I didn't like but….opiate is a very, very hard addiction./

P4.
Someone gave them to me on the streets. I didn't get them from a doctor./ If I had known about it I would have said something to the doctors when I overdosed. They just gave them to me. They had quit and the just gave them to me./
I Started getting them on the street./ I stop using them because I didn't have the money./

P5.
I never went to a doctor and I was never prescribed the medication by a doctor./ Everything was off the street./
The Suboxone, they are cheap on the street. I rather buy a Suboxone than a pill. It a very big different./
So I got some Suboxone, I had a friend that came to me and told me that he had gotten on a program and that it was the best thing that could have happen for him. He said that he couldn't get out of bed when he was withdrawing or coming off. He said that if it wasn't for the Suboxone and staying in the aftercare program he wouldn't have made it.

Constituent: A feeling of easy with minimal challenges

P1.
I when online the first time I was in A.Z. I was able to see Dr. the next day./
I had to travel 6-7 miles.
Here in El P. it was pretty ease to get an appointment even thought it was pretty crowded over there.
I was on a waiting list for two days./
It was about 10-12 miles./

P6.
I was not on the waiting list long it was about a week./
I had to drive about 40 miles. My farm was about 40 miles from town. It was a normal trip for me. It wasn't anything out to the ordinary./

Constituent: Equivocal attitude toward staff

P1.
To them you just another number and another patient, but the people on the crisis line they understand because the people on the crisis line are former users, they

understand what you are going through, they (Atlantis)have a 24 hour crisis for patient and non-patients you can call that number./
Everyone was positive. Once I was there it was positive, beside the phone call and getting push back and forward, once I was a patient everyone was nice and understanding./
Sometime the ladies at the front desk don't understand what you are going through but the crisis line do./
The front office was standoffish but very understanding on the crisis line. They tried to help you work through this, telling me not to hurt or harm myself, don't hurt anybody else, we will get you in.
It was fine once I got there physically in the office, everything was good. It was respectful, confidential, and everyone was professional, so it was alright./
He is an advocate for the drug, he thinks it works./

P2.
They did their job, they were professionals but there always seem to be an under tone. I don't know if it was me, are if it was there, but it seem that there was this under tone of me being trash./You know, me being what I'm, it could have been in my mind but I'm very self-conscience./
But with the professionalism, they maintain their professionalism.

P3.
The staff was very, very helpful and they were concern about your well being and trying get you off of opiates./
Dr. M was caring and he wanted to know what was going on in your life and made should you were ok as well, so I would say they did any excellent job./
Aftercare staff gave me a list of meetings for AA to go to and support groups, they gave me a list of all the information where I could go for support as well as a list for doctors who prescribe Suboxone./

P4.
The doctor was nice but I had a couple people look at me like a piece of shit, you dope head./

P6.
Well, it was a detox doctor so there was a little bit of prejudice about who you are. We know who you are, go sit down.
There was a little bit of attitude, but when I would describe to them that I was a chronic pain patient, I wasn't coming in there with needle hanging out of my arm. I was coming in because the doctor stopped giving me my chronic pain medication./
They could start treating me like a human being or they could treat me like all the other people they had in there (addictives)./
Most of the staff in aftercare was dedicated to helping people find help and doctors. Most of them had been through it them self./

P7.
I felt like there was definitely a negative connotation when you even call the office for that first visit and you call and say hi, I'm calling about the Suboxone program. They treat you with not a lot of respect and it like here is another junkie or an addict that we have to deal with, and that you going to come into the office….with the negative connotation of it, it wasn't a great experience. I guess it wasn't that great, I guess I definitely didn't look to going to the office and seeing those people. It was a turn off, just going in to see those people and they know what you are there for./ A couple of these doctors…..the one I went to they do other things than just buprenorphine, so you just sit it the office and they look and say oh I know why he here, for the buprenorphine program of what not. So it definitely effect my willingness, so I got to go to the doctor to get my prescription, I didn't look forward to it./ It was difficult because it wasn't very many of them.
Some people in aftercare were helpful./

Constituent: Dealing with stigma toward medication management

P7.
One particular NA meeting I when to they were against it, they would discourage against it. They look at buprenorphine as you were not totally clean if you are still using a substance./
Not too many people was open about it./
I felt myself that I was not really sharing that I was taking the medication and I didn't want to put that out there and let the group know that I was keeping that to myself./

Question #4

Constituent: Experience of minimal side effects

P1.
The side affect for me was a little bit insomnia because the drug (buprenorphine) does bring you up a little bit. Constipation was a side affect for me, urinating was a problem because it affects your prostate a little bit, it's hard to get a strong stream of urine because
the drug acts like an opiate and that what a opiate does, it shuts down your intestines and it affect your ability to urinate. But those are some of the side affect, but they are minimal.
The side affect would the same if you were using opiates.

P2.
The side affect are there but they are nothing compare with out it, compared to the opioids of feeling down and withdrawing, there no comparison without it.
Compared to the side affects, I say take it, because it nothing compare to what you're going to go through without it./ A lot of lack of motivation for me, struggling in my mind not to use./

Without using the medication is horrible, cold sweat, diarrhea, vomiting, headache, sleeplessness, you know days without sleeping there is nothing you can do./ Compare without using and using, the different is like night and day. Compare to the two, the side effects are easy./

P3.
The side affect, I only felt for about a week. It made me feeling kind of sleepy and drowsy, but it only lasted about a week and than it went away. Other than that the taste was really awful but it helped me do the things I needed to do every single day, so it does work I do recommend it./

P4.
The side effect was that it made me tired./
My urine was really, really yellow, it might sound funny but…I didn't eat as much as I usually do./

P5.
I would also recommend give the people the knowledge about how addictive Suboxone can be as well. I wasn't addictive to Suboxone because it made me sick I never had to stay on Suboxone long enough to feel any side effect from it. It just takes me about a strip. They just make me sick to my stomach, so I want to get off it as so a possible./
It makes you sleep so that's not really a benefit./

P6.
I didn't have any bad side effects. I've heard other people talk about having side effects especially with the pills./

P7.
The side effect really wasn't there for me, if anything maybe a little drowsiness or tiredness, there wasn't any side effect./

Constituent: Recipients of positive benefits

P6.
Mind was all positive. The benefit for most people it would be to stay off drugs./ You can ask anybody on drugs they would say their main goal is to get off drugs./ Number one I would say ask your doctor and be honest with your doctor. I think it effect people differently. I think all medication effect people differently so if you are having some sort of side effect you should tell your doctor. If you are feeling great and doing well you should tell your doctor that too. I think they can up the dose or lower the dose, not like when I was on it they just slapped a patch on you./

P7.
Everything about the buprenorphine program except the cost was totally beneficial to me./ I would definite tell a person who was interested in get into a

program like this, I would tell them of all the good thing about it, it will take away the craving, the trigger, the diarrhea, the upset stomach, and sleepiness or withdrawal symptom none of that was there for me when I was on the medication./
I think this was the best thing I ever came across in my treatment and I wouldn't have been able to maintain one day of sobriety without this medication. I wouldn't go to a facility that didn't offer this. I believe it has changed my life 100% for the better./

Constituent: Using buprenorphine and aftercare tools to make responsible lifestyle changes

P6.
Life style changes would be up to the person. Going to aftercare and using all the tools that is available to you./ The schools out there, the jobs out there, I think a person can change their life a 100%./
If they just want to use it as a substitute for drugs and just stay on it and keep the same life style they won't get better./

P5.
When my husband got in trouble we kind of realized how serious it was.
The Suboxone helped my husband in jail. Because he was sick, sick, he was using a lot more than I was. I felt that if the Suboxone could help him and the amount that he was using, I felt that it could help me. So I found some and I came off the same time that he was in jail. We kind of did it together I guess./ If he could do it there, going through how miserable it was in there, than I could do it out here.

Question #5

Constituent: Suffering the negative consequences of abrupt termination of buprenorphine

P1.
Coming cold turkey off Suboxone is worst than coming cold turkey off of an opiate, it is the worst….symptoms are not quite as heavy but the longevity is because the half life to Suboxone is very high, it stays in your systems for a very long time up to about a week so you don't see the withdrawal symptom for about the three or four day (after you stop using Suboxone) so it hit you hard and that the reason I didn't have access to it…. The first two time was not by choice, I went back to my drug of choice which was opiate, so I had a little bit of gap when I was coming off Suboxone, the withdrawal symptoms was so difficult I had to go back on my pain killers…/
Two time I came off Suboxone I when right back to my pain killers and than I when back to Suboxone and back to pain killers so when I'm on Suboxone everything is fine./
The time I come off of it….I was either on something. I was either on suboxone or on an opiate./

I never had a big time of sobriety because I couldn't handle the withdrawals and the depression. I was able to remain free for about a month at the most, I was never done with the program so you can't say I was done with the program, I was still right in the middle of my therapeutic use of Suboxone,/
I would take for four months so I was still taking a pretty good dose and than I would quit cold turkey so I would have to go back to suboxone or opiate after a month I couldn't handle the depression the running nose, the aches, the pain so I went back to my drug of choice the pain killers./
The second time I was on it for eight months, my dose was fairly moderate so the withdrawal was not that bad but the addiction pulls at you so I want to go back to the Suboxone or pain killers./ The pain killers was ready available so I went back to the pain killers./

P2.
I use the medication for about 3-4 months./ At that point I was far enough along that I was able to go without anything./
I didn't go all the way through with it. Once I stop the medication, I dropped it all. I dropped the program./ I tried to do it myself. It lasted for 2 or 3 months with just support with me and my wife. We were supporting each other./
The people at work didn't know what I was going through and a lot of my friend didn't know the situation I was in./ I didn't have anything to fall back on as far as support. In a small town, there was no where to go. There was no N.A. there was A.A. that didn't seem to help, that just made me have craving./
When I quite taking, not that I was feeling sick, I just didn't want too. It didn't seem worth while./ I was clean for about four or five months. I should have gotten out of town when I could have gotten away from certain people, but I didn't and I fell back into it./
After I stop taking the medication, I lost my job, not able to get up.

P3. I used the medication for about 6 months. I stop using it because I relapsed yes! I relapsed to be completely honest, and started using again./
The depression start coming back about after a week after stop using the Suboxone./ I stop going to aftercare meetings because I relapsed. I stopped going to meetings and everything else./ The depression have definitely come back./
I started feeling sick, but it was not like methadone or other strong opiate medication. I did feel the depression coming on./ The depression really hasn't completely gone away because I'm not medicated for my depression right now.

P4.
I use Suboxone for about three months while in treatment and about a month after I got out of treatment, this is before I relapsed.
So I started drinking, I started drinking heavy. I lost everything because it was helping me./ I was in treatment for three months, I was lock up./

P5.
Staying off of drugs depends on who I'm around and what and when I can get something. If I'm not around it and it's not stuck in my face I'm ok. Once I start to use and it's stuck in my system it's hard to stay off it. If I can clean up and stay off it I'm fine./
I stop because I feel better which takes me about a week./
Once I start feeling fine I'm done. Kind of wing myself off everything./
I just use it long enough to get the pills out of my system. As soon as I feel that the pills are gone I stop taking the subs./ When I stop taking the subs I'm fine. I take the subs long enough based on what I need. I just break it down to what I need. I don't take the whole thing, I just take tiny pieces, because they make me sick, really, really sick to my stomach. So I take a piece until I feel like I'm ok. I just break them down. I kind of wing myself off a full strip. I start with a large piece down until I feel like I don't need them anymore./ The anxiety and sweats are all gone even if I don't finish the strips. The longest I've stayed off was two months around about, 2-4 months./

P6.
I guess I use the medication for about 6 months. I quit using the medication because I had to go take care of my mom she had Alzheimer's and she needed me./ After I stopped taking the medication I wasn't feeling right. I wouldn't be feeling ok, you know that feeling when you can sit down and watch tv and not worried, and not have a million things buzzing through your head./
I think depression and anxiety go hand in hand. Like I said I augmented that with alcohol. I didn't use opiate after stopping the medication./
I went on methadone and stayed on methadone until Michael Jackson died./ Than the doctor said he didn't think methadone was a good drug for me. Anna Nicole Smith died around the same time.
He gave me a month supply and told me to wind myself off. Well that's not the right thing to say to someone who is opiate dependent./ Unfortunate I went to street drugs. Getting off the methadone was horrible./
I went to the hospital twice. In the hospital they made me ok. I told them that I'm going to go home but I'll be back. The withdrawal from methadone would never go away. So I went to street drugs, heroin./ I used heroin when I was in my teens and early twenties./
After coming off buprenorphine, I didn't have time for aftercare. I was taking care of my mother. I didn't have time for any programs.

P7.
I stopped using because of the convenience of the doctor and mostly the cost of the medication and the visits.

After I stopped using buprenorphine I felt that some of the old me and some of the trigger came back./
After I stopped the medication I felt like I didn't need the meeting any more so I stopped going to the home group and hanging out the with the people I went to meeting with./ So all that, led me back to my old ways and pick up and started using.
From when I started to using I kind of notices over a period of time I was agitated of things that use to not brother me or affect me and I started to have some of those old behavior that when I was using started to come back, the depression mildly came back./
I was able to stay clean for about 3-4 months, It felt like I didn't need to be in meetings and I already knew everything that was to know./ I went through the steps, I didn't do the program and I was clean for this period of time, you know I was fixed, I though I was cured of my disease, which I know now you're never cured./ After I was taken off the medication I started to withdraw and stopped participating in aftercare and because I was thinking I was clean and cured./

Question #7

Constituent: Psychological fear of withdrawal symptoms

P1.
Don't increase the dosage like a lot of people on the street, they will take it to try and get high instead of using it the way it suppose to be used as a therapeutic maintenance drug the way I looked at it, a lot of guys they don't do that./ People are afraid to come off the Suboxone, because the drug work so well and it work so positive and it take away all the symptoms of withdrawal and craving, they are afraid to come off of it because they think they are going to back craving the opiate and going through a hard withdrawal./
If you follower the protocol and taper it down, down, down it's a lot easier because I been there. They think they are going to go through hard core withdrawal so they are going to look for the their drug of choice on the street, they are going to the throw Suboxone to the side and go back to their drug of choice because it is cheaper it easier to get./
If you follow the protocol and taper the drug like I've done so if you do come off of it, it a whole lot easer to come off at 2-4mg than 8 or16mg, so I followed the protocol of the doctor. Dr.V. knows what he is doing.

P3.
I was just wondering if other people were having withdrawals from it when you coming off it? How to you get off it? Do you just wing yourself down from it? I wasn't sure if other people experience withdrawals from it./

P5.
If it wasn't for the Suboxones, I wouldn't have gotten off of the pills. I wouldn't have had the nerves, I was too scared.
I have a friend who is addictive to Suboxone, he feels he need a strip everyday./

Suboxone is just like a pill or heroin user, you have to have it everyday or you don't feel right. It like when I use to smoke marijuana, I had to smoke everyday or I didn't feel right./ /

P6.
There is two types of pills, one with Narcan and one without. I think it's really psychological, every addictive is afraid of Narcan. To say it's in the pill that surely is going to make the person afraid to take it and get side effects./
The other one that doesn't have Narcan, that's the one I would turn to because it doesn't have Narcan. That's the one I would use./

Constituent: Feelings of frustration and anger

P1.
I went to New Mexico where they have a program to get Suboxone for free at one of the clinic over there if you are considered disable….see you have to wait two years to get your Medicare, once you are consider disable you have to wait two years to get your Medicare./
Once I was on Medicaid I went back on the medication until I saw Dr. V. I went six month without taking anything./
I believe they need to make a generic for the Suboxone or make the drug afford./
If you are coming in for Suboxone you probably hit rock bottom already. Now you come in and they write you a scribe and you go to a pharmacy or go to Wal-Mart where it's cheap and they tell you it $500 for your meds, what do you do? You don't do anything, you can't./ You go back to the doctor…like what happen to me the first time.
Before I was unable to get in to see the doctor I was frustrated and anxious, thinking damn I can't get in, what I'm going to do, do I have to go cold turkey again which doesn't work for me./
At first the staff try to put me off for two week, but I told them I was going through hardcore withdrawals right now, that I was….had tried to commit suicide one of the times I tried to come off on my on, I was very, very depressed, I was physically drained, and aching all over, so I told them I really needed to get in, so I called the crisis number which is a different number for the Dr., so they was able to get me in though the back door the next day/ So I just gut it out until I got to see the Dr./

P5.
I don't know how doctor can prescribe prescription drugs. I didn't really know about prescription drugs until I start hanging out with certain people. I got on the pills and I didn't know the pills were like that./ When I came off the Xanax, I didn't know that Xanax were a drug either, because I was on them for some long./
The pills were prescribed by a doctor so I didn't know how serious they were or how addictive I was to the Xanax./

P6.
I would like to get back on the medication. But I don't have an I.D, no money, and finding a doctor, it has been hard to find a doctor in El Paso./
I think everyone is an individual and the more people you can interview the better the story would be. If you only interview a few people you may get a loped sided picture./
P7.
I think it was when I called the doctor's office about a week on the waiting list, which was going to be a long week until that doctor's visit./
I was living at home with my family in Philly. I have three younger brothers. I knew it was going to be very difficult be around the people that I love and I wanted to be back to normal. I knew how I was going to be so I had a lot of anxiety to get the medication./
Dealing with the doctors and trying to change your appointment and arrange the next appointment, it was very difficult to do so because there weren't a lot of doctors and they were very busy, so if you missed you appointment they didn't want to see you again./ You missed an appointment they were pretty much telling you well you going to have to see another doctor and we don't want to deal with you./
Many doctors didn't prescribe it or wanted to be involved with the stereotype of dealing with a junky or an addict or something along those lines./
I wish there was more access to this medication, it's kind of hard to see a doctor, not many doctor prescribe it and the price is very expensive./
Hopefully over time that will change, so definitely I'm 100% that this is the best way to go for an aftercare and treat your addiction and deal with your depression once you do get clean and stop using./

Presentation of the Data and Results of the Analysis

The Psychological Structure of the Live Experience of Former Aftercare Participants Treated With Buprenorphine for Protracted Depression Related to Opiate Withdrawal

Introduction

The psychological structure of the participants' experience of the phenomena was created using imaginative variation of the transformed meaning unit that was delineated from the raw data (Appendix C) (Giorgi, 2009).

Findings

P's experience in the aftercare phase of treatment for opiate dependency, without the use of medication management such as buprenorphine, was met with an intense emotional challenge such as protracted depression. The severity of the depression had a major impact on P's commitment to family and daily obligations. P became suicidal and had no desire, motivation, or drive to interact with significant others or participate in the aftercare program.

The protracted depression made it difficult to abstain from opiate drugs and alcohol abuse, complicated by feelings of shame and disappointment from reflecting on negative consequences of a present and past chaotic lifestyle as a result of addictive behaviors.

Buprenorphine as a part of P's treatment modality is viewed as a "miracle drug" that provided P with a feeling of euphoria, unlike the high of opiates, but gaining a renewed outlook on life, commitment to family and daily obligation, no desire or compulsion to use opiates, and adherence to treatment and aftercare participation.

Another daunting challenge P faced, due to financial, socioeconomic hardship, or lack of adequate insurance to cover the high cost of buprenorphine, is gaining access to a healthcare provider certified to prescribe buprenorphine. There is a feeling of disparity and dejection due to lack of insurance, limited access in P's geographic location, having to travel long distances and being on the waiting list, to gain access to a certified healthcare provider. P's desperation forces P to focus on alternative measure to overcome the increase challenge P is faced with. P's desperate measures was to relapse back to

opiate drugs such as street heroin, pain killers, or self medicating by purchasing buprenorphine from the street black market.

The black market for opiates and buprenorphine is cheaper and accessible than the high cost and limited access of obtaining buprenorphine from a healthcare provider. A sense of ease is experienced once P was able to overcome the challenges to gaining access to a healthcare provider and obtain buprenorphine.

The negative attitude and stigma of the healthcare providers and office staff toward P created an uncomfortable feeling, negative attitude, and reluctance toward wanting to follow through with treatment. P's equivocal attitude toward the staff resulted from the staff's initial poor attitude toward P coming in for treatment and P's appreciation of the positive professionalism displayed by the medical staff once P became their patient.

P displeasure with support groups such as N.A. was manifested by the unwillingness to support P use of buprenorphine as part of P's aftercare treatment modality. P is not an advocate of the N.A. philosophy or stigma against the use of buprenorphine. P's sense of guilt for using buprenorphine was that sobriety was not truly achieved because of the use of a partial opiate such as buprenorphine, but P focuses on the positive benefits P was receiving as well as the benefits some of P's group members were receiving from using buprenorphine. Buprenorphine was effective in alleviating protracted depression and had minimal and manageable side effect compared to street opiates and methadone.

Buprenorphine treatment with aftercare support is viewed as positive tools to making responsible lifestyle changes in P's life. The consequences of abruptly and not

properly terminating the use of buprenorphine under doctor supervision caused P to experience an uncomfortable re-bound side effect, not as intense and severe as methadone, heroin, or opiate pain killers but mildly similar to the withdrawal symptoms from opiates.

The psychological dependency to buprenorphine creates a reluctance to titrate down or off buprenorphine due to the psychological fear of potential re-bound side effect, which has led P to relapse back to the use of opiates or obtain medication off the street.

The introduction of a generic drug and increase accessibility of healthcare providers, willing to treatment opiate users in an office sitting, will be conducive toward P's positive experience and decrease anger and frustration to help increase adherence to treatment and aftercare participation.

CHAPTER 5. RESULTS, CONCLUSIONS, AND RECOMMENDATIONS

Introduction

This chapter provides a summary and discussion of the results, including drawing conclusions from the evidences revealed through the analysis of the data. Implications for continued research and practical applications to education, including using the results to improve the quality of treatment are discussed in this final chapter.

Discussion of the Results

The experience in aftercare begins once a participant enters into the aftercare phase of their treatment post detoxification from opiate drugs. Several major finding emerged from the data. This study begins by exploring the severity and duration of the participants experience with protracted depression while participating in the aftercare phase of their treatment without the use of buprenorphine. Poor adherence and high drop out rate in aftercare may be a result of the participants' experience of stress and protracted withdrawal symptoms during the early recovery stage of treatment (Hyman, Fox, Hong, Doebrick and Sinha, 2007). All seven participants acknowledged that protracted depression had a devastating effect on their emotional well being and had a negative effect on their attitude concerning participation in aftercare as well as staying committed to family and social obligation.

Psychological disorders or Substance use disorders (SUD) associated with substance abuse or addiction can have a tremendous impact on society as well as an

individual personal life (Volkow & Skolnick, 2012). Participants reported experiencing fatigue and lack of motivation to carryout daily activities. Two of the participants revealed that at times their depression was so severe they experienced feelings of suicidal ideation and one participant admitted to overdosing on opiates related to his experience with protracted depression. Baggett, et. al., 2013, revealed that suicide and deaths rate related to psychoactive substance abuse doubled, while overdose related deaths tripled from 2003 to 2008 compared to similar studies conducted from 1988 to 1993. Participants may be highly susceptible to relapsing back to opiate drugs up to twelve weeks after participation in a treatment program (Franken, DeHann, Van Der Meer, Haffmans, & Hendricks, as cited in Hyman, Fox, Hong, Doebrick & Sinha, 2007). Participants in this study admitted that their experience with protracted depression made it difficult to abstain from opiate use. The intense desire to use opiate drugs created a feeling of desperation and resulting to creative ways to obtain and use opiate drugs. One participant admitted to criminal behaviors and doctor shopping to obtain their prescriptions, this behavior led to a brief encounter with the legal system. Three of the participants admitted to obtaining buprenorphine off the street black market to self-medicate and alleviate the protracted depression if they are unable to obtain buprenorphine from a healthcare provider due to financial hardship or limited access to a healthcare provider in their area certified to prescribe buprenorphine.

In a study by Barry et al., (as cited in Mendelson, Flower, Pletcher, & Galloway, 2008), participants reported a high level of satisfaction with office base buprenorphine treatment. Participants in a study conducted by Caldiero, et al., (as cited in Mendelson, Flower, Pletcher, & Galloway, 2008), revealed that buprenorphine had a positive impact

on their attitude and adherence to participate in treatment. All seven participants in this study revealed that once they were able to obtain buprenorphine and use the medication as part of the aftercare program they felt rejuvenated with a renewed outlook on life. Buprenorphine was viewed as a "miracle drug" that allowed the participants to refocus on family and social obligation, develop a positive attitude toward participation in aftercare, and abstains from opiates without the desire or craving to use.

Participants were confident that buprenorphine had a positive affect on their lives and was instrumental in alleviating the protracted depression. The participant's positive attitude toward medication management may have a major impact toward adherence to treatment on as well as creating a positive outlook on making healthy behavioral changes (Petersen, Hutchings, Shrader, & Brake, 2001).

Approximately 45 million individuals in the United States are uninsured. These individuals lack significant or adequate healthcare coverage due to limited access to a healthcare provider (Miller, 2001 cited in Levant, House, May, & Smith, 2006). Most insurance plans do not include buprenorphine as part of their formularies, or the participants would have to pay a higher cost for the inclusion of buprenorphine as part of their healthcare plan (Horgan, Reif, Hodgkin, Garnick, & Merrick, as cited in Mendelson, Flower, Pletcher, & Galloway, 2008). Participants in this study reported that their attitude to use or continue the use of buprenorphine was affected by factors such as financial hardship, limited access, attitudes of the doctor and staff members as well as dealing with the stigma of support groups such as NA. Advocates and support groups such as N.A. and A.A. have a drug free approach to the treatment of addiction. These groups argue that the use of any type of medication management to treat drug dependency is considered as

substituting one drug for another and therefore creating dependency for another drug. Medication management in the N.A. group is viewed as unacceptable and does not follow with their philosophy concerning the treatment of addictive behavior (Wesson, 2004).

Johnson et al., 2003, revealed that participants reported to have had no major adverse reaction from the use of buprenorphine. Most of the symptoms reported were mild opioid like discomfort. The participants of this study reported that the physical and psychological side effect experienced from using buprenorphine were not a major factor in their treatment. Participants explained that the side effects from the use of buprenorphine were mild and manageable compared to the use of heroin.

Participants complain of experiencing mild to moderate rebound withdrawal, though not as intense as heroin or methadone, if they abruptly terminated the use of buprenorphine, without properly titrating down off the medication over a period of time under a doctor's supervision. Participants in this study admitted to experiencing psychological fear of potential withdrawal or depression related to having to titrate down or off buprenorphine before they were expecting to do so.

A study conducted by Sullivan et al., (as cited in Mendelson, Flower, Pletcher, & Galloway, 2008), suggested that buprenorphine treatment in an office-based setting will allow for greater accessibility to a certified healthcare provider for opiate users, seeking outpatient treatment, who have limited or no access to methadone clinics or facilities. Participants from this study argued that increased accessibility and flexibility of the healthcare provider combined with an affordable generic version of buprenorphine will help optimize adherence to treatment and participation in an aftercare program. The major stumping block to increasing accessibility to a certified provider to prescribe and

treat an opiate user, suffering from protracted depression and other withdrawal symptom, will be the reluctance of doctors not willing to treat an opiate user in their private office due to not wanting to be associated with individuals with an addictive lifestyle or the lack of interest from some providers related to the thirty patient limit restriction (Adamsson, 2003).

Implication of Practice

Several implications emerged from the finding of this study for doctors and other healthcare providers who work with individuals recovering from opiate addiction. The findings in this study highlights a need for change in attitudes among doctors and healthcare providers as well as a change in an approach related to treatment and care of individual recovering from opiate addiction. Doctors, healthcare as well as addiction providers may benefit by acknowledging, recognizing, not trivializing, or ignoring social and personal factors that may impact the opiate user's participation and adherence to remain in treatment. The argument for an integrative approach which includes medication management and psychological treatment under one umbrella would help to address life issues as well as the treatment and care of the participant in a more effective manner. This integration approach would help to eliminate disparity among those who are uninsured or underinsured as well as avoiding wasteful spending on less effective programs or modalities. An integrated approach to addiction treatment could provide needed funding which could help create programs that are affordable and easily accessible for those who are living in area where healthcare is limited or not available to participant seeking treatment for opiate addiction (Levant, House, May and Smith, 2006).

Limitations

One of the limitations of this study is that the emerged finding was synthesis from individuals self-reporting of their experience during the aftercare phase of treatment. The researcher does not suggest that the experiences actually occurred as reported by the participants. Second this study was conducted utilizing a qualitative methodology. The population for this study was smaller compared to a quantitative methodology which uses a larger population to obtain raw data. This study would be better served utilizing a quantitative approach or a mix-methodology (quantitative and qualitative approach). Using a mix-methodology approach, the quantitative approach would allow for the collection of data from a larger population as well as allow for obtain information from the experience of a small sample of the target population using a qualitative approach. The third limitation of this study was that each participant was interviewed once during the data collection process. A second interview may have allowed the participants to reflect and share with the researcher a deeper and richer lived experience related to treatment in aftercare while treated with buprenorphine for opiate withdrawal protracted depression. Finally, this research study did not focus on other aspects of the participants' lived experiences that may have impacted the participant's adherence to aftercare or depressed moods.

Conclusion

This research study addressed the participants' lived experiences in aftercare, treated with buprenorphine for opioid withdrawal protracted depression. Participation in the aftercare phase of treatment while suffering from opioid withdrawal protracted depression without the proper medication such as buprenorphine, dealing with intangible

issues such as poor attitude from healthcare professional, lack of medical coverage, and limited accessibility to proper treatment facilities can be a daunting challenge for an opiate user. The understanding of the participants' lived experiences in aftercare can serve as a guideline for healthcare and addiction providers who are interested in developing a foundation for an integration program that will meet the needs of the opiate users.

Recommendations for Future Research or Interventions

Further research is needed to examine and develop a better understanding of the opiate user's socio- economic, psychological, and physical needs to help optimize the participant's participation and adherence to aftercare treatment.

REFERENCES

Adamsson, N. B. (2003). Medical treatment: Barriers to implementation of buprenorphine in opioid addiction treatment. *Journal of Addictive Disorders*. Retrieved from http://www.breining.edu.

American Psychiatric Association: (2000) *Diagnostic and statistical manual of mental disorders (4th ed-TR).* Washington, DC, American Psychiatric Association.

Auerbach, C. F. & Silverstein, L. B. (2003). *Qualitative data: An introduction to coding and analysis.* New York, NY: New York University Press.

Baggett, T. P., Hwang, S. W., O'Connell, J. J., Porneala, B; C;, Stringfellow, E. J., Orav, E. J., Singer, D. E., & Rigotti, N. A. (2013). Mortality among homeless adults in Boston: Shifts in causes of death over a 15 year period. *JAMA Intern Med*. 173 (3) 189-195.

Becker, A.B., Strain, E.C., Bigelow, G.E., Stitzer, M.L. Johnson, R.E. (2001). Gradual dose taper following chronic buprenorphine. *American Journal of Addiction*. volume. 10 111-112.

Bickel, W.K., Amass, L., Higgins, S.T., Badger, G.J., Esch, R.A., (1997). Effects of adding behavioral treatment of opiate detoxification with buprenorphine. *Journal Consultant Clinical Psychology*. volume. 65, 803-810.

Buprenorphine: A new tool in the arsenal, by the *HRSACareAction Newsletter-Providing HIV/AIDS care in a changing environment*-March 2004, pages.1-11. Retrieved August 1, 2007, from file://E:\HRSACareAction-ProvidingHIV-AIDS.

Caldiero, R. M., Parran, T. V., Adelman, C. L., & Piche B. (2006). Inpatient initiation of buprenorphine maintenance verses detoxification: Can retention of opioid dependent patients in outpatient counseling be improved? *American Journal on Addictions* 15(1): 1-7.

Cater, M., Machtmes, K., & Fox, J. E. (2013). A phenomenological examination of context on adolescent ownership and engagement rationale. *The Qualitative Report*, volume 18, article 31, 1-13.

Clinical guidelines for the use of buprenorphine in the treatment of opioids addictions. *Treatment improvement protocol (TIP) series 40*. Center for Substance Abuse

Treatment. DHHS publication (2004) number. (SMA) 04-3939. Rockville, MD: Substance abuse and mental services administration,

Compton, P., Darakjian, J., & Miotto, K. (1998). Screening for addiction in patients with chronic pain and "problematic" substance use: Evaluation of a pilot assessment tool. Journal of Pain and Symptom Management, 16, 355-363.

Creswell, J. W. (2009). *Research design: Qualitative, quantitative, and mixed methods approaches (3rd ed.).* Thousands Oaks, CA: Sage.

Daley, D.C. & Moss, H.B. (2002). *Dual disorders (3rd ed.).* Minneapolis, MN: Hazelden.

DeMaria, P. A. & Patkar, A.A. (2008). The implementation of bupernorphine/naloxone in college health practice. *Journal of American College Health*, 56, (4), 391-193.

Der-Avakian, A. (2006). Potentiation of opiate and psychostimulant reward by uncontrollable stress and the role of glucocortioids, pages. 1-2(University of Colorado at Boulder) Abstract retrieved March 14, 2007, from http://proquest.umi.com.

Dodgen, C.E. & Shea, W. M. (2003). *Substance use disorders. Assessment and treatment.* London Academic Press.

Fishman, M. J., Wu, LT., & Woody, G. E. (2011). Bupernorphine for prescription opioid addiction in a patient with depression and alcohol dependence. *American Journal of Psychiatry* 168: 7.

Gastifriend, D. R. (2003). *Addiction treatment matching: Research foundations of the American Society of Addiction Medicine* (ASAM). Binghamton, NY: Haworth Medical Press.

Giorgi, A. (2009). *Descriptive phenomenological psychological method: A Modified Husserlin approach.* Pittsburgh, PA: Duquesene University Press.

Giorg, A. (1985). *Phenomenology and Pyschological research*. Pittsburgh, PA: Duquesene University Press.

Hyman, S. M., Fox, H., Hong, K. A., Doebrick, C., & Sinha, R. (2007). Stress and drug-cue-induced craving in opioid-dependent individuals in naltrexone treatment. *Experimental and Clinical Psychopharmacology*. volume 15, number. 2 134-143.

Jaffe, J. H. & O'Keeffe, C. (2003). From morphine clinics to buprenorphine: regulating opioid agonist treatment of addiction in the United States. *Drug and Alcohol Dependence,* volume 70, Issue 2 Supplement.

Johnson, B. A. (2007). Opiate addiction: Medical condition or moral failing? *The Lancet*, 369 (9561), 549-550.

Johnson, R.E., Strain, E. C., & Amass, L. (2003). Buprenorphine: How to use it right. *Drug and Alcohol Dependence*, volume 70 Issue 2 Supplement.

Julien, R. M. (2000). *A primer of drug action (rev. and updated)*. New York, NY: W. H. Freeman and Company.

Khantzian, E. J. (2003). Understanding addictive vulnerability. *Neuro-Psychoanalysis*, number 5, 5-21.

Khantzian, E. J. (1997). The self-medication hypothesis of substance use disorders: A reconsideration and recent applications. *Harvard Review of Psychiatry*, 4, 231-244.

Kintz, P. & Marquet, P. (2002). *Buprenorphine therapy of opiate addiction.* Totowa, NJ: Humana Press, Inc.

Leshner, A. (1997). Addiction is a brain disease and it matters. *National Institute of Justice Journal,(1998) pp 1-6.*

Leshner, A. (2003) Accessing opiate dependency treatment medications: Buprenorphine products in an office-base setting. *Drug and Alcohol Dependence. 70, p103-104.*

Levant, R. F., House, A. T., May, S., Smith, R. (2006). Cost Offset: Past, Present, and Future. *Psychological Services*. volume 3. number.3, 195-207.

Marshall, C., & Rossman, G. B. (2006). *Designing qualitative research (4th ed.).* Thousand Oaks, CA: Sage.

McNeece, C. A. & DiNitto, D. M. (2005). *Chemical dependency: A system approach (3rd ed.).* New York, NY: Pearson Educational, Inc.

Mendelson, J., Flower, K., Pletcher, M. J., & Galloway, G. P. (2008). Addiction to Prescription Opioids: Characteristics of the Emerging Epidemic and Treatment With Buprenorphine. *Experimental and Clinical Psychopharmacology*. volume 16, number. 5. 435-441.

Merriam, S. B. (2002). *Qualitative research in practice: Example for discussion and analysis.* San Francisco, CA: Jossey-Bass.

Miller, N. (2006). Prescription opiate medications: Clinical assessment and treatment of addiction, tolerance, and dependence. *Psychiatric Annals*, 36 (6), 390-396.

Mintzer, I. L., Eisenberg, M., Terra, M., MacVane, C., Himmelstein, D. U., & Woolhandler, S. (2007). Treating opioid addiction with buprenorphine-naloxone in community-based primary care settings. *Annals of Family Medicine*, 5, 146-150.

Moore, S. P. (2002). Neurological impairment in adults who have dual diagnosis: A critical review of the literature, Abstract, Alliant International University, San Diego California. pages.1-2. Retrieved March 14, 2007 from http://proquest.umi.com.

Mueser, K. T., Noordsy, D. L., Drake, Robert, R. E., & Fox, L. (2003). *Integrated treatment for dual disorders.* New York, NY: The Guilford Press.

National dialogue on co-occurring mental health and substance abuse disorders, by the *National Association of State Mental Health Program Directors and National Association of State Alcohol and Drug Abuse Directors* (1999). Alexandria, VA and Washington, DC: NASMHPD/NASADAD.

North American opiate medication initiative (NAOMI) by the *Backgrounder, NAOMI* study April 2006, pages.1-5. Retrieved August 13, 2007 from http://naomi.backgrounder.com

Nyhuis, P.W. & Gastpar, M. (2005). Klinik fur psychiatrie und psychotherapie der Univeritat Duisburg-Essen, Rheinische Kliniken Essen. *Pharmacopsychiatry*, 38 DOI: 10.1055/s-2005-918797

Nyhuis, P.W., Specka, M. & Gastpar, M. (2006). Does the anti-depressive response to opiate treatment describe a subtype of depression? *European Neuropsychopharmacology,* volume 16

Opiate Addiction: Making a difference today, by the Society for Neuroscience pages 1-2. Retrieved August 30, 2007 from www.sfn.org .

Sadock, B. J. & Sadock, V. A. (2007). *Kaplan & Sadock's synopsis of psychiatry: Behavioral sciences/clinical psychiatry (10th ed.).* Philadelphia, PA: Lippincott Williams & Wilkins.

Seidman, I. (2006) *Interviewing as qualitative research: A guide for researcher in education and the social science (3rd ed).* New York, NY: Teachers College, Columbia, University.

Srivastava, A. & Kahan, M. (2006) Buprenorphine: A potential new treatment option for opioid dependence. *Canadian Medical Associate Journal. 174*(13),1835.

Strosser, C. (2007). Buprenorphine for depression? Retreived August 8, 2007 from website file://E:\Buprenorphinefordepression-That'sPoppycock!.htm

Suni P., Hutchings, P., Shrader., & Brake, K. (2011). Integrating health care: The clear advantage for underserved diverse populations. *Psychological Services*. volume 8, no. 2, 69-81.

Tan, E. M., Eiger, R. I., & Roth, J. R. (2007). A life of drugs and 'downtime'. *Current Psychiatry*, volume 6 number 8.

Twerski, A. J. & Nakken, C. (1997) *Addictive thinking and the addictive personality (2nd ed.).* New York, NY: MJF Books.

Volkow, N. D. & Skolnick, P. (2017). New medications for substance use disorders: challenges and opportunities. *American College of Neuropsychopharmacology*. volume 37. 290-292.

Wesson, D. R. (2004). Buprenorphine in the treatment of opiate dependence: Its pharmacology and social context of use in the U.S, [dagger]. *Journal of Psychoactive Drugs*, 119-28.

Woodman, R. & Radzyminski, S. (2009). Women's perception of life following breast reduction: A phenomenological study. *Plastic Surgical Nursing,* volume 9, number 1, 39-46.

Zancy, J., Bigelow, G., Compton, P., Foley, K., Iguchi, M., & Sannerud, C. (2003). College on problems of drug dependence taskforce on prescription opioid non-medical use and abuse: Position statement. *Drug and Alcohol Dependence,* 69, 215-232.

APPENDIX A. STATEMENT OF ORIGINAL WORK

Academic Honesty Policy

Capella University's Academic Honesty Policy (3.01.01) holds learners accountable for the integrity of work they submit, which includes but is not limited to discussion postings, assignments, comprehensive exams, and the dissertation or capstone project.

Established in the Policy are the expectations for original work, rationale for the policy, definition of terms that pertain to academic honesty and original work, and disciplinary consequences of academic dishonesty. Also stated in the Policy is the expectation that learners will follow APA rules for citing another person's ideas or works.

The following standards for original work and definition of *plagiarism* are discussed in the Policy:

> Learners are expected to be the sole authors of their work and to acknowledge the authorship of others' work through proper citation and reference. Use of another person's ideas, including another learner's, without proper reference or citation constitutes plagiarism and academic dishonesty and is prohibited conduct. (p. 1)
>
> Plagiarism is one example of academic dishonesty. Plagiarism is presenting someone else's ideas or work as your own. Plagiarism also includes copying verbatim or rephrasing ideas without properly acknowledging the source by author, date, and publication medium. (p. 2)

Capella University's Research Misconduct Policy (3.03.06) holds learners accountable for research integrity. What constitutes research misconduct is discussed in the Policy:

> Research misconduct includes but is not limited to falsification, fabrication, plagiarism, misappropriation, or other practices that seriously deviate from those that are commonly accepted within the academic community for proposing, conducting, or reviewing research, or in reporting research results. (p. 1)

Learners failing to abide by these policies are subject to consequences, including but not limited to dismissal or revocation of the degree.

Statement of Original Work and Signature

I have read, understood, and abided by Capella University's Academic Honesty Policy (3.01.01) and Research Misconduct Policy (3.03.06), including Policy Statements, Rationale, and Definitions.

I attest that this dissertation or capstone project is my own work. Where I have used the ideas or words of others, I have paraphrased, summarized, or used direct quotes following the guidelines set forth in the APA *Publication Manual*.

Learner name and date	Samuel Marcel November 8, 2013
Mentor name and school	Steven Schneider, Ph.D. Capella University

APPENDIX B. INTERVIEW QUESTION

Open-ended Interview approach for In-person Interview:

Feel free to say as much as you want, they are all open-ended questions. Everything you say is important information for my study, so please, if in doubt about if you should add any information in, definitely do!

To begin I would like to thank you for participating in this study. I am interested in your unique experience as an opiate user who is using buprenorphine as a treatment modality to treat protracted depression related to opiate withdrawals. I may ask questions occasionally or ask you to repeat something to make sure I understand what you mean. (if needed, this will be done after I receive and read your response) The purpose of this study is to understand, through your perspective, if buprenorphine has been helpful in relieving your feelings of depression, and if so how. Your experience related to this topic and what you share with me is important to this study. For the purpose of accuracy in capturing the interview I will be taking notes and using two digital audio recorders during the interview process. The interview will last approximately 60 to 90 minutes. I will be asking several questions, you will have the option to refuse to answer any question that may be uncomfortable to you.

Do you have any questions before we begin?

Research Question:
What is the lived experience of aftercare for clients treated with buprenorphine for opioid withdrawal protracted depression?

Guided Questions:

1. First, I'm interested in knowing the affect opioid withdrawal depression had on your participation in an aftercare program without the use of buprenorphine?
   a. How intense was the depression?
   b. How long did the depression last?
   c. How was your attendance affected in the aftercare program?
   d. What was your attitude toward completing the aftercare program verses dropping-out of the program early related to the feelings of depression?
   e. How difficult was it for you to remain free of opioid use while in aftercare?
   f. How were you able to maintain your commitment to your family and other daily obligations?

Thank you for sharing with me how depression affected your mood and behavior without the use of buprenorphine while in aftercare. Now, I would like to know what your experience in aftercare was like treated with buprenorphine for opioid withdrawal depression. What was different, if any, about your mood, participation and behavior?

2. What challenges, if any, did you face graining access to a doctor who prescribed buprenorphine while participating in aftercare?
   a. How many days were you on the waiting list before you were able to see a doctor to be prescribed buprenorphine?
   b. How far did you have to travel to get to a doctor qualified to treat client with buprenorphine?
   c. How did the cost of the medication affect your attitude about using buprenorphine?
   d. Describe to me the overall attitude of the doctor's staff members (including the physician) toward the clients seeking access to the doctor's office.
   e. What was the attitude of the aftercare staff toward help clients gain access to a qualified doctor who can prescribe buprenorphine?

3. This next question is aimed directly at getting your thoughts and feeling about the benefits and side effect of using buprenorphine. Suppose I was a new client participating in the aftercare program and was seeking your thought and feelings about using buprenorphine during my enrollment in the aftercare program. What would you be willing to share with me about using buprenorphine? Share with me the benefits you experienced using of this medication. What about the side effect you have experienced from the use of this medication?

4. This next question will focus on the time period you used buprenorphine while in aftercare. The time limit for the use of this medication for maintenance use is about one year or stopping the medication earlier at the request of the client or if the client is not in compliance with the treatment plan. How long did you use buprenorphine while in aftercare?
   a. What was your reason for discontinuing the use of buprenorphine?
   b. What are some of the changes that took place in your life after discontinuing the use of buprenorphine?
   c. How long were you able to remain free of opioid use after discontinuing buprenorphine?
   d. Share with me the effect it had on your participation in aftercare once you were taken off of buprenorphine.

5. For this next question, I would for you to be the expert on the usage and benefits of buprenorphine for aftercare clients. You've been given an opportunity to set on an aftercare treatment panel. A physician in the audience asked you for your recommendation for using buprenorphine as part an aftercare treatment plan, to help reduce the early drop-out rate from aftercare, for clients suffering for opioid

6. withdrawal depression. Based on your experience with buprenorphine while participating in an aftercare program, what would be your recommendation to this physician concerning the use of buprenorphine as part of the aftercare treatment plan?

   a. What are the strengths and weakness of using buprenorphine as part of a treatment plan to help reduce the early drop-out rate from aftercare program?

7. Thank you for sharing your experience with me. Your information will be very helpful to my research study. Before completing this interview, I would like to know if there is anything important, I may have overlooked that you believe would be important to this study, you would like to share with me. Anything at all you'd like to add?

APPENDIX C. MEANING UNITS AND TRANSFORMATION OF MEANING UNITS

Meaning Units	Transformation of Meaning units
Q1.1. (p.1) P1 reveals he experienced probability the worst depression he can ever have./	Q1. 1. P1 stated that after the detoxification from opiate use, he developed severe depression without the use of buprenorphine.
2. P1 didn't want to get out of bed. P1 used to be total sleeping for 24 hour or he would be wake and be an insomniac for 24 hour a day. P1 would go through cycles, the first three day would be nothing but sleep, the next three days P1 would be awake, you can't move, you just want to lay there even though you are wake, that lasted about two weeks when P1 went cold turkey the first time./	2. P1 stated that he would experience periods when he had three day cycles where he would lay in bed fully awake all day long not able to function or he would be experience days when he would just sleep for approximately 24 hour a day. This cycle would last for about week in duration without the use of buprenorphine.
3. For P1 the depression lasted about two to three week when P1 went cold turkey. P1 didn't go to the aftercare program as for as counseling and that. P1 went the first time he was on Subutex while in A.Z. in 2007. P1 didn't try to participate because P1 really didn't have the motivation to participate in meetings, counseling or aftercare program.	3. During the two week period that P1 was experiencing severe depression, without the use of buprenorphine, he didn't have the motivation or energy to participate in any aftercare program until he started a buprenorphine program.

4. P1 biggest thing was looking to relieve his withdrawal symptom which would be to go back on his opiates. P1 had no motivation for an aftercare program. P1 never ever was in a program until P1 got on Suboxone./	4. P1 admitted that during his depressed state, related to opiate withdrawals, the only thing he was concern with was how to alleviate the withdrawal symptoms he was experiencing after detoxification from opiate use.
5. P1 stated that it was very difficult to stay free of opiate use without Suboxone, it was almost impossible./	5. P1 was having a difficult time remaining free of opiate use while in aftercare without the use of buprenorphine.
6. P1 revealed that when you are on opiate the way he was and for as long as he was you get intense cravings as well as psychological and physical craving, when your body is physically craving the drug and so is your mind, so you get peak and valleys. P1stated that when he would have a valley P1 would go look to use and when P1 was on a peak he was ok for a little while until the drug wore off than he would get withdrawals again. Than P1 would go out looking for drugs and this is why he was start on Subutex or Suboxone./	6. P1 revealed that because of his prolong and high level of opiate use, after the detoxification process he would have severe physical as well as psychological craving for the opiates. During the depressed mood or physical craving P1 would result back to opiate use to alleviate the craving and physical symptoms.

7. Before Subutex or Suboxone P1 was still able to go to work and try to hide it from others but his wife knew something was wrong because he wouldn't eat he would just wanted to sleep. P1 would fake it at work and he was miserable. P1 was just a walking shell of himself, to put it in a nut shell. P1 states it wasn't me it was just to keep up the facade it was there but it wasn't there. P1 did what ever it took just to get through the day so he wouldn't lose his job (further on P1 talk about how he lost his family and was homeless for ten months but we can get into that later)./	7. P1 explained that even though he was miserable due to the depressed mood he was experiencing, he was able to maintain some level of function at work. P1 wife was aware that P1 was not emotionally or physically doing well based on her knowledge of his usual activities as well as his display of decreased commitment toward family obligation.
Q2. 8. P1 depression was like this cloud was lifted off you and you get a renewed life. It's hard to describe, it like you are high but you're not high it feels like you're on the opiate but you're not, you feel like you on it, your body doesn't crave it, your body doesn't crave it, you are happy not feeling depressed at all, don't have any craving./	Q2. 8. P1 had a new experience and look on life once he was prescribed and started using buprenorphine. The psychological as well as the physical symptoms that were hampering P1 was no long an issue nor did P1 had to relapse back to opiate use to feeling well or function throughout the day. With the use of buprenorphine P1 depressed feeling was alleviated.
9. P1 didn't think about using. P1 have energy, it's like someone had zapped P1 with a drug that didn't actually give P1 the high P1 was looking for but P1 didn't really need it./	9. P1 new found experience with life, without the use of opiate, gave P1 the energy to function as well as to experience the feeling of euphoria similar to how he would feel from opiates.

10. P1 had everything there like P1 was high, energy, motivation – all the things that goes with being high but you are not actually high because it a partial opiate blocker so it doesn't let you get the thrill high but it let you function like you were high (does that make any sense?). It's a miracle drug. I mean, to me when I'm on my Suboxone (right now with Dr. V. he doesn't prescribe Subutex because it doesn't have the blocker in it which is Narcan)./	10. Buprenorphine for P1 was like a miracle drug that gave P1 the energy, motivation, and the euphoric feeling to function and carry out his activities of daily living without the thrill high that P1 would get from opiate use.
11. P1 doctor in A.Z. gave him Suboxones because he said it was faster acting (laugh) but they're all the same to P1 because P1 don't use when he is taking the buprenorphine. He don't need to use, P1 didn't have the desire to use./	11. P1 recall a time when he was prescribed Suboxone (buprenorphine and Narcan) by a doctor as an out patient because of its fasting results and to prevent injecting the drug to obtain the thrill high similar to opiate use. P1 states that on buprenorphine he was committed to use the medication as prescribed. Buprenorphine help to alleviate the desire to use opiates.
12. P1 have used twice over the four- five years that P1 been on and off Suboxone /Subutex. P1 have used opiates when he ran out of the medication./	12. P1 admitted to relapsing back the opiate drugs over the past four-five years went he was not on buprenorphine.
13. It very expensive, P1 have insurance but it doesn't cover the medication because it's not considered a medical necessitate so the insurance carrier don't cover it because there not a generic for Suboxone./	13. Due to the high cost of buprenorphine and the insurance company unwillingness to cover the cost of the medication, it was too expensive for P1 to continue the use of buprenorphine for a long period of time.

Q3. 14. There were no challenges for P1. P1 when online the first time he was in A.Z. Dr. M was able to see P1 the next day. P1 was prescribed Subutex the highest dosage which was16mg two 8mg tablets, one tablet in the morning and one tablet in the evening and other medications to relief the symptoms of withdrawals (Klonopin and Ambien for sleep I think). P1 wasn't supposed to mix anything else with these drugs that was it./	Q3. 14. P1 shared that his first experience attempting to gaining access to a doctor, who was certified to prescribe buprenorphine, was a positive experience. P1 did not experience being on a long waiting list for long period before seeing a doctor.
15. Here in El P. Dr. V, P1 have been seeing him for about three years, it was pretty ease to get an appointment even thought it was pretty crowded over there, so P1 had to tell him the was out of medication and was back using but P1 was sober for three days so P1 was going through hard core withdrawals and they saw P1 the next day. Dr. V. prescribed 12mg of Suboxone, 8mg in the morning and 4mg in the evening. P1 was on a waiting list for two days./	15. P1 second experience gaining access to a doctor, due to his change of location, was meet with little difficulty but was also a positive experience. Due to the amount of patient that the doctor was seeing, P1 had to describe himself as being in a state of withdrawals, although he had not used in three, in order to get in to see the doctor as soon as possible.
16. P1 had to travel 6-7 miles in El P, Dr. V. is on the eastside, in A. Z. it was about 10-12 miles./	16. P1 commute to see a doctor certified to prescribe buprenorphine range approximately 6-12 miles in distance from his house.
17. The cost was a big kicker, it's very, very expensive, P1 had to re-budget even though P1 make very good money in construction, it cost about $300.00 a month. So when you're at the higher dose it very expensive we had to re-budget out family budget in order to get my medication. So it took a little hit out of our budget./	17. P1 reveals that a major draw back to using buprenorphine would be the high cost of the medication. Even for P1 who consider himself in the upper middle class, the high of the medication had a major impact on the family budget. P1 and his family had to re-budget, the financial obligations in order for P1 to continue using buprenorphine.

18. At first the staff try to put P1 off for two week, but P1 told them he was going through hardcore withdrawals right now, that he was….had try to commit suicide one of the times he tried to come off on his on. P1 was very, very depressed. P1 was physically drained, and aching all over, so P1 told them he really needed to get in, so P1 called the crisis number which is a different number for Dr. V. so they was able to get P1 in through the back door the next day./	18. In order for P1 to gain immediate access to a doctor, during his second time using buprenorphine, P1 had to reveal to the front office staff his past experiences with suicidal attempts related to severe depression as well as physical symptoms. P1 was able to get an immediate appointment the following day by using the crisis line available to individuals in a crisis.
19. P1 believed sometime the ladies at the front desk don't understand what you are going through, but the crisis line does. You can become so depressed that you can become suicidal. The front office was standoffish but very understanding on the crisis line. They try to help you work through this, telling me not to hurt or harm myself, don't hurt anybody else, we will get you in./	19. P1 believed that front office staff was not as passionate or knowledgeable, compared to the staff on the crisis line, about the severity of physically or psychological symptom of opiate withdrawal for a person who are experiencing these symptoms. P1 gives kudos to the crisis line staff for their committed effort toward helping P1 during his crisis to stay positive and claim as well as working hard to find a way to help P1 gain access to the doctor the next day.
20. So P1 just gut it out until he got to see Dr. V. Before P1 was unable to get in to see the doctor P1 was frustrated and anxious, thinking damn I can't get in, what I'm going to do, do I have to go cold turkey again which doesn't work for me. You looking for all these ways trying to explain to them that you need to get in, you need to get in./	20. P1 reveals that his experience on the waiting list to get in to see the doctor was fill with frustration and anxiety that was driven by his pass experience with withdrawals and depression without the use of buprenorphine. P1 had to be creative in finding ways to gain access to a doctor as soon as possible.
21. P1 states he was looking for all these ways trying to explain to them that he need to get in, you need to get in. To them you just another number and another patient, but the people on the crisis line they understand because the people on the crisis line are former users, they understand what you are going through, they (Atlantis)have a 24 hour crisis for patient and non-patients you can call that number./	21.P1 believed he had to be creative to over come the stigma of the front office staff toward opiate user seeking to gain access to a doctor. P1 view of the crisis line is that they are individual with a history of addiction behaviors and they appeared to be passionate and understand toward P1 needs than the doctor's front office staff was.

22. Everyone was positive. Once P1 was there it was positive, beside the phone call and getting push back/forward, once P1 was a patient everyone was nice and understanding. You have to give your U/A, it was fine once P1 got there physically in the office everything was good, it was respectful, confidential, and everyone was professional so it was alright./	22. P1 believed the office staff was professional, curious, and respectful toward him once he became a patient of the doctor.
Q4. 23. The benefits are it completely take away the withdrawal symptoms and when you first take it, like P1 said, it like this cloud is lifted, you feel like a new human being physically and mentally./	Q4. 23. The benefit of using buprenorphine while in aftercare it helps to alleviate the depressed mood and being able to feeling like a different person physically and mentally.
24. The side affect for P1 was a little bit insomnia because the drug (buprenorphine) does bring you up a little bit. Constipation was a side affect for me, urinating was a problem because it affect your prostate a little bit, it's hard to get a strong stream of urine because the drug acts like an opiate and that what a opiate does, it shuts down your intestines and it affect your ability to urinate. But those are some of the side affect, but they are minimal, there are over the counter drugs you can take to help you out there./	24. P1 revealed that the side effects he experienced from the use of buprenorphine were minimal such as constipation, dysuria, and insomnia. P1 believed that the side effect was not a major concern or complication for him because he was able to use over the counter medication to help alleviate the side effects.
25. The biggest thing….if you can feel good there is no desire to go back out on the street to use, this drug (buprenorphine) help P1 to do that and when P1 on it he is a different human being. Even his family says that they push the Suboxone because it works./	25. With the use of buprenorphine as part of his aftercare treatment, P1 as well as his family felt like P1 was a different person, a person who did not have to continue seeking opiates or return back to his addictive lifestyle. P1 family was pleased with results of buprenorphine that they were willing to continue to support P1use of buprenorphine as a treatment modality in aftercare.

26. The side affect would the same if you were using opiates. P1 was a heroin and mostly a pain killer person. P1 would take up to 30 to 35 pain killers a day, so P1 was a hardcore pain killer user./	26. P1 believes that the side effect of buprenorphine would be similar to those you may experience from opiate drugs such as heroin and pain killers.
27. P1 would go to heroin when he couldn't use pain killers. P1 would doctor shop and when P1 would run out of doctors….Texas has computers that is tied in to all the pharmacies that are tied together so they can check and see when you got the prescription for opiate or hard pain killers, they won't refill it if the time has not elapsed (you know what I'm saying) so they would deny you, if you just filled it a week ago. So if it said renew in 21 days that would be three weeks, P1 would go out of state, P1 would go to New Mexico get it refilled if he had to, or buy pills off the street which is real expensive and when that didn't happen P1 would go to heroin which P1 didn't like but….opiate is a very, very hard addiction./	27. P1 shared that he would result to alternative measures such as using heroin, doctor shopping in different cities or states to buy prescription pain kills. P1 also resulted to buying pain killer off the street in order to fulfill is urges and craving when he was not using buprenorphine.
Q5. 28. This is P1 third attempt at sobriety with Suboxone. The first two time P1 was on it for four months, another time for eight months./	Q5. 28. P1 revealed that twice before he attempted sobriety with buprenorphine. The first time he was able to stay clean from opiate use for about four months while on buprenorphine. The second attempt he was able to stay free of opiate use for approximately eight. P1 believe that buprenorphine was effective toward help him to remain free of opiate use for a period of time.

29. The reason P1 stop was he was working in A.K. P1 got sent up to A.K. to work and the medication was not available when P1 went on to his ship. P1 was out on the Bering Sea working. P1 were doing oil ridge work, P1 was a surveyor and he couldn't get the drug. P1 had to go cold turkey. Coming cold turkey off Suboxone is worst than coming cold turkey off of an opiate, it is the worst….symptoms are not quite as heavy but the longevity is because the half life to Suboxone is very high, it stays in your systems for a very long time up to about a week so you don't see the withdrawal symptom for about the three or four day (after you stop using Suboxone) so it hit you hard and that the reason P1 didn't have access to it….	29. P1 states that his use of buprenorphine ended abruptly related to being transferred, because of his work, to a state that didn't have buprenorphine available as part of the aftercare treatment modality. P1 revealed that not having buprenorphine as part of his treatment program created withdrawal symptoms similar to, if not as, worst than withdrawing for opiates. The duration of the withdrawal symptoms was longer due to the half life of buprenorphine.
30. The second time it was financially. P1 was between jobs so he were living off what he had made for the last three months and P1 couldn't afford the medication it's very expensive./	30. P1 experienced a second disruption in his treatment with buprenorphine related to financial hardship. The disruption came at a time when P1 was transitioning between jobs and was living on a fix income, which he was able to save during the time he was employment, and was unable to afford to purchase buprenorphine.
31. The first two time was not by choice, P1 went back to his drug of choice which was opiate, so P1 had a little bit of a gap when P1 was coming off Suboxone, the withdrawal symptoms was so difficult P1 had to go back on his pain killers…two time P1 came off Suboxone he when right back to my pain killers and than he when back to Suboxone and back to pain killers so when P1 is on Suboxone everything is fine. The time P1 came off of it….he was either on something. P1 was either on Suboxone or on an opiate./	31. Reluctantly P1 relapsed twice. The relapse experiences were filled with alternating back and forth from opiate use, to detoxification from opiates, and back to treatment with buprenorphine. P1 acknowledge that when he is on buprenorphine he has a sense of normalcy in his life compared to the chaotic lifestyle when he is using opiates.

32. P1 never had a big time of sobriety because P1 couldn't handle the withdrawals and the depression. P1 was able to remain free for about a month at the most, P1 was never done with the program so you can't say P1 was done with the program, P1 was still right in the middle of his therapeutic use of Suboxone./	32. In the pass while in the aftercare program, P1 sobriety and participation in the aftercare program, was short lived because of the withdrawals symptoms and feelings of depression P1 experienced once he stopped using buprenorphine.
33. P1 would take it for four months so he was still taking a pretty good dose and than he would quit cold turkey, so he would have to go back to Suboxone or opiate after a month he couldn't handle the depression the running nose, the aches, the pain so P1 went back to his drug of choice the pain killers. The second time P1 was on it for eight months, P1 dose was fairly moderate so the withdrawal was not that bad but the addiction pulls at you so P1 want to go back the Suboxone or pain killers. The pain killers was ready available so P1 went back to the pain killers./	33. P1 earlier experiences with buprenorphine lasted from approximately four to eight months, while P1 was on a high therapeutic dose. When P1 abruptly terminate his treatment he returned to using pain killers to avoid the withdrawal symptom associated with opiate cessation.
34. The third time P1 was on it for nine months. P1 followed protocols, P1 been sober, he been following up with Dr. V. every 6 weeks. My U/As have been clean and no feeling of depression or nothing./	34. The third experience with buprenorphine was a positive experience for P1. P1 was able to remain sober and participate in aftercare without relapsing back to opiate drugs. P1 is proud that he was able to successfully maintain a longer period of clean U/As as well as not experiencing depression related to opiate withdraws.

35. When P1 was taken off, not by choice, the only think in his mind was how he was going to get something to get him high or how he was going to get some Suboxone again, so there was no motivation for participation. P1 participation was how he was going to get the drugs./	35. P1 continues to recall how his time without the use of buprenorphine was completely dominated with thinking of ways how to get pain killer or how to buy buprenorphine. Participation in aftercare without buprenorphine was an after thought.
36. P1 got in trouble in A.K. P1 did a year in jail. P1 did a year in prison for forging prescriptions. P1 hired a top dollar lawyer, P1 sat in jail for eight months they let him out after a year, a year which was eight months P1 had no probation or parole which was great because they want to put him on five probation which they didn't do so he got out…P1 had a ride back to Texas that was 2009-2010/	36. P1 admitted that some of the creative ways to get pain killers, while he was not on buprenorphine, was to steal doctors' prescription pads, DEA numbers, to forge doctors' name in order to get pain killers. P1 spent eight months in jail for forging prescriptions.
37. What the drugs did to P1 was that it made me….P1 forged prescriptions, calling the doctors. P1 would call in prescriptions over the phone like he was a doctor. P1 had like ten different doctors DEA number from Texas. It's normal for people who going to A.K. or from the lower 48 states that fish or work in construction, most of the worker or from down here(lower 48 states) A.K. doesn't have the people, it's not that many people up there, it was pretty ease to do for about six months until they did a sting on P1./	37. P1 feeling shameful of how his opiate addiction was out of control, that he had to result to criminal activity such as using doctors' DEA numbers and forging prescriptions in order to continue his use of pain killers.

Q6. 38. P1 would say it's a 100% beneficial if they are strictly opiate user./	Q6. 38. P1 stand behind the use of buprenorphine a 100% if the participant is a true opiate user seeking an intervention to alleviate depression and other symptoms associated with opiate withdrawals
39. It's better than the methadone program, because P1 hear that methadone is another drug that have a long half life that is worst to kick than sometime the drug itself. The side affects (from buprenorpine) are minimum, for P1 its like a miracle drug, it takes away the craving, the depression, it gives you energy, you take as directed and don't mix it with any other drugs the medication itself is a miracle worker./	39. P1 favored the use of buprenorphine over methadone because of its low side effect, short half life, and its rapid response toward alleviating the withdrawal effect of opiates.
40. Now, there are people who misuse Subutex because there is no Narcan or blockers in Subutex. People will break down the drug and inject the Subutex and overdose because the drug is a 100 times more powerful than morphine in it pure form. It's a very power drug. But P1 would say it a very positive drug to use in the aftercare program, it works, it works./	40. P1 believes that buprenorphine is an effective drug management tool toward alleviating depression in opiate users as well as helping to maintain or increase participation in aftercare. But he is cautious of individuals abusing buprenorphine, because of its potency, as an alternative to get high.
41. In A.K. they were still using methadone program for people coming off heroin or hard pain killers and P1 was on methadone for only a month, lucky for only a month. They tried starting P1 on a high dosage P1 was taking 80mg of methadone which is a pretty high dosage and P1 quit cold turkey himself and went back to using pain killers because when they start to taper you down, they do it real hard and P1 felt his body/himself that methadone was harder to kick than the actual opiate, P1 not a big fun of methadone./	41. P1 revealed that his negative experience with methadone was related to the process of tapering off methadone, which led P1 to return back to pain killers to avoid the withdrawal effect from the abrupt cessation of methadone. P1 felt that the withdraw symptoms from methadone was harder than the withdrawal from the pain killers he was trying to get off of.

42. You have to stay on your dosage and you have to take the medication as directed, you can't miss a dose, you have to be honest with the doctor if the dose is not too high and you having withdrawal symptoms, you having running a nose and craving, you have to be fore coming with the doctor./	42. P1 shared that in order for buprenorphine to be effective he believes the participants have to take charge and be responsible for their treatment process by taking the medication as ordered and communicating with their doctor if the medication is causing side effects or the dosage is not working for them.
43. The negatives are is there are some drugs you can't take with Suboxone and for some people P1 heard that the drug doesn't work. He don't know why, it works for him./	43. One main concern that P1 have with taking buprenorphine is that you have be careful with taking this medication with another medication because of the danger of harmful drug interaction.
44. Going cold turkey is a big no, no with Suboxone. So if you know you not going to have the medication before you run out make an appointment with your doctor so they can give you something while doing that time of financial crisis, to give you a benzodiapine or something to help alleviate…/	44. P1 would like warn potential participants that being responsible for your treatment is very important. Withdraws from buprenorphine can be a very uncomfortable experience. To avoid running out of medication and suffering the withdrawal symptom from buprenorphine, the participant needs to be proactive financially as well as communicating with the doctor if there is a personal crisis that may prevent the participant from refilling their medication prescription on time.
45. So when you come off Suboxone you get insomnia it just like coming off an opiate and it a big negative, so what do you do when you're coming off Suboxone so what do you do for the whole eight months you were on it? You were sober, now you're coming off it, what do you do? You go out and look for pain killers if the doctor doesn't work with you. You have to do something when you coming off of it to help you sleep so you make that transition without going cold	45. P1 states that after a period of using buprenorphine to quite abruptly could lead to uncomfortable withdraws similar to opiate withdraws. For P1 these experiences usually led back to using pain killers again if he was able to get in to see a doctor.

turkey because its just like an opiate coming off Suboxone is the same thing./	
46. The strengthens would be that you function like a normal person when you're on Suboxone, you never can tell…..it like an opiate but it doesn't get you high or make you sleepy, it keep you awake, it give you energy you don't have depression, you actually have a feeling of euphoria and things like that. That's what Suboxone does for P1. It actually gives him a lift it let P1 function like a normal person on a day to day basis/.	46. P1 believes that one strengthen of buprenorphine is having a sense of normalcy. P1 stated he had energy to carry out his daily functions without the depression related to opiate withdraws.
Q7. 47. The cost of the drug is real important for people who are walking into the office thinking they going to get on Suboxone, They heard it was a wonder drug./	Q7. 47. P1 states that due to the high cost of buprenorphine, participants have to be realistic about their financial obligations and the ability to pay for the cost of the medication for a longer period of time and do not use this medication if they can't afford it. Don't just look at the medication as a miracle drug if you can't afford it.
48. If you don't have insurance or a way to buy it, you can get put in a corner real quickly taking the 8mg dosage. The 8mg is like $10.00 a pill, so if thirty of those and that is just 8mg a day which is median dosage or median/moderate/high dosage and 30 pills times ten that's $300.00 for moderate dosage, if you're on 60 pills which is a high dosage that's $600.00 a month and you're going to have to spend that out of your pocket a month. P1 don't know to many people in El P. that can afford $600 a month on	48. If a participant doesn't have insurance or another financial resource to pay for the buprenorphine treatment program it can create a financial hardship on the participant and family members. The participants may get caught up in a vicious cycle of treatment and relapse back to opiates.

medication especially if they are a user coming off the street who didn't have a job to begin with, it a vicious cycle./	
49. People who are coming in are people who are coming off of heroin or pain killers who have probably lost their job already and there family. If you are coming in for Suboxone you probably hit rock bottom already. Now you come in and they write you a scribe and you go to a pharmacy or go to Wal-Mart where it cheap and they tell you it $500 for you meds, what do you do? You don't do anything, you can't./	49. P1 shares that for an opiate user living on the street, without family or some type of financial support, or a job using buprenorphine may be an unrealistic option for those individuals.
50. You go back to the doctor…like what happen to him the first time P1 was between jobs and just got out of jail in A.K. and he came back to El P. so P1 saw Dr. V., luckily he found work in the month P1 was home. Because P1 is a professional and P1 is good at what he do, but take a person off the street coming from the Opportunity Center who been using heroin and all of a sudden he want to get clean, they send you upstairs to the clinic and they will send you to a methadone clinic which not to many left in El P. But they will put you on methadone or refer you and than you find out about the three doctor in El P. that prescribes./	50. P1 states that his experience, the first time, was that the doctor wanted to place him and other opiate users on methadone during the aftercare program. P1 was able to avoid using methadone because he had financial support to help purchase buprenorphine. Other user had to use methadone.

51. When Dr. V. was on vacation Dr. E. would see P1, but he would prescribe Subutex./	51. Another unfavorable experienced for P1, was doctors would prefer to prescribe him a different type of medication when his primary doctor was on vacation.
52. There is a black market on the street, normally it a person who is sober, they go in and say they are coming off what ever and they get a prescription for a large amount like 60 of the 8mg pill and that's a lot and that person who have a third person which is a median which take that person to buy the drug at a premium price and than sell it on the market to people who is kicking heroin or kicking pain killers./	52. P1 states that there is an assessable and affordable street market for opiate users seeking (and can't afford) to use buprenorphine to alleviate side effect of withdraws related cessation of heroin or pain killers.
53. Acting as a street doctor and they sell those pills for $20 a piece and people buy them because it works, they know the drug works. P1 sold out once, that was a long time ago because P1 was cutting down on his dose, so he sold some pills, but there a big black market out there for Suboxone on the street in this town./	53. P1 shared that there was a time when he was tapering off buprenorphine he became part of the black market by selling his unused buprenorphine to other opiate use in aftercare.
54. People who can't afford the full prescription might buy a portion of it, that is what P1 did the first he got his $500 prescription. P1 bought enough for ten days, that's ten day that P1 know that he going to be ok./	54. P1 was able to sell his unused medication to individuals who was looking to use buprenorphine and was only able to buy a small portion of buprenorphine at a time.

55. Than in the mean time P1 would try to re-budget the money, P1 would do anything he could so he could get his meds. P1 family was a 100% behind him./	55. P1 family was very supportive of P1 use of buprenorphine, while in aftercare, that they were willing to restructure the family budget to support P1 in treatment.
56. The last time P1 was off his med was last year June of 2011. P1 went completely off his meds leaving a crazy addictive life. P1 got kick out of my house and P1 was homeless for 10 months. P1 didn't work he didn't do nothing./	56. P1 life was filled with chaos in 2011 when he abruptly stopped the buprenorphine program. P1 was separated from his family, lost his job, and was homeless as a result of using opiate drugs.
57. P1 went to New Mexico where they have a program to get Suboxone for free at one of the clinic over there if you are considered disable….see you have to wait two years to get your Medicare, once you are consider disable you have to wait two get your Medicare. Once P1 was on Medicaid P1 went back on the Suboxone until he saw Dr. V. P1 went six month without taking anything./	57. While going through the process of getting his life back together, P1 applied for Medicaid and Medicare and went out state where there were a clinic that treated individual, at no cost, who were deem as being disable. Once P1 had the financial support he was able to return to his home state to be treated with buprenorphine.
58. P1 believes they need to make a generic for the Suboxone or make the drug afford. If you follow the protocol and taper the drug like P1 done so if you do come off of it, it a whole lot easer to come off at 2-4mg than 8 or16mg, so P1 followed the protocol of the doctor./	58. P1 stated that there are several factors that need to take place in order for buprenorphine to be effective. P1 hope that there will be a generic version of the buprenorphine that is affordable and assessable to opiate users for treatment. Users need to adhere to the doctor protocol and taper the medication down to a comfortable dosage that would not create withdrawal like symptom once the participant stop using buprenorphine.

59. Dr.V. knows what he is doing. He is an advocate for the drug, he thinks it works. Don't increase the dosage like a lot of people on the street, they will take it to try and get high instead of using it the way it suppose to be used as a therapeutic maintenance drug the way P1 looked at it, a lot of guys they don't do that./	59. P1 trust in his doctor allowed him the feeling of comfort to use the medication as prescribed for therapeutic use and not to abuse the medication to get high. P1 fears that some opiate users may not have trust or the willingness to follow the doctor's instruction about using buprenorphine, this may lead users to abuse buprenorphine for recreational purpose to overcome the fear of withdraws.
60. People are afraid to come off the Suboxone, because the drug work so well and it work so positive and it takes away all the symptoms of withdrawal and craving. They are afraid to come off of it because they think they are going to go back to craving the opiate and going through a hard withdrawal./	60. P1 believes that opiate users may be reluctance to taper off the use of buprenorphine because of the fear of opiate withdraws and depression.
61. If you follower the protocol and taper it down, down, down it's a lot easier because P1 been there. They think they are going to go through hard core withdrawal so they are going to look for the their drug of choice on the street, they are going to the throw Suboxone to the side and go back to their drug of choice because it is cheaper, it easier to get./	61. Based on P1 experience with buprenorphine, opiate users will fear they are going to have withdrawal symptom if they taper off buprenorphine. Opiate users may forgo the doctor's instruction and seek their drug of choice once off the buprenorphine to avoid any withdraw symptoms.
Q1.P2 1. No motivation, no drive, it was hard to get up and go to work. P2 just didn't want to do anything. No drive, P2 kept telling his wife. P2 couldn't get going, a lot of lying around doing nothing, a lot of sleeping./	Q1. P2. 1. P2 experience with depression, while in aftercare, was so severe that he wasn't able to function. His daily activity involved lying in bed and sleeping.

2. The depression lasted for quite a while. P2 start using, it stayed around until than. Even recently P2 still find him self extremely depressed. P2 not sure if it's because past drug use or my current situation, it's hard to say./	2. P2 stated that his depression related to opiate withdraws lasted for a long period of time until P2 relapse back to his drug of choice. P2 contribute his recent experience with depression to his current life situations.
3. P2 didn't really have much of an aftercare program, it was far away. They gave P1 the medicine and told him to take it. But when P2 had to be there he was there as far as attendance went. P2 guess it was ok. P2 try to do what he supposes to do./	3. P2 was unable to participate in aftercare on a regular bases relate to the distance he had to travel to attend the program. P2 attended the aftercare meeting when he could.
4. Even though the urge wasn't there, the motivation kept P2 down, there was no motivation there were no motivation. P2 don't think it was the depression at that point so much. It's hard to tell the different between the depression or lack of motivation./	4. P2 states there was a time when he was unable to differentiate between lack of motivation and depression. He was unable to carry out his daily functions due to lack of motivation or the feeling of depression.
5. P2 was able to not use opiate for awhile. P2 don't know if it was peer pressure or the need to get started, P2 started using again. It lasted for about three months. P2 stayed busy with work, on snowy days, no work, bore and gloomy days./	5. P2 was able to remain free of opiate use for a period of three month, while in aftercare, by staying busy with work until he relapsed back to his drug of choice due to peer pressure and the craving to use.

6. Other than going to work, P2 didn't maintain much of a relationship with anybody other than his wife that he would see daily. Everyone else that P2 would see daily, weekly, or monthly P2 just dropped off from seeing them. P2 sort of dropped off the face of the earth for awhile. People were wondering if P2 was alright. When they would call P2 didn't have much to say to them. It affect it a lot, P2 kind of wanted to disappear./	6. P2 relationship with others, other than with his wife, was usually limited to work. P2 had no desire to interact with others who he once had a positive relationship with. P2 physically and emotionally want to disappear from others.
7. There was a lot of shame involved with the situation. The shame was that P2 got himself in this situation in the first place and needed treatment to deal with it. It carried through the whole situation. P2 really didn't talk to anybody, for a short answer. P2 just shut away from everybody./	7. P2 voluntary isolated him self from others due to the shame that P2 felt concerning his drug use and needing treatment to overcome his addictive behavior.
Q2. 8. With the medication everything was fine. The craving was gone from the opioid. P2 didn't have a lot of energy like he had before. P2 is highly motivated, but he wasn't, but the carving was gone. It worked great. It worked great for staying off the opioids./	Q2. 8. Once P2 was placed on buprenorphine the experience was positive, except for the increase in energy, toward alleviating the craving and helping P2 to remain free of opiate use.
9. The commitment was lacking still, P2 did what he had to but P2 didn't do a whole lot of extra./	9. While on buprenorphine P2 was able to carry out his daily functions. Other than with his wife P2 continue to suffer with maintaining a relationship with others.

10. P2 didn't use. P2 stayed true to the program. P2 really wanted to stay away from the opiates. P2 didn't like the dependency of it. But the motivation level was nothing. The symptoms of the sickness, sneezing, chills, running nose, it took that away. It allows you to function but P2 didn't want to function./	10. Even through P2 continued to experience a decrease in motivation to carry out daily functions, P2 feared the potential dependency of buprenorphine. P2 stayed true to aftercare program with buprenorphine by remain free of opiate use.
Q3. 11. It was very difficult. P2 had to go over a 100 miles to get to a doctor who prescribed Suboxone. From up in the mountains of N.M. to the plains it was over a 100 to 120 miles to get to a doctor. That was the closes one, the only one P2 was able to find. It took awhile./	11. One of the main challenges for P2 to get into a buprenorphine program while in aftercare was the lack of available providers in his home town. P2 had to travel approximately 120 miles to the closes available doctor certified to prescribe buprenorphine to treat opiate addiction.
12. It took almost a month to two months before P2 could get in there./	12. Another challenge that P2 faced was being on the waiting list for approximately two month to gain access to a certified doctor.
14. There was no cost. P2 had state covered insurance and it paid for it so there was no cost. But P2 know what it cost and he probably wouldn't have paid for it if he didn't have the insurance./	14. Cost of the medication was not a challenge for P2 due to having insurance coverage. P2 revealed that without insurance he would not be able to afford the medication.

15. There was cheaper ways to not be sick P2 would have probably kept using opioids./	15. Without insurance P2 states he would have continued to use opiate, to alleviate his withdraws or depression, because it's inexpensive and much more available than buprenorphine.
16. They did their job, they were professionals but there always seem to be an under tone. P2 don't know if it was him, are if it was there, but it seem that there was this under tone of him being trash./	16. The doctor's staff was professional, but for P2 there appeared to be an undertone or stigma from the staff that viewed the participants as trash.
17. You know, for P2 being what he is, it could have been in his mind but P2 is very self-conscience./	17. P2 understands that the undertone that he was feeling from the office staff may just have been his own self-conscience or shame about how he view himself.
18. But with the professionalism, they maintain the professionalism./	18. P2 was satisfied with the professionalism displayed by the office staff.

19. At the time it was not heard of, a lot of people didn't know what I was talking about. Not many people knew about it, P2 had to research it himself, and talk to other doctors about it. It was new, not many people knew about it, P2 had to ask his doctor about it./	19. Buprenorphine was not well known to the healthcare providers in the town where P2 was living. P2 was committed to become responsible to search for a certified provider who would be willing to accept him as a client into their buprenorphine program.
Q4. 20. P2 would say use the medication, it works very well for taking the addiction away or relieving the symptoms and helping you get past that./	Q4. 20. P2 advice would be to use buprenorphine while in aftercare because of its effectiveness in alleviating the depression as well as other withdrawal symptom associated with opiate withdraws.
21. The side affect are there, but they are nothing compare with out it. Compared to the opioids of feeling down and withdrawing, there no comparison without it. Compared to the side affects, P2 say take it, because it nothing compare to what you're going to go through without it./	21. For P2 the side effects of buprenorphine are no comparison to the withdrawal symptoms a person may experience from opiate withdraws without buprenorphine.
22. A lot of lack of motivation for P2, struggling in his mind not to use. P2 shut down quite a bit, people was wondering what was wrong with him. P2 was with them, with the drug he was using. Not using kind of made P2 a recluse./	22. Without buprenorphine P2 struggle with decrease motivation and severe depression combine with day to day struggles of remaining free from opiate use and isolating himself from those who were using opiates.

23. Without using the medication it's horrible, cold sweat, diarrhea, vomiting, headache, sleeplessness, you know days without sleeping there is nothing you can do. Compare without using and using buprenorphine, the different is like night and day. Compare to the two, the side effects are easy./	23. P2 share the side a person may experience using buprenorphine to alleviate or prevent withdraws or depression out weighs the horrible withdrawal experience they may experience without it.
Q5. 24. P2 used the medication for about 3-4 months. P2 didn't go all the way through with it./	Q5. 24. P2 voluntary abruptly terminate his aftercare and use of buprenorphine only after 3-4 month of being in the program.
25. P2 started making too much money, and P2 couldn't afford it any more. When they stop paying for it P2quite taking it. They stop paying for it. It was about eight dollars a strip, something like that. It was way too much./	25. P2 explains that the cost of the medication was main cause for the early terminate from the aftercare program and the use of buprenorphine. Once the insurance stop paying for the medication, P2 was unable to afford to purchase the medication.
26. At that point P2 was far enough along that he was able to go without anything./	26. P2 confidents in his sobriety, participation in the aftercare program along with taking buprenorphine for a long period of time P2 felt safe and confident that he could remain free of opiate use without taking buprenorphine.

27. After P2 stop taking the medication, P2 lost his job, not able to get up. P2 gets up at the crack of dawn. P2 shave and get ready for work. When P2 quite taking it, not that he was feeling sick, He just didn't want too. It didn't seem worth while./	27. P2 state that he relapsed back to opiate use once he dropped out of aftercare and stopped using buprenorphine. P2 lost his job as well as the depression and lack of motivation returned. For P2 life didn't seem worth while.
28. P2 was clean for about four or five months. P2 should have gotten out of town when he could have gotten away from certain people, but he didn't and he fell back into it. Once P2 stop the medication, he dropped it all. P2 dropped the program./	28. P2 revealed that approximately five months after he stopped participating in aftercare and was no longer taking the buprenorphine he returned back to his old lifestyle and addictive behavior.
29. P2 tried to do it himself. It lasted for 2 or 3 months with just support with P2 and his wife. We were supporting each other. The people at work didn't know what P2 was going through and a lot of his friend didn't know the situation he was in. P2 didn't have anything to fall back on as far as support./	29. Without medication management to address his depression, a strong support group such as aftercare program, and trying to hide his situation from co-work. P2 had to rely on his wife for emotional support.
30. In a small town, there was no where to go. There was no N.A. there was A.A. that didn't seem to help, that just made P2 have craving./	30. Living in a small town that didn't have a support program like N.A. was difficult for P2 to find the support group that he could connect with. Without a support group to turn to P2 quickly relapsed back to opiate drugs.

Q6. 31. P2 would say take it and keep with the schedule program./	Q6. 31. P2 advises others to use buprenorphine and adhere to the aftercare program as prescribed because it's effective toward alleviating the depression as well as other withdrawal symptoms from opiate abuse.
32. P2 would tell the doctor that it works. It takes away the symptoms./	32. P2 suggestion to healthcare providers would be to use buprenorphine as part of the aftercare program because it's effective toward alleviating depression and withdrawals symptoms.
33. People like P2 they don't want to do it. The sickness, keep them going. The Suboxone help take away the sickness and give them a chance to stay clean, so P2 tell them to take it./	33. P2 experience is that opiate users will continue to abuse opiate drugs to avoid withdraws associate with opiate cessation. P2 affirms that buprenorphine will help opiate users to remain free of opiate use as well as alleviating the withdraw symptoms if they continue with the program as prescribed.
34. The weakness is that you still have to take a medication./	34. The draw back is the stigma of using buprenorphine, you still have to be on a medication.

Q7. 35. P2 don't have much to say, but he think if it was the depression, the depression is what kept him from going and lack of motivation. If not it was from the drug and not having the Suboxone, but it was definitely there./	Q7. 35. P2 continue to struggle with weather the mood he was feeling was related to depression from the opiate withdraws and not being on buprenorphine or was it just a lack of motivation from opiate use that kept him seeking opiate drugs. He believes that something was definitely affecting his mood and constant drug seeking behavior.
Q1. P3 1. It was pretty severe. P3 didn't want to get out of bed. P3 felt overwhelm and sadness. P3 had the physical pain, P3 was…. just didn't want to do anything, just all the symptom of depression. P3 just didn't want to get out of bed and not wanting to start the day. Not wanting to get up and get dress, go out, or see anyone, talk to anyone./	Q1. P3. 1. P3 depression was so severe that she was unable to perform routine activities such as getting out bed, getting dress or socializing with others.
2. P3 would say her depression is on going. P3 been feeling depressed for about 7 month now, little over 7 ½ months./	2. P3 continued to experience depression related to opiate withdraws 71/2 months after she stop using buprenorphine.
3. It helped a little bit because there was support there, but P3 actually do better with medication instead of just support group. If P3 had the medication for depression and support group it would be the best./	3. Attending aftercare was helpful for P3 to deal with her feeling of depression. P3 believed that aftercare with the use of buprenorphine would be much more effective to deal with her depressed mood than just attend aftercare without buprenorphine.

4. P3 felt disappointed in herself, she just felt disappointed in herself. She should be doing better. P3 guess she is still kind of going through that depression. P3 still struggle with it everyday. P3 look down on herself because of it./	4. P3 struggles with the disappointment in herself as well as the feelings of depression related to not being able of overcome her current lifestyle.
5. P3 don't want to be in this state of mind but she still is./	5. P3 stated that she is frustrated with her current emotional state.
6. It was very difficult very difficult to stay clean. P3 would relapse without the medication. P3 would try the methadone clinic, to try something new./	6. P3 struggled to remain free of opiate drugs without the use of buprenorphine. P3 use methadone when she was unable to use buprenorphine.
7. P3 didn't. P3 wasn't able to commit to anyone without it./	7. Without buprenorphine P3 was unable to maintain any type of relationship or participate in the aftercare program.

8. When P3 didn't have it she was physically ill. When P3 was on it she able to function and work on a daily bases, but without it she couldn't get anything accomplish./	8. P3 was unable to accomplish any task or function throughout the day without the use of buprenorphine. Buprenorphine allow P3 to accomplish her goals throughout the day.
Q2. 9. P3 The medication made P3 feel normal. P3 can do her daily task with no problems./	Q2. 9. With the use of buprenorphine, P3 felt as sense of normalcy in her life. Daily task were much easier to accomplish throughout the day.
10. P3 didn't think about opiates. It took her mind away from opiates. P3 don't understand how but it did. It does work for her as like methadone, methadone works better for P3, but buprenorphine does work./	10. P3 although P3 prefers methadone over buprenorphine, she believe that buprenorphine was effective toward helping to alleviate the withdraw symptoms and craving from opiate drugs.
Q3. 11. Mainly insurance for P3. P3 couldn't afford insurance. And finding a doctor certified to prescribe buprenorphine was a problem./	Q3. 11. Two challenges that P3 faced trying to gain access to a doctor, first was not having insurance to cover the cost of buprenorphine and second finding a certified doctor to prescribe the medication.

12. The nearest doctor was about 2 hour from me (L. C. NM)./	12. P3 had to travel approximately 2 hours from her home town to gain access to a doctor certified to prescribe buprenorphine.
13. They had it every Thursday, you could go in every Thursday and do the intake and on Fridays you would see the doctors, so about two day on the waiting list./	13. P3 was on the waiting list for two day. The first day was the intake and the second day was seeing the doctor to get the prescription for buprenorphine.
14. It was about a 140 miles P3 think/	14. The distance P3 had to travel from her home town to a certified doctor qualified to prescribe buprenorphine was approximately 140 miles.
15. P3 thought it was a little expensive. It was expensive and it makes it a little hard. And it did affect P3 attitude as to…. other opiates are cheaper for her, P3 kind of thought of it that way. Because the Suboxone is expensive if you don't have insurance, which P3 don't have insurance. It was a $130 for 30 days./	15. P3 revealed that the high cost of buprenorphine and not having insurance to cover the medication did challenge P3 to weather she wanted to use another opiate medication or drugs to overcome depression and withdraws symptoms.

16. The staff was very, very helpful and they were concern about your well being and trying to get you off of opiates. Dr. M was caring and he wanted to know what was going on in your life and made should you were ok as well, so I would say they did any excellent job./	16. P3 was pleased with her experience with the doctor and office staff. P3 felt that the doctor and staff was very caring and concerned about their clients well being.
17. Aftercare staff gave P3 a list of meetings for AA to go to and support groups, they gave her a list of all the information where P3 could go for support as well as a list for doctors who prescribe Suboxone./	17. P3 explains that the aftercare staff was supportive toward helping her find a support group as well as providing P3 with a list of doctors who prescribed buprenorphine.
Q4. 18. The benefits were that P3 felt normal and P3 was able to do her daily functions with no problems./	Q4.18. Buprenorphine helped P3 to create a sense of normalcy in her life, allowing P3 to carry out her daily functions without feeling depressed or feeling a lack of motivation.
19. P3 didn't have much feeling of depression until she stop taking it./	19. P3 experience of with depression begin when she abruptly stop using buprenorphine.

20. The side affect, P3 only felt for about a week. It made P3 feeling kind of sleepy and drowsy, but it only lasted about a week and than it went away. Other than that the taste was really awful but it helped P3 do the things she needed to do every single day, so it does work. P3 do recommend it./	20. P3 would recommend that buprenorphine to be part an aftercare program. The side effects that P3 experienced with using buprenorphine were sleepiness, drowsiness and unfavorable taste. The side effects of buprenorphine were minimal but the result of the medication was effective toward alleviating the depression and helping to function everyday.
21. P3 used the medication for about 6 months. P3 stop using it because she relapsed. Yes! She relapsed to be completely honest, and started using again./	21. P3 used buprenorphine for approximately 6 months until she relapsed back to opiate drugs.
22. P3 started feeling sick, but it was not like methadone or other strong opiate medication. P3 did feel the depression coming on./	22. Once P3 abruptly stop using the buprenorphine she begin to experience mild withdraw symptom, but the depression was not as intense as methadone or other opiate drug.
23. The depression really hasn't completely gone away because P3 not medicated for her depression right now. The depression had definitely come back. The depression start coming back about after a week after stop using the Suboxone./	23. P3 began feeling the depressed mood approximately a week after she stopped using buprenorphine. P3 continues to struggle with mild depression at time due to not begin able to afford and purchase medication to alleviate the depression.

24. P3 stop going to aftercare meetings because she relapsed. P3 stopped going to meetings and everything else./	24. Once P3 stopped taking buprenorphine, she relapsed back to opiate drugs and stop going to aftercare and group meetings.
25. P3 would say take the doctor's advice and stick with the program./	25. P3 would advice potential participants seeking to use buprenorphine to follow the doctor's instruction and continue with the aftercare program.
26. P3 would tell the doctor to use the medication because it does work./	26. P3 would recommend to healthcare provider be to buprenorphine as part of the aftercare program because it helped her and it could help others.
27. The weakness, P3 really didn't see a weakness unless you stop taking the medication. When P3 stop taking it she got the depression. P3 don't know if it happen to all people, but that would be the weakness./	27. The only weakness or complication with using buprenorphine would be the return of depression if the participants abruptly stop using the medication.

28. The strengths are that you can perform a normal daily life with it./	28. For P3 the strength to using buprenorphine as part of the aftercare program would be the opportunity to have a sense of normalcy in your life.
Q7. 29. P3 was just wondering if other people were having withdrawals from it when you coming off it? How to you get off it? Do you just wing yourself down from it? P3 wasn't sure if other people experience withdrawals from it./	Q7. 29. P3 questions weather her experience with coming off buprenorphine was similar or unique to other individuals who stopped use the medication. P3 was curious how other individual on buprenorphine was able to get off the medication without experiencing the depression or withdrawals.
Q1. P4. 1. Immediately when P4 got sick he couldn't move he couldn't get out of bed. P4 just basically laid there for a couple of days, than somebody give him the stop signs (Suboxones). They kind of made him tired but when P4 got up he was alright, P4 wasn't sick like he was./	Q1. P4. 1. P4 experience with depression, once he detoxified off opiate drug, was so severe that he was unable to function throughout the day until he used buprenorphine to overcome the depressed mood.
2. P4 still depressed, he still think about it (without the medication)./	2. Without the use of buprenorphine, P4 continue to suffer from mild depression.

3. P4 didn't go to any aftercare program. P4 overdosed and he was thinking he had to do something before he's dead./	3. P4 recalls a time that he had overdosed on opiate drugs. Fearing the possibly of dying from his drug addiction, P4 realized that he had to make a change in his life that didn't involved using opiate drugs.
4. P4 would drink and drink and drink. Than someone gave me two of those stop signs and P4 took them for a couple of days./	4. P4 altered his opiate addiction with abusing alcohol until a friend introduced him to buprenorphine.
5. P4 still drinking, because is he still depressed. P4 get depressed because he's on the streets. The drugs are what put me on the streets./	5. P4 continued to use alcohol when he became depressed about his poor socioeconomic situation.
6. Now P4 just trying to get his life back together, it's depressing because P4 realize how badly he screwed himself./	6. P4 is working hard to overcome his socioeconomic situation, but emotionally it's hard.

7. P4 didn't stay clean at all, he just start back doing it and someone turn me back on to the stop signs./	7. P4 reveals that in the pass he was caught in a vicious cycle of detoxifying and using opiates. The addictive cycle was difficult to manage until he started using buprenorphine.
8. P4 is separated. Nobody wants to talk to me. P4 trying to get his life back together./	8. P4 explains that he is separated from his family related to his addictive lifestyle.
Q2. 9. It made P4 slow down and think; instead of trying to get more dope. He's ok. P4 just think a lot and it did make him tired./	Q2. 9. P4 believed the medication has helped him. The buprenorphine medication allowed P4 to focus on positive things in his life without constantly seeking his drug of choice.
10. The craving was gone. P4 think it helped. P4 took the stop signs, and he start slowly taking lots and lots of them. P4 had used them before about a couple of years ago. It made P4 more level headed, it slowed P4 down instead of wanting to go strong (using opiates)./	10. In P4 pass history with buprenorphine he reveals that it was effective toward helping P4 to develop as sense of normalcy in his life. The medication alleviated the cravings which helped P4 remain free of opiate use.

11. P4 wasn't really depressed just random thoughts. P4 kept thinking and thinking until P4 pretty much made himself depressed./	11. P4 sad mood is usually manifested by his constant thoughts about his socioeconomic status and being separated from his family.
Q3. 12. Someone gave them to me on the streets. P4 didn't get them from a doctor./	Q3.12. Due to P4 socioeconomic status and lack of financial resources to pay to see a doctor and purchase buprenorphine, P4 had to rely on friends on the street to give him the medication.
13. If P4 had known about it he would have said something to the doctors when he overdosed./	13. P4 felt he could have receive assistance from the hospital if he would discussed with the doctors or staff his financial and living situation as well as his desire to use buprenorphine to abusing opiates.
14. They just gave them to P4. They had quit and the just gave them to P4./	14. P4 received assistance from individuals, on the street, who was willing to give P4 their unused buprenorphine medication to help overcome his feeling of depression.

Q4. 15. It slowed P4 down and let him think. P4 made his mind up about doing what he was doing./	Q4. 15. The benefit of using buprenorphine allowed P4 to think positive about turning his life around without having to focus on using opiate drugs.
16. The side effect was that it made him tired./	16. The side effects that P4 experienced was feeling tired throughout the day.
17. P4 don't know if he was just depressed. He just wanted to sleep a lot./	17. P4 was confused weather he was depressed without the medication or was it that he just wanted to sleep and not function.
18. P4 just wanted to shoot his head off when he's thinking./	18. The racing thoughts that P4 was experiencing was so overwhelming at times P4 became depressed and just didn't want to think about his life or personal issues.

19. P4 urine was really, really yellow, it might sound funny but…P4 didn't eat as much as he usually do./	19. Some of the minor side effects that P4 experienced with buprenorphine were lost of appetite and urine discoloration.
Q5. 20. P4 use Suboxone for about three months while in treatment and about a month after he got out of treatment, this is before P4 relapsed and started getting them on the street./	Q5. 20. P4 first experience with buprenorphine was during a time he was in treatment for three months and for about one month after discharge to an aftercare program.
21. P4 stop using them because he didn't have the money./	21. P4 abruptly stopped using buprenorphine while in aftercare due to his financial hardship.
22. P4 had more agitation and shaky after stop using the medication. P4 also became more emotional for a while./	22. P4 began to experience a rebound effect related to the abrupt termination of buprenorphine some of the symptoms included agitation, shakiness, and emotional distress.

23. The question the researcher asked P4 a while ago, P4 dropped a few tears on that one (commitment to family). P4 was thinking about his daughter. That's one of the side-effect./ It made him lose my family after P4 stop taking the medication./	23. P4 explained that his tearful mood was due to talking about losing his family while looking back at how his drug addiction had affected his life.
24. P4 started drinking really heavy. That was his side effect./	24. P4 alternative coping skill to deal with his thoughts, concerning his living arrangement and being separated from his family, is to abuse alcohol when he is depressed.
25. P4 lost everything because it was helping him. I was in treatment for three months, I was lock up. P4 stop using the medication when he got out because P4 didn't have enough money for it./	25. Having access to buprenorphine while in a lock down program allow P4 to focus on the positive things in his life. P4 relapsed back to his drug of choice, lost his family and home once P4 was discharge from treatment and was unable to afford buprenorphine due to his financial hardship.
26. So P4 started drinking, he started drinking heavy. P4 just wanted everybody to leave him along. P4 wanted everybody to get away from him. P4 didn't want to go to NA, didn't want to go to AA, P4 just wanted everyone to leave him along./	26. Without the use of buprenorphine, P4 isolated himself from others, stop participating in aftercare, AA, and NA meeting. P4 didn't want to associate with anyone.

27. P4 was pretty emotional, he would get angry quickly. When P4 was taking it, it took a lot to make him angry. When P4 got off of it he would get piss off about anything. P4 would fight pretty much about anything./	27. Once P4 stopped using buprenorphine he became emotional unstable, which led to angry outburst and aggressive behavior toward others, compared to being able to manage his emotions when he was on the buprenorphine.
28. P4 wouldn't have anyone to prescribe them to now any way and P4 wouldn't have to money to buy them. P4 use to have insurance, but now he have nothing./	28. Once P4 lost the insurance coverage that he once had that paid for the buprenorphine medication, he wasn't be able to pay to see a doctor and purchase the medication due to his financial hardship.
29. P4 hasn't been with his family in all most 7 years. It kills him./	29. The seven years that P4 has been separated from his family related to addictive his lifestyle and economic status is overwhelming for P4 to deal with at times.
Q6. 30. P4 say it helps./	Q6. 30. P4 personal opinion concerns the use of buprenorphine as part of the aftercare program is that it is effective to helping individual to overcome their depression and stay in treatment.

31. If you got insurance you are good, if not they are expensive. P4 think a prescription for a month is about $600-700. But that was about a couple of years ago./	31. P4 believes buprenorphine is expensive if an individual does not have insurance to cover the high cost of medication.
32. But for the doctor, if someone wants to get off opiates and for depression you're feeling bad for a little while but than you will feel better./	32. P4 message to the healthcare providers would be that the medication is effective toward helping individual seeking to get off opiate drugs as well as those dealing with depression after opiate use.
33. Strengths, you will feel better, you won't have the cravings or feel like your body is falling a part. Because when you come off of opiates you just don't have any energy./	33. One of the strength of using buprenorphine is that you once again have energy to function without the craving and withdrawal symptoms that can affect an individual coming off of opiate.
34. With the stop signs you feel better; you eat more, and tend to me nicer to other people. P4 don't know what the chemical compound is but after a while…it doesn't hit immediately but after a little while you can tell the different in yourself. You just have to make sure you take it when you support to take it./	34. P4 believes if an individual use the medication as directed by the doctor they will have a positive outcome such as increase appetite and emotional stability that will allow for a positive interaction with other people.

35. Don't drink on it. If you drink on it you will be laying on the floor. You will pass out. P4 can drink a 12 pack of beer and he would have a buzz. P4 can drink three beers and stop and go to sleep./	35. P4 warns that drinking alcohol and using buprenorphine may create a dangerous drug interaction.
36. Weakness is when P4 take a piss, it's strong and dark. When you can smile your on pee it is strong. P4 don't know if it is cleaning my system out or what, but that is the only thing P4 notices./	36. A side effect that P4 experienced was foul odor and discoloration in his urine. The cause of this side effect was unknown by P4.
37. No withdrawal effect really because P4 went to drinking heavy and it calm him down quickly./	37. P4 alternating buprenorphine with alcohol allowed him to not experience any type of withdrawal symptoms from the buprenorphine.
Q7. 38. Nothing really. It the way to go really. It better than sucking down another drug./	Q7.38. P4 reflection on the use of buprenorphine is that it's a positive alternative to using opiate drugs.

39. Try to get insurance because it is expensive. When P4 was getting it in MI while in treatment he could afford it./	39. P4 was able to afford buprenorphine when he had insurance. Once he lost his insurance he couldn't afford it and relied on friends off the street to supply him the medication. Without insurance the medication is expensive to use.
40. It was doctor everywhere. The doctors was nice but I had a couple people look at me like a piece of shit, you dope head./	40. There was easy access to a doctor in the area where P4 lived. P4 experience with the doctors was positive, but at times he felt this stigma about him. P4 felt that he was being looked at in a negative way by the office staff.
41. P4 had a really nice job, but now he's flying a sign on the street to make money./	41. P4 reflects back on a positive lifestyle, having a family and job, before his drug addiction caused him to have to support himself by living in a shelter and being a pan handler at times.
Q1. P5 1. Other than the fact P5 felt like she was going to kill herself, it was horrible.	Q1. P5. 1. The depressed mood P5 experienced after detoxifying from opiate drug was emotionally devastating for her.

2. It hurt and P5 didn't want to do it, she was scared so P5 didn't.	2. P5 reluctant and hesitant toward participating in the aftercare program was manifested by the depressed mood related to withdrawals from opiate drugs.
3. It lasted until P5 felt fine or until she could get a hold of something. P5 didn't do the program. Someone told P5 where she could get the Suboxone so P5 just took them./	3. P5 was able to alleviate her depression, without participation in aftercare or seeing a doctor, by self medicating with buprenorphine that P5was able to obtain from her friends.
4. P5 wasn't going to do that (aftercare program). P5 father (having to tell father she was on drugs and medication), having to tell him would kill him, so P5 was going to do that. P5 was going to take care it herself (my problem)./	4. P5 was willing to risk self medicating herself, without being under a doctor's supervision, than be confronted by her father for participating in an aftercare program and taking medication related to opiate addiction.
5. It's really hard to get off opiates. It's hard, it's really hard. The friends around so P5 would use it, so it was hard. P5 like to get high, it's probably the highest high P5 ever had, so it's really hard.	5. P5 lifestyle, circle of friends, and the euphoric feeling of being high made it hard to abstain from opiate use.

6. P5 didn't know. P5 didn't keep her obligations. P5 do now but before she didn't. P5 really can't answer that question./	6. P5 struggle with maintaining her commitment to family and other personal obligations.
Q2. 7. It was a lot better. P5 didn't feel like that. Honest if it wasn't for the Suboxone P5 wouldn't have gotten off the drugs (prescription pills)./	Q2. 7 The buprenorphine helped alleviate the depression, abstain from opiate use, and develop a sense of normalcy in P5 life
8. P5 highly, highly recommend that if you are going through depression (or withdrawal) to take them./	8. P5 strongly recommend the use of buprenorphine for those individual who are suffering from depression or other withdrawal symptom associated with opiate withdraws while in aftercare.
9. P5 kind of mean, when P5 coming off the drugs, she's not very friendly. But P5 is fine when she use the Suboxone. Now she better. P5 rather be sober than to be on drugs, thank god for the subs (Suboxone)./	9. Reflecting on her pass experience with depression, related to opiate with withdraws, the depression had a major impact on her mood as well as her interaction with other. P5 didn't like the rude and cruel person she was doing her depressed mood.

Q3. 10. P5 never went to a doctor and P5 was never prescribed the medication by a doctor. Everything was off the street./	Q3. 10. P5 had no interaction with doctors or aftercare staff after detoxifying from opiates. P5 relied on her inter circle of friends or the street black market to provide her with the buprenorphine when she needed it.
11. It usually took P5 about a full Suboxone.	11. P5 self medicating process involved monitoring and adjusting the amount of buprenorphine she needed to help alleviate her depressed symptoms related to opiate withdraws.
12. P5 was never addicted to Suboxone. P5 don't like the way it make her feel. It make P5 feel good but it make her sick to her stomach, so P5 don't like taking them so she don't get addicted to them./	12. P5 would limit her use of buprenorphine to avoid the experience of gastric discomfort the medication would cause her when she took it. P5 believed that her limited use of buprenorphine would also prevent any potential addiction to the medication.
13. The Suboxone, they are cheap on the street. P5 rather buy a Suboxone than a pill. Its a very big different./	13. The cost of buying buprenorphine on the street market was more attractive to P5 than buying and relapsing back to opiate medication.

(no experience with doctors or staff)	14. P5 was able to circumvent the challenges, of gaining access to healthcare providers and the high cost of paying for a prescription without health coverage, by buying the medication off the street.
Q4. 14. The benefits are it gets rid of the anxiety and the feeling like you are going to have a heart attack and going to die. It did get rid of urges./	Q4. One of the major benefits that P5 received, from using buprenorphine, was the alleviation of her emotional distress as well as the urge to use opiate drugs.
15. You can't take the Suboxone and use because you will get sick so you just don't use./	15. P5 warns that using opiate drugs with buprenorphine may cause a dangerous drug interaction and cause an adverse reaction.
16. So, it took away urges to do that because, it made P5 sick. It makes you sleep so that's not really a benefit./	16. For P5 the benefit is it eliminated the urge to use opiate drugs, but the drawback of the buprenorphine is that it made P5 sleepy.

17. The other benefits are you are able to function without drugs. P5 can actually function without it (prescription drugs). Get out of bed, without the subs P5 can't function with the withdrawals. Now P5 is fine without the medication./	17. P5 is appreciative toward buprenorphine for helping her to develop a sense of normalcy in her life, to be able to function and be productive without the need to use opiate drugs.
18. The side effect of coming off the Suboxone? P5 never had to stay on Suboxone long enough to feel any side effect from it. It just takes P5 about a strip. They just make P5 sick to her stomach, so P5 want to get off it as so a possible./	18. P5 preferred to limit her use of buprenorphine as much as possible to avoid the gastric distress that she would experience from using buprenorphine.
Q5. 19. P5 just used it long enough to get the pills out of her system. As soon as P5 feel that the pills are gone P5 stop taking the subs. When P5 stop taking the subs she's fine. P5 take the subs long enough based on what she need. P5 just break it down to what she need. P5 don't take the whole thing, P5 just take tiny pieces, because they make her sick, really, really sick to her stomach. So P5 take a piece until she feels like she's ok. P5 just break them down. P5 kind of wing herself off a full strip. P5 start with a large piece down until she feels like she don't need them anymore. The anxiety and sweats are all gone even if P5 don't finish the strips. Once P5 start feeling fine she's done. Kind of winged her self off everything. P5 stop because she feel better which takes me about a week./	Q5. 19. P5 monitored her use of buprenorphine very carefully. She used the buprenorphine for approximately a week until she felt comfortable and was no longer experience any type of effect related to opiate withdraws. Once she was feeling better and free of withdraws she titrated the dosage down until she was off the medication.

20. If it wasn't the subs P5 wouldn't have gotten off the Oxys./	20. Buprenorphine was a helpful tool for P5 to help overcome her addiction of opiate medication.
21. Staying off of drugs depends on who P5 is around and what and when P5 can get something. If P5 is not around it and it's not stuck in my face she's ok. Once P5 start to use and it's stuck in her system it's hard to stay off it. If P5 can clean up and stay off it she's fine. The longest P5 have stayed off was two months, around about 2-4 months./	21. In P5 pass attempts of sobriety, the longest P5 was able to abstain from opiate use was approximately 4 months. P5 understood that if she didn't change her lifestyle and circle of friends she would continue to be caught-up in the vicious cycle of sobriety and relapse.
Q6. 22. P5 would recommend the subs to help with the withdrawal. Because it's the hardest drug to get off (pain pills/opiates). But you have to want to get clean. P5 didn't want to come off the drugs, but once she was off P5 wanted to stay off. It took my husband going to jail and me coming to El.P. to want to sober up and live my life like I should. If you want to, the subs are the way to go./	Q6. 22. P5 reveals that opiate addiction is very hard to overcome. It took the incarceration of P5 husband that convinced her that she needed to get off the opiate drugs and make a change in her life. P5 is a strong advocate for the use of buprenorphine, for those individual who truly want to come off opiate drugs, because it helped her overcome her addiction to opiates.
23. P5 had a friend who is addictive to Suboxones. He has to have a piece everyday or he doesn't feel right. He afraid of come off. P5 guess she was the same way because P5 didn't want to come off. P5 was scared of hurting, it hurts./	23. P5 reflects backs on her reluctant to stop using opiate drugs and compares it to one of her closest friend who continued to take buprenorphine daily because of his fears of going through withdraws.

24. And P5 had Xanax withdrawals as well. P5 rather have the opiate withdrawal than the Xanax. P5 thought she was going to die one night when she was coming off Xanax. P5 really through she was going to die. P5 took Xanax for 7 years and that was the last time she took them. After dying that night, really feeling like she was dying, P5 haven't taken a Xanax. P5 has got off all the pills./	24. P5 shares that she was once addictive to benzodiazepines. Her experience with benzodiazepines withdraws was far worst than that of opiates. Once again it took a major event to occur in P5 life to convince her to change her life around. P5 is proud that she now free of drug use.
25. But P5 highly, highly recommend Suboxone, it's the way to go. If the doctors don't want to use Suboxone, P5 don't know of any other way./	25. P5 suggestion to healthcare providers would be to use buprenorphine as part of the aftercare program. P5 would like to know what would be the other alternatives if doctor didn't want to use buprenorphine in aftercare.
26. They say Xanax but for me Xanax is a horrible way to go because you can become addictive to Xanax and it just knocks you out. But that's the only two ways P5 was ever told (Subs or Xanax)./	26. P5 states she would not be an advocate for using benzodiazepines as part of the aftercare program because of the potential to form an addiction to the medication.
27. The strengths are that it help get through the process of withdrawals without dying, that's the problem you feel like crap. So even if you want to stop like P5 want to stop, it was hard a first. P5 was scare to come off the pills and when P5 didn't have the Suboxone P5 kept using the pills so she wouldn't feel bad./	27. The reluctant to stop using opiate drugs was overcome by the use of buprenorphine. Buprenorphine helped P5 transition comfortably through the withdrawal process, from opiate use, without suffering significant physical or psychological withdraws.

28. P5 didn't want to go to the doctor and P5 won't go to the doctor, because P5 don't have insurance and P5 thought she didn't have that big of a problem. It take P5 only a full Suboxone strip so she wouldn't go to a doctor for that./	28. The available and afford street black market as well as the lack of or not able to afford insurance were considerable factors that weighed on P5 not seeking medical assistance to obtain buprenorphine. Therefore she chose to self-medicate, monitoring her reaction to the medication and only using what she needed to accomplish her goal of sobriety.
Q7. 29. P5 wouldn't have come off the pills if it wasn't for the Suboxone./	Q7. 29. P5 believed that she wouldn't have overcome her addiction for opiate drugs if it wasn't for the buprenorphine.
30. But P5 would also recommend give the people the knowledge about how addictive Suboxone can be as well. P5 wasn't addictive to Suboxone because it made her sick, but P5 have a friend who is addictive to Suboxone, he feels he need a strip everyday. It just like a pill or heroin user, you have to have it everyday or you don't feel right. It like when P5 use to smoke marijuana, P5 had to smoke everyday or she didn't feel right./	30. Reflecting back to one of her closest friend and her pass psychological dependency on marijuana. P5 believes that potential participants seeking to use buprenorphine as part of their treatment in aftercare need to be inform about the danger of potentially becoming psychologically or physically dependent on buprenorphine because it's a partial opiate and similar to other opiate drugs.
31. Now that P5 body knows what it feels like to be sober, she's ok with it. For a long time if it wasn't the marijuana it was the pill but she's ok now. It's been a long time since P5 have been sober, P5 is now 26 and she's glad to say she's headed in the right path now./	31. Enjoying a life of sobriety, at age 26 without the need to use drugs, P5 is proud of her accomplishments and the path she is currently on.

32. If it wasn't for the Suboxones, P5 wouldn't have gotten off of the pills. P5 wouldn't have had the nerves, she was too scared. P5 felt horrible, horrible, horrible, and she wouldn't have gone to a doctor. So if it wasn't for the Suboxone P5 would have probably overdosed on the pills. It was getting bad./	32. P5 fear of withdraws and depression, from opiate drugs, were so intense and out of control that if P5 friends didn't introduce her to buprenorphine she would have probably overdose from addiction of opiate medication.
33. When my husband got in trouble we kind of realized how serious it was. And the Suboxone helped my husband in jail. Because he was sick, sick, he was using a lot more than P5 was. P5 felt that if the Suboxone could help him and the amount that he was using, P5 felt that it could help her. So P5 found some and she came off the same time that he was in jail. We kind of did it together she guess./	33. The impact that opiate had on P5 life and her husband being incarcerated forced them to make changes in their behavior. P5 felt that if her husband was able to overcome his withdrawal symptoms, with buprenorphine considering how out control his use of opiates was, P5 felt that buprenorphine would surely help her to alleviate her dependency on opiates.
34. If he could do it there, going through how miserable it was in there, than P5 could do it out here. So P5 got some Suboxone and she had a friend that came to her a told her that he had gotten on a program and that it was the best thing that could have happen for him. He said that he couldn't get out of bed when he was withdrawing or coming off. He said that if it wasn't for the Suboxone and staying in the aftercare program he wouldn't have made it. He wouldn't have been able to take care of his kids anymore./	34. P5 decision to used buprenorphine was fueled by her husband valid effort to get off opiate while incarcerated as well as her close friend encouragement and sharing his life experience how he was able to obtain a sense of normalcy in his life and able to take care for his children with the help of an aftercare program and taking the buprenorphine.
35. P5 don't know how doctor can prescribe prescription drugs. P5 didn't really know about prescription drugs until she started hanging out with certain people. P5 got on the pills and she didn't know the pills were like that./	35. P5 is puzzled by how easy it is for doctors to prescribe prescription drugs as well as how available the prescription drugs are and easy to get from ordinary people on the street.

36. When P5 came off the Xanax, she didn't know that Xanax were a drug either, because she was on them for some long. The pills were prescribed by a doctor so P5 didn't know how serious they were or how addictive she was to the Xanax./	36. One of the drugs that P5 was addictive to for so long was a Xanax that was prescribed by her doctor. P5 was unaware of the impact the medication would have on her life and she didn't consider the medication as being something that she could eventually become addictive to.
37. P5 met her husband and start hanging with all the friends right after the death of her mother so it was kind of like P5 didn't care anymore she start doing whatever it took to cope. P5 use the pills to take away the emotional pain but it almost took away my life./	37. P5 addictive lifestyle began, after the death of her mother, when she met her husband and got involved with his circle of friends. P5 began to abuse the prescription medications that she got from friends as a means to help her cope with the death of her mother. Consequence of using the prescription medication almost ended P5 life.
Q1. (P6) 1. P6 didn't want to go. P6 didn't want to participate in aftercare. If P6 is depressed she didn't want of go and sit in front of a bunch of people and tell them about her life. P6 just wanted to stay home and eat cookies and watch tv./	Q1. P6. 1. P6 had no desire to participate in an aftercare program due to the depressed feelings she was experiencing from the opiate withdraws. She preferred to isolate herself, from others, by staying at home and entertain herself.
2. At her worst, P6 was suicidal. P6 attempted suicide a number of times. Wounded up in hospitals because of it, it was intense./	2. P6 depression from the opiate withdraws was so severe that she became suicidal on several occasions. The severity and intensity of P6 depression and attempted suicides result in P6 being hospitalized.

3. When P6 withdraw from the pain medication? You're talking about the time with burpernorphine? It was only a couple of week before they put P6 on the methadone. Which helped P6 a little bit physically, but she was still depressed and still in a lot of pain. So probably about a month P5 was in depression./	3. P6 stated her depression lasted for approximately a month after she stopped using her pain medication. P6 was prescribed methadone to help alleviate any type of withdraws symptom she may experience after she was taken off the pain medication. Methadone had a mild effect toward alleviating the physical symptoms but it didn't eliminate the depression that P6 was experiencing from the opiate withdraws.
4. P6 just didn't go to aftercare. P6 feel like aftercare was there for a good reason but if she wasn't feeling well she didn't want to get in the car and drive 40 miles. P6 lived out in the country. P6 just didn't want to get in the car and drive all that way to talk to people if she wasn't feeling well./	4. P6 acknowledged that she was aware of the important of participating in aftercare but the intensity of her depression, combined with the distance she had to travel from her home to the nearest program, made it extremely difficult be committed to the program.
5. P6 was only free of opiate use for only a few weeks. It was difficult, very difficult. Like P6 said she had diarrhea, throwing up, intense pain, and depression./	5. P6 confessed that she was only able to abstain, from opiate use, for only a few weeks into her sobriety. The depression and physical withdrawal symptoms P6 was experiencing, after coming off the pain medication, was unbearable.
6. P6 just locked herself in her house and just got sick all over the place. It was horrible, horrible. It was so scary P6 don't ever want to go through it again. And P6 will do just about anything not to go through it again, anything./	6. P6 described her experience with opiate withdraws as being so horrible as well as being physically and emotional debilitating that she basely confine herself to her house. P6 confess that the depression was possible the worst experience she ever had in her life. P6 believe she would have done just about anything she had to do to never go through that experience again.

7. P6 didn't maintain my commitments. P6 just didn't. Her family suffered, her friends suffered. P6 didn't maintain any commitments. P6 was pretty much shut off. P6 went into a shell./	7. P6 revealed that she voluntary isolated herself from everyone and everything that was significant in her life. The depression hindered her from maintaining any type of personal or family commitments. The misery she was feeling forced her into a shell.
Q2. 8. P6 went to the doctor, another detox doctor and P6 saw a sign on the wall about patches, this was some years ago. It was about 1998-2000, P6 don't remember, it's hard to remember that far. It was when it first came out./	Q2. 8. P6 recalls that she first became aware of buprenorphine during a visit to a doctor who was treating individual for addictive behavior.
9. It said you can pick up your patches on Wednesdays. So P6 ask the nurse about it and she said, oh no P6 insurance wouldn't pay for that. And P6 said why not and she said that P6 insurance is Medicaid and it wouldn't cover that./	9. P6 inquiry about the possibility of using buprenorphine was met with brief discouragement by the doctor's nursing staff. The nurse explained that P6 would not qualify for the use of buprenorphine because P6 Medicaid insurance wouldn't cover the cost of buprenorphine.
10. She said it's a very expensive drug and P6 ask about how much and she said about $250 dollars. P6 said that is expensive but what if P6 had the money? She said well we can talk to the doctor, so P6 made an appointment and when back. P6 talked to the doctor about her $250 and her started on the patches./	10. Once P6 was able to demonstrate that she would be able to pay out of pocket, for the cost of the medication, P6 was able to make an appointment to see the doctor and get a prescription for buprenorphine.

11. P6 was thinking this is going to be like Darvocet you know. This isn't going to help her, but it did a lot. It helped P6 right away. P6 mood was thankful and happy./	11. P6 confessed that she had very little confidence in buprenorphine to alleviate her pain and depressed mood. Immediately after taking the medication P6 noticed a major change in she emotional status. P6 recalled having a positive attitude and feeling happy after taking the medication.
12. They had a lot of commitments with that patch, like blood and urine test. P6 think they were studying it. But P6 didn't care because she was feeling better, so if they ask her to do something P6 did it./	12. P6 believed that at the time she started using buprenorphine the clinic may had been conducting a study with individuals taking the medication. Therefore, P6 had to be fully committed to the program's requirements and instructions placed on her by the clinic. P6 stayed committed the program and followed the instructions of the staff as required of her. The requirements were minimal for P6 because the buprenorphine was having a positive impact on her life compared to when she was not on the medication.
13. P6 family was happy. P6 kept all her obligations, P6 was just another person. P6 was able to work./	13. Using buprenorphine help create a life changing experience for P6. P6 was able to stay committed to personal and family obligations. P6 was able to manage her life and work again without confining herself to her bed because of depression and physical pain.
14. P6 lived in the country and P6 raised dogs. When P6 was sick, friends came in and helped her with my dogs. They got minimum care like food, water and brushing because they were cocker spanners and you can't let them get tingled up. P6 had most of them shaved. They were show dogs so P6 started taking care of them again and showing her dogs and selling her puppies. P6 business started doing well again./	14. P6 raised dogs to sell and show. Due to the emotional and physical pain that P6 was experiencing, she had to rely on friends to provide basic care for her dogs. P6 had no motivation to care for her animals. Her dogs began to suffer due P6 neglect. With the use of buprenorphine, P6 was able to focus on her business and provide the necessary care her dogs needed. Being able to manage and take control of her life allowed P6 business to become successful and profitable once again.

15. P6 bought a new car over a six month period of time. P6 went to a dealer because she was no difference than anyone else. P6 said to herself, she's going to go in and fill out an application and she got a ford explorer. And P6 also got a job grooming dogs at a local grooming place. The lady who owned it gave P6 a job because she knew P6. It helped P6 with dog food for P6 business at home. P6 had a computer so it helped her do a lot of business over the internet. P6 had people come from out of state looking at P6 puppies and selling them, P6 did very well./	15. While taking the buprenorphine, P6 was able to see her business and profits grow as well as being able to work outside of her home. As P6 managed her life and increase her work load, profits from her business allowed P6 to enjoy positive things in her life such as the purchase of a new car and get a computer to help expand her business to outer state customers.
Q3. 16. Well when P6 was seeing that doctor P6 didn't have any problems./	Q3. 16. P6 can't recall experiencing any major challenges, other than not having insurance and having to pay out of pocket for buprenorphine, when she saw the doctor.
17. Than P6 mother got sick and P6 had to go take care of her in Hawaii. So P6 moved to Hawaii, and they put her back on methadone, they didn't have the medication. The buprenorphine haven't come out in pills yet. Although P6 did ok on methadone, P6 was able to take care of her mother, she had Alzheimer's./	17. The illness of P6 mother force P6 to relocate to an area that didn't have buprenorphine available. P6 once again was forced to use methadone to avoid experiencing any type of physical or psychological withdraw symptoms.

18. P6 was there for about five or six years. P6 started drinking./	18. During the six years that P6 had to care for her mother and having to rely on methadone, due to not having access to buprenorphine, P6 admitted that she also started using alcohol regularly.
19. P6 was not on the waiting list long it was about a week./	19. The first time P6 chose to use buprenorphine, she was on the waiting list for approximately one week before getting into the program.
20. P6 had to drive about 40 miles. P6 farm was about 40 miles from town. It was a normal trip for P6. It wasn't anything out of the ordinary./	20. P6 recalled that the nearest doctor, certified to prescribe buprenorphine, was approximately 40 miles from her home. P6 didn't consider the distance of the doctor from her home as any thing out of the ordinary it was seen as a routine trip for P6.
21. P6 believed it was very high priced. P6 didn't understand why her insurance wouldn't pay for it. It paid for everything else. But P6 was willing, for how it made her feel, P6 was willing to put up the money and pay for it. P6 was thinking about back in the day how she would spend money on drugs, so it was minimal./	21. A major criticism of using buprenorphine, for P6 was the high cost of the medication. P6 refused to be discouraged from using buprenorphine due to Medicaid not willing to cover the cost of the medication. P6 weigh the cost of the medication verses the positive outcome she received from using the medication. P6 reflected back on the amount of money she would waste on using illegal drug therefore, P6 felt that the out pocket cost for buprenorphine was minimal.

22. Well, it was a detox doctor so there was a little bit of prejudice about who you are. We know who you are, go sit down. There was a little bit of attitude, but when P6 would describe to them that she was a chronic pain patient, she wasn't coming in there with needle hanging out of her arm. P6 was coming in because the doctor stopped giving P6 her chronic pain medication. So they had the story so they can do what ever the wanted to do with it. They could start treating P6 like a human being or they could treat her like all the other people they had in there (addicts)./	22. P6 perceptions of the staff, although it was a clinic that treated individual with drug addiction, were that there was a negative stigma and prejudice attitude toward individuals seeking treatment from their drug addiction. P6 was able to avoid that negative stigma and prejudice attitude from the staff by identifying herself as a patient who was suffering from chronic pain and was seeking treatment get medication to alleviate her pain. P6 felt it was up to the staff how they were going to treat her, with respect like a human being or disrespect because of her condition and their negative review of people with addict behavior.
23. Most of the staff in aftercare was dedicated to helping people find help and doctors. Most of them had been through it them self./	23. P6 believed that most of the staff she dealt with in aftercare was positive and dedicated to helping their clients get proper treatment and assistance they needed to achieve their sobriety and abstain from drug use. P6 believed that most of the staff in aftercare was sympathetic to her needs because of their pass experience with addiction.
Q4. 24. Number one P6 would say ask your doctor and be honest with your doctor. P6 think it effect people differently. I think all medication effect people differently so if you are having some sort of side effect you should tell your doctor. If you are feeling great and doing well you should tell your doctor that too. P6 think they can up the dose or lower the dose, not like when P6 was on it, they just slapped a patch on you./	Q4. 24. P6 strongly suggests that individuals, seeking to use buprenorphine to communicate and be honest with their doctor about their positive or negative experience with buprenorphine. P6 believe that doctors are much more knowledgeable about the use and implementation of buprenorphine than in the pass. The doctors are willing to adjust the dosage to accommodate to individual physical and emotional needs.

25. The benefit for most people it would be to stay off drugs right? You can ask anybody on drugs they would say their main goal is to get off drugs./	25. P6 stated the major benefit of using buprenorphine, while in aftercare, is that it can help individual like herself abstain from opiate use. P6 believe that the main goal, for most individual addictive to some type of drugs, would be to free of drug use.
26. Life style changes would be up to the person. Going to aftercare and using all the tools that are available to you. The schools out there, the jobs out there. P6 think a person can change their life a 100%. If they just want to use it as a substitute for drugs and just stay on it and keep the same life style they won't get better./	26. P6 is confident that an individual can turn their life around with the use of buprenorphine while participating in an aftercare program. P6 cautions that life style changes would be up to the person. If an individual is just seeking to use buprenorphine as a substitute or just using the medication because it just something new to use or their goal is just to continue to abuse drugs and keep their same life style and self defeating behaviors, than buprenorphine will not be helpful or should be used.
27. P6's was all positive. P6 didn't have any bad side effects. P6 have heard other people talk about having side effects especially with the pills./	27. P6 can't recall having any major adverse reaction related to the use of buprenorphine compare to the information she received, about the side affect from using buprenorphine, from some of her circle of friends.
28. There is two types of pills, one with Narcan and one without. P6 think it's really psychological, every addict is afraid of Narcan. To say it's in the pill that surely is going to make the person afraid to take it and get side effects. The other one that doesn't have Narcan (Subutex). That's the one P6 would turn to because it doesn't have Narcan. That's the one P6 would use./	28. P6 is concern that some of the information she obtain from other opiate users about side effect from buprenorphine may be psychological. The psychological fear may be due to the opiate users fearing induced opiate withdraws from using buprenorphine with Narcan. P6 confess that she would rather use buprenorphine without Narcan to avoid experiencing any type of induced withdraws.

29. P6 took herself off the medication because she had to go take care of her mom./	29. P6 was unable to continue the use of buprenorphine when she relocated to any area, to become the care taker for her mother, where buprenorphine was not available as part of her aftercare treatment.
30. As far as withdrawals, P6 was lucky enough that she didn't have that much time before seeing a doctor. P6 had an appointment set up when she got there, so P6 went right on methadone./	30. P6 reveals that she didn't immediately experience withdraw effect after she stop using buprenorphine because she was able to gain access to a doctor soon after she relocated and therefore was able to get on methadone before her prescription buprenorphine expired.
31. But like P6 said there was something missing. So P6 started drinking to fill the hole that she thinks people like her have. They have this big hole in them and P6 think methadone was only filling it three quarters. Where buprenorphine was feeling it a 100%. The methadone was only filling it 75% and P6 had to throw in some alcohol to fill it. Which wasn't too good, because alcohol is a depressant and you go through the whole thing of a hang over and than feel good and hand over./	31. Comparing her experience to using buprenorphine to her experience using methadone to prevent withdraws, P6 felt that methadone was effective in eliminating the physical withdraws but didn't alleviate the emotional pain as effective as buprenorphine. In an attempt to alleviate the feeling of emptiness or depression P6 went through a vicious cycle of using alcohol, which is a depressant, which led to having a hang over to drinking again to alleviate the hang over.

Q5. 32. P6 guesses she used the medication for about 6 months. P6 quit using the medication because she had to go take care of her mom, she had Alzheimer's and she needed P6./	Q5. 32. P6 acknowledged that she used buprenorphine for approximately six months before she had to stop using the medication because of lack of access.
33. After P6 stopped taking the medication she wasn't feeling right. P6 wouldn't be feeling ok, you know that feeling when you can sit down and watch tv and not worried, and not have a million things buzzing through your head./	33. P6 shares that when she was no longer using buprenorphine and was place on methadone, she began to have racing thoughts as well as the return of depressed feelings. She didn't feel relaxed or comfort as she did when she was using buprenorphine.
34. P6 think depression and anxiety go hand in hand. Like P6 said she augmented that with alcohol. P6 didn't use opiate after stopping the medication./	34. To suppress her feelings of depression and anxiety P6 augmented alcohol with the use of methadone. P6 admitted that she didn't use opiate drugs to alleviate her depression.
35. P6 went on methadone and stayed on methadone until Michael Jackson died. Than the doctor said he didn't think methadone was a good drug for P6. Anna Nicole Smith died around the same time. He gave me a month supply and told me to wind myself off. Well that's not the right thing to say to someone who is opiate dependent./	35. P6 is very critical of the way she was treated by her doctor after the death of M. J. and A. N. S. P6 felt her doctor was insensitive toward her physical and psychological needs when he abruptly abandoned P6 while she was still dependent on him for medication management. P6 doctor gave a prescription for one month supply of methadone and instructed P6 to titrate herself off the medication on her own. P6 angrily stated that this not a professional thing to do to an individual who is dependent

	and seeking treatment for opiate addiction.
36. Unfortunate P6 went to street drugs. Getting off the methadone was horrible. P6 went to the hospital twice. In the hospital they made P6 ok. P6 told them that she is going to go home but she'll be back. The withdrawal from methadone would never go away. So P6 went to street drugs, heroin. P6 used heroin when she was in her teens and early twenties./	36. After P6 was forced to get off methadone by an uncaring provider, P6 started using heroin to avoid the withdrawal effect of coming off of methadone. P6 felt as if the withdraws from the methadone would never go away. P6 explain the withdrawal from methadone was so horrible that she went to the hospital twice to get medication to alleviate the withdrawal she was experiencing from the methadone. P6 decision to use heroin was a reflection of using heroin during her teens and early twenties.
37. After coming off buprenorphine, P6 didn't have time for aftercare. P6 was taking care of her mother. P6 didn't have time for any programs. She needed my help and methadone allowed me to care for her. P6 could have done a better job she thinks, but she was dying, she was like a baby. P6 had to change her diapers and do everything for her./	37. P6 emotional reveals that after she stopped using buprenorphine and the demands of taking care of her mother, P6 didn't have time to participate in aftercare. P6 use the methadone in order to care for her mother.
Q6. 38. P6 would ask him what his other choice was. P6 don't see any other competition. He could let these people suffer or he could help them out. The medication helped me and if it helped me it can help other people. P6 is not a strange human being so if helped her it could help someone else./	Q6. 38. P6 would challenge any doctor who refused to use buprenorphine as part of the aftercare program. The doctor could choose to be insensitive to the opiate users physical and psychological needs and let them continue to suffer or he can use the medication because it work toward helping opiate users achieve goal of sobriety while participating in aftercare. P6 believe that her experience would not be unique, if it helped her it could help other achieve their goal of

	sobriety and become productive in their life.
39. It would help under supervision. P6 don't think they should just throw the medication at them. They should look at each case and see how long they been using. P6 thinks both parties should be honest. You need the counselor to be honest and the client to be honest, saying I been on drug for a long time. What can I do to help myself now? I'm tired of it./	39. P6 highly suggests that buprenorphine be use under supervision. Doctors need to continue to monitor individual and determine the treatment level on a case by case assessing the severity of the individual addiction and their level of use. The opiate user needs to be honest with their doctors and counselor about years and amount of use in order to receive appropriate treatment. The healthcare providers need to be honest with the individual about how they can assist the individual to achieve their goal of sobriety.
40. There are a lot of people who will be honest like that. But if you get someone who just want to try something new….you get a lot of people who hear about a new drug and say of yeah I want to try that. So the counselor or doctor who give out the medication have to be careful and make sure the person is serious and making a real life change./	40. P6 warn healthcare providers again prescribing buprenorphine without assessing if indeed this individual is seriously seeking to make a real life change or if that individual is their because they heard about a new drug available to substitute or add to the addiction. For the most part P6 believe that people will be honest and up front about their goals to get off opiate drugs but there is that small group out there to just get another drug to abuse.
41. Weaknesses, P6 is thinking of weaknesses. Some people can abuse it./	41. A major weakness or concern for P6 with the use of buprenorphine is that it can be abuse by that small group of people not seeking a life change but seeking a new drug to use.

42. The strength is that it can put a person into a normal life. As normal as they ever had. Like P6 she had a business and a new car. Those are the things P6 always wanted but could never get. No cops banging on the door and no warrants out for her. Just a nice peaceful life and that's what everybody dream of./	42. The strength of using buprenorphine would be helpful the individual create sobriety and a sense of normalcy in their life. P6 was proud of her life changing experience while she was on buprenorphine. P6 reveal that she was able to buy and have things in her life that she thought she could never get, P6 saw herself as finally achieving a sense of peace and calm in her life that she believed everyone dreams of. A major accomplishment for P6 was having a lifestyle that didn't include the police and arrest warrants.
43. P6 see the only weakness is that people can abuse it. It expensive for the poor man./	43. P6 worried that for people who are poor and have no insurance buprenorphine can be very expensive to use as a treatment modality in aftercare. And there is always the concern of abuse by individual not seeking sobriety or a positive change in their life, they are just looking for a new drug to get high on.
Q1.(P7). 1. P7 suffered severe depression after he stopped using buprenorphine and went back to his living environment where they said people, places, and things./	Q1. P7. 1. P7 experience severe depression once he stopped using buprenorphine. After P7 stopped using buprenorphine he immediately returned back to his old lifestyle and circle of friends which caused P7 to relapse back to using opiate drugs.

2. P7 felt like he was outcaste from a lot of his friends if they were using and P7 was trying to stay clean. P7 was looked at differently. /	2. P7 revealed that when he was on buprenorphine and no longer using opiate drugs, he was outcast by his circle of friends. P7 friends didn't want to associate with him since P7 was no longer involved in or participate in the same drug lifestyle.
3. P7 didn't have a lot of ambition and couldn't do a lot of the things that he loved. P7 was withdrawn from a lot of his family and friends where P7 wanted to be along by himself and not around company and stuff like that. So P7 suffered a great deal of depression after he stop using./	3. P7 experienced severe depression after detoxifying from opiate drugs and not in aftercare or using buprenorphine. P7 voluntary isolated him self from family and friends. P7 had no ambition to function and follow through with daily commitments.
4. For P7, he can't really think of it as a time period, it just came and went over time and until this day P7 can't tell what it's from. P7 still have a little bit of depression./	4. P7 states he is under able to put a particular time period to when he was depressed and when he was not depressed. P7 continues to suffer at time with small episode of depression that is unexplainable to P7.
5. The main period of depression was about six months after stop using buprenorphine. P7 felt like the one thing that helped his depression was going to the NA meeting, but NA is only one hour to two hours a day. You can only go to so many meeting a day to try to distracted yourself from an out of your mind about using or something like that./	5. P7 explained that he experience severe depression for approximately six month once he stopped using buprenorphine during his aftercare program. During the six months of depression P7 relied on NA meeting for support and to help distract his thoughts and urges from wanting to relapse back to opiate drugs.

6. P7 felt withdrawn and wasn't as interested in it and kind of sided tracked. P7 mind might have been in other places than where it should have been with participating in NA or AA meetings or home group or anything like that./	6. P7 confessed that at times he was not fully committed or attentive to NA meeting as he should have been. There were times that P7 craving and urges cause him to focus more on seeking his drug of choice rather than on being true participant in the meetings.
7. P7 felt like the one thing that helped his depression was going to the NA meeting but NA is only one hour to two a day./	7. P7 felt the NA meeting was a good support for him at times while he was dealing with his depression. NA allowed P7 to redirect his thoughts from wanting to use opiates for a short period time throughout the day.
8. Of course in the back of your mind you think about taking the easy way out and stop dealing with the program, you don't want to deal with it anymore or deal with the people weather it's from dealing with the people or too much pressure, like a little clicky where people look at you funny or you kind of outcaste from the people depending on your clean time. But P7 attitude, P7 always tried to stay positive about the aftercare program./	8. P7 states that for the most part he had a positive attitude about participating in aftercare. He confessed that there were times he just wanted to drop out of the program and go back to using opiate drugs. P7 was unsure what was causing his frustration, weather it was peer pressure or the feeling of being outcast by certain people in the meetings based on his clean time in the meeting.
9. But it was definitely hard it wasn't any fun. It was very difficult, very, very difficult to take clean in aftercare. Without the Suboxone P7 felt like it was nearly in possible but P7 also felt like it might have been him, that's my personal thing, but it was very difficult./	9. P7 found it extremely difficult to abstain from opiate, drugs while in aftercare, without the use of buprenorphine. P7 was uncertain weather his difficulty abstaining from opiate drugs was related to withdrawal or it was just him wanting to use

10. It was very hard to maintain commitments with family or friends or people from the meetings and stuff like that. P7 didn't have a lot of energy, lack of sleep, didn't have a good appetite. P7 founded it very hard to keep commitments or go out and be social with family or friends./	10. During the period of depression P7 founded it difficult to maintain his commitments to family, friends or associate with individual from his support group. P7 states that the depression from the opiate withdrawal had a major impact on his appetite, sleeping pattern and well as lack of energy to be productive or socialize with significant others in his life.
Q2. 11. It was a miracle drug for P7. In partial it total changed P7 mood. P7 felt like being with his friends and family./	Q2. 11. P7 view buprenorphine as being a miracle drug. The medication gave him that energy and motivation to socialize and maintain his commitments with others.
12. P7 felt better physically and mentally. P7 didn't have body aches, he didn't have cravings, things that would trigger him started going away and P7 wanted to be with people and go different places and do some of the things he like to do for his addiction./	12. P7 acknowledged that with buprenorphine he had a change of life experience. He preferred do the things that he once enjoyed. P7 enjoyed being with family and friends as well as enjoying pleasurable things in life without the craving, physical pain or emotional distress. P7 felt that with buprenorphine he was able deal with stressful things that would trigger him to want to relapse back to opiate drugs.
13. Some of the things P7 like to do when he was on the buprenorphine was, P7 like playing sports, go out to the movies. P7 like music, that's a big part of his life. P7 is really in to art, so being able to sit down and concentrate and draw and paint was a big thing for him./	13. P7 revealed that with buprenorphine he was able to play sports, enjoyed going to movies, listen to music, and what was most important to P7 was the ability to sit down once again and concentrate on drawing and painting.

Q3. 14. The main challenge was financially because it was very, very expensive. And the insurance companies….the insurance companies didn't accept a co pay or anything like that so it was all cash payments./	Q3. The major challenge P7 faced using buprenorphine was the cost. The cost of using buprenorphine was very expensive. P7 insurance did not cover the cost of the medication. Therefore, he had to pay for the medication out of pocket.
15. Many doctors didn't prescribe it or wanted to be involved with the stereotype of deal with a junky or an addict or something along those lines./	15. The second challenge P7 faced using buprenorphine was gaining access to a certified doctor who could prescribe the medication to him. P7 believed that the stigma and prejudice attitude of most doctors about treating addicts is probably the main challenge for individual seeking treatment. P7 believes this stereotypical attitude doctors have about addicts is a major reason why so few doctors are willing to certify to prescribe buprenorphine or willing to see addicts in their office.
16. P7 think it was when he called the doctor's office about a week on the waiting list, which was going to be a long week until that doctor's visit./	16. P7 estimates he was on the waiting list, after he contacted the doctor's office, for approximately one week. Emotionally that was a long week for P7.
17. P7 was living at home with my family in Philly. P7 have three younger brothers. P7 knew it was going to be very difficult to be around the people that he loved and he wanted to be back to normal. P7 knew how he was going to be, so P7 had a lot of anxiety to get the medication./	17. Living at home with his parents and three younger siblings was very difficult for P7 during the week he was waiting for his appointment to see the doctor to get on buprenorphine. The waiting period for P7 was filled with a lot of anticipation and anxiety about getting the medication and gaining a sense of normalcy back in his life as well as being with the people he loved.

18. P7 travel cross the city in Philly to get to his doctor's office which was about a half hour to 45 min drive for each appointment. So it was difficult calling these doctors to see where P7 could go and it would be the least expensive and the closest so… It was about 30-40 miles away./	18. Searching for the closest and least expensive doctor was another challenge for P7. P7 doctor search took him about 30-40 miles across town, which was about a 30-45 min drive to his attend his appointments.
19. The cost was…the way P7 weighed in his mind was that the cost of using in the long term was going to be a lot more expensive than paying for the doctor's visits and paying for the medications. The first doctor P7 saw…the first visit was about $300 dollars and every month it was about $150 dollars and that was not including the medication. That was just for the visits./	19. Although the medication was expensive, P7 weighed his options to how much his addiction and using opiate would cost him in the long term if he didn't receive treatment with the buprenorphine. The cost of the doctor's visits and buying the medication would cost P7 approximate $150-300 or more monthly.
20. From an addict stand point it a lot easy to go day by day using drugs went it's about $20 dollars to get fix or get well than trying to save money to see a doctor. So the cost does affect it./	20. P7 believes the cost of the doctor's visits and purchasing the medication will have a negative impact on an individual's attitude about using buprenorphine. P7 acknowledged that for him and most users, the mind set would be to use their drug of choice because it's less expensive than trying to save money to see a doctor to get on the buprenorphine, which will be and additional cost.
21. P7 felt like there was definitely a negative connotation when you even call the office for that first visit and you call and say hi, I'm calling about the Suboxone program. They treat you with not a lot of respect and it's like here another junkie or an addict that we have to deal with, and that you going to come into the office….with the negative connotation of it, it wasn't a great experience. P7 guess it wasn't that great, P7 guess he definitely didn't look to going to the office and seeing those people. It was a turn off, just going in to	21. P7 sadly states that he didn't have a great experience as a patient. The stigma and prejudice attitude toward addicts seeking treatment and lack of respect from the office staff was a major turn off for him. P7 revealed that he did not look forward to his doctor's visits. The negative connotation he perceived from the staff, when he would call for the first visit didn't make for a comfortable visit.

see those people and they know what you are there for./	
22. A couple of these doctors…..the one P7 went to they do other things than just buprenorphine, so you just sit it the office and they look and say oh I know why he is here, for the buprenorphine program of what not. So it definitely effect my willingness, so P7 got to go to the doctor to get his prescription, P7 didn't look forward to it./	22. P7 states he didn't look forward to his doctor's visit due to the negative attitude of the doctors and office staff. The doctors, that P7 visited, main practice were not in Addiction Medicine or chemical substance. P7 felt that because the doctors scope of practice was usually in some other field, the doctor were not very sympathetic to the physical and emotional needs of individual seeking treatment for their addiction.
23. It was difficult because it wasn't very many of them. Dealing with the doctors and trying to change your appointment and arrange the next appointment, it was very difficult to do so because there weren't a lot of doctors and they were very busy, so if you missed your appointment they didn't want to see you again. You missed an appointment they were pretty much telling you well you going to have to see another doctor and we don't want to deal with you./	23. P7 felt that his doctors were not very flexible in their scheduling or willingness to work with individuals if you miss or needed to change an appointment. If an individual missed an appointment the doctor would basely discharge you or not see you and suggest that the individual seek treatment with another doctor. P7 explain that due to the limited number of doctors certified to prescribe buprenorphine, it would be very difficult to gain access to another doctor if your doctor discharge you from his service.
24. Some people in aftercare were helpful. One particular NA meeting P7 when to they were against it, they would discourage against it. They look at buprenorphine as you were not totally clean if you are still using a substance. Not too many people was open about it./	24. P7 felt that for the most part the staff in aftercare was support and helpful to P7 to gaining access to services. P7 had a bad experience with a NA meeting. The NA group was not advocates or supportive of individual in the group using buprenorphine. The group discouraged against the use of buprenorphine. The group's philosophy was taking medication was just substituting one drug for another and by using buprenorphine the individual wasn't truly sober or abstaining

	from drug use.
25. P7 felt himself that he was not really sharing, that he was taking the medication and P7 didn't want to put that out there and let the group know that he was keeping that to himself./	25. To avoid the stigma or the peer pressure about using buprenorphine, P7 make a conscience decision not to share with his group that he was using buprenorphine.
Q4. 26. The side effect really wasn't there for P7, if anything maybe a little drowsiness or tiredness, there wasn't any side effect./	Q4. 26. P7 didn't have any major adverse reaction from the use of buprenorphine. P7 states that the minor side effects he experienced from using buprenorphine were mild drowsiness and feeling of fatigue.
27. The benefit was that P7 felt like he was really back to normal like before he was using. P7 felt like he was back to his old self. P7 felt like he could go out into the world and do what he wanted to do, the craving wasn't there. Everything about the buprenorphine program except the cost was totally beneficial to P7./	27. Other than the high cost of using buprenorphine, P7 felt that just having the feeling of being his old self, being able to go out into the world and socialize with others without the carving as well as feeling a sense of normalcy back in his life was the major benefits he received from using buprenorphine.

28. P7 would definite tell a person who was interested in get into a program like this. P7 would tell them of all the good thing about it, it will take away the craving, the trigger, the diarrhea, the upset stomach, and sleepiness or withdrawal symptom none of that was there for me when P7 was on the medication./	28. P7 would highly recommend buprenorphine to anyone who was interested in using buprenorphine as part of their aftercare program. P7 states he would be more than happy to share how buprenorphine was able to help him in alleviating his depression and other withdrawal symptoms.
Q5. 29. P7 started using the medication in detox for seven days and when P7 got out he went to see the doctor and he use the medication for nine months./	Q5. 29. P7 used buprenorphine for approximately seven day while he was in the detoxification unit. After being discharged from the hospital P7 was assessed by his doctor and prescribed buprenorphine. P7 use buprenorphine for approximately nine months while in aftercare.
30. P7 stopped using because of the lack of convenience of the doctor and mostly the cost of the medication and the visits. After P7 stopped using buprenorphine he felt that some of the old him and some of the trigger came back./	30. P7 abruptly terminated his use of buprenorphine due to financial hardship and inconvenience of available doctors. P7 shared that once he ended his treatment with buprenorphine P7 began to experience some of his old triggers again. The triggers as well as returning back to his addictive lifestyle led P7 back to using opiate drugs again.
31. From when P7 started to using, he kind of notices over a period of time he was agitated at things that use to not brother him or affect him and P7 started to have some of those old behavior that when he was using started to come back, the depression mildly came back./	31. P7 shares that once he stop using buprenorphine and he began to use opiate drugs again, P7 started to experience mild feeling of depression, becoming agitated easily as well as the return of his addictive and self defeating behaviors.

32. P7 was able to stay clean for about 3-4 months, after P7 stopped the medication. He felted like he didn't need the meeting any more, so P7 stopped going to the home group and hanging out with the people he went to meeting with. So all that, led me back to my old ways and pick up and started using. P7 felt like he didn't need to be in meetings and he already knew everything that was to know./	32. P7 was able to abstain from opiate use for approximately 3-4 months after he stopped using buprenorphine. P7 withdraw from his NA home group and the people that he would usually associate with in the meeting. P7 felt that he no longer needed to participate in the aftercare program, but not taking the medication and participating in the aftercare program only led P7 back to his addictive lifestyle.
33. P7 went through the steps, P7 didn't do the program and he was clean for this period of time, you know he was fixed, P7 though he was cured of his disease, which P7 know now you're never cured./	33. P7 stated after once he stopped using buprenorphine he was not truly committed to any program. P7 confessed that he just pretended to follow through with the aftercare and NA meeting. In P7 state of mind he believed that he was cured of his addictive behavior. Reflecting back P7 know now that he was not cured from his addiction to opiate drugs.
34. After P7 was taken off the medication P7 started to withdraw and stopped participating in aftercare any because P7 was thinking he was clean and cured./	34. P7 stopped participating in his aftercare program, he felt he didn't need the program anymore because he was sober and cured from opiates.
35. P7 feels it's a total benefit. That is one thing he would do if he call a detox unit is ask if they used buprenorphine as part of the aftercare program. P7 wouldn't enter a treatment program if they didn't offer buprenorphine as part of their treatment program./	35. P7 believes that using buprenorphine in aftercare would be a major benefit for the individual experiencing depression or other physical symptoms. P7 states that if he was a client seeking to detoxify off opiate drugs, the first thing he would ask of the program would be if they used buprenorphine as part of the aftercare program, if not P7 would look for a program that offered buprenorphine as part of aftercare.

36. P7 think it's a miracle program, and P7 would back an aftercare program a 100% for using buprenorphine./	36. P7 perception of buprenorphine is that it acts as a miracle drug toward alleviating the depression and withdrawal symptoms from opiate. P7 would stand by and support any program that would use buprenorphine in their aftercare program.
37. The only weakness P7 see is that you might feel a little bit guilty for using the medication because you are kind of cheating because you still not clean you still need a substance to maintain you sobriety./	37. P7 warns that an individual may have a sense of guilt for using buprenorphine. The guilt may be related to having to use buprenorphine to abstain from opiate use. The stigma of using buprenorphine is that you may feel as if you are cheating or that you really haven't achieve your sobriety because the person is still dependent on a substance to maintain their sobriety.
38. P7 don't see much abuse with the medication./	38. P7 admitted that he was unaware of anyone abusing buprenorphine.
39. But what P7 was told in NA is that you have to be totally clean. But P7 have a lot of friend in NA that went to the doctor and got the same result with buprenorphine. They did very well and stay in the program and once they stopped the medication they drop-out of the program and wasn't too interested any more in maintaining their sobriety and when back to using./	39. Although their was a negative connotation in the NA meets against the use of buprenorphine, because their philosophy was that you must be free of all substance to be truly sober or free of chemical substance. P7 realized that there were several members of his NA group that were using buprenorphine and had received the same positive outcome as P7 didn't. When those members abruptly stopped their treatment with buprenorphine, just as P7, those individuals drop-out of the program, was unable to maintain their

	sobriety and relapse back to their drug of choice.
40. P7 can say it was kind of addicting because it was one on the first thing P7 did in the mornings. P7 felt like he wanted to take his medication because that was the best way you eliminate the craving before they start./	40. P7 stated that at times he felt that he was becoming too dependent on the buprenorphine when he was taking it. P7 compares his dependency on buprenorphine as being addictive to opiates. P7 confessed that taking the buprenorphine was usually the first thing on his mind in the morning when he got out of bed. P7 felted he needed the medication because it alleviate the withdraw symptoms.
Q7. 41. In closing, P7 think this was the best thing he ever came across in his treatment and P7 wouldn't have been able to maintain one day of sobriety without this medication. P7 wouldn't go to a facility that didn't offer this. P7 believe it has changed his life 100% for the better./	Q7. 41. P7 truly believe that buprenorphine turn his life around from being unmanageable and out of control to a manageable and productive lifestyle. P7 felt that buprenorphine was the only way he was going to overcome his addiction and maintain his sobriety from opiate drugs.
42. P7 wish there was more access to this medication, it's kind of hard to see a doctor, not many doctors prescribed it and the price is very expensive. Hopefully over time that will change, so definitely P7 is 100% that this is the best way to go for an aftercare and treat your addiction and deal with your depression once you do get clean and stop using./	42. P7 stands by the use of buprenorphine in aftercare a 100% to treat depression or any other physical symptoms an individual may be experiencing after the use of opiate drugs. P7 believes that there need to be more access to getting the medication. P7 believed that better access could be accomplished by have more doctors certified to prescribe buprenorphine, the cost be less expensive, their need to be some type of financial assist, or resources for those individuals unable to pay out of pocket for the medication.