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# The Lived Experience of Using Opiates Among Young Adults

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# THE LIVED EXPERIENCE OF USING OPIATES AMONG YOUNG ADULTS

by

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ABSTRACT

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The purpose of this research study is to explore the lived experience of using opiates, as described by young adults aged 18 to 25 years. Over the last 2 decades, opioid use disorders (OUDs) and opiate overdose deaths have increased dramatically in the United States. What used to be a problem primarily contained to minority groups in poor inner-city areas is now increasingly common in all races, genders, ages, and classes. There has also been an alarming increase in opiate use—including fentanyl, both legal and illegal—among young adults. While much of the literature has been focused on the opiate use and those with OUDs, there is limited research on the lived experiences of opioid use. The results of this study add to the growing body of research in this population.

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To my mother (Margaret Towela Dongo), words cannot express what you mean to me. Thank you for your strength, love, and guidance. You taught me to never to give up. To always see the possibilities in every situation.
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DEDICATION

I dedicate this dissertation to the memories of my father (Dr. Simeoni Wiziman Mbewe Kunkhuli and my brother (Pio Mbewe Kunkhuli). Dad, every step of the way, I felt your presence. When I wanted to give up, I remembered how you told me about reading by candlelight late at night in your home in Kunkhuli village in order to get an education. How your mother gave you her last kwacha to send you to school. And you did it eventually, getting your EdD from Teacher's College, Columbia University. Thank you for setting such high standards.

Pio, you are the angel we lost within the first year of coming to this country. You have protected us, guided us, and reminded us to live our lives to the fullest. I am forever grateful and your forever-loving sister.

# CHAPTER I: AIM OF THE STUDY

## Introduction

In 2017, the U.S. Department of Health and Human Services (HHS) declared the opioid crisis to be a public health emergency (Centers for Disease Control and Prevention [CDC], 2018b). The language in the public discourse on the problem is confusing due to the multiple terms used to describe it, including *opioid addiction*, *opioid dependence,* and *opioid use disorder* (OUD). In the context of the current study, addiction was defined as a chronic brain disease that shares similarities with other illnesses that can be characterized by neurobiological, genetic, behavioral, developmental, psychosocial, and environmental factors that may influence their development and manifestations (American Society of Addiction Medication [ASAM], 2011). Greater clarity of meaning and understanding is needed to address this major health problem and facilitate treatment, recovery, and the prevention of relapse.

Physical dependence has been defined as a result of the brain adaptation to repeated expose to strong psychoactive drugs which results in tolerance (Kosten & George, 2002). A dependent individual requires more and more of the drug to achieve the initial positive effect and relies on continued use of the drug to prevent painful and uncomfortable withdrawal symptoms. Even when used as directed, opioids can cause physical dependence. Unlike addiction, physical dependence can be managed and resolved by slowly lowering the dose, or "tapering." A person who is physically dependent on prescribed opioid medications but is not addicted does not experience a loss of control, intense cravings, compulsive drug use, a failure to meet work, social, or family obligations, or other adverse symptoms that characterize addiction.

Addiction is also reported to involve impaired control over drug use, compulsive use, and continued use despite harm and craving (World Health Organization, n.d.). Typically, a person who is an addict uses the drug to excess—and, over time, is primarily motivated by the need to

acquire and abuse the drug. This may lead to an addict's loss of employment, home, friendships, and family relationships. Given the current alarming statistics on the opioid epidemic, the purpose of this paper was to explore the lived experiences of opioid use among young adults.

**Background**

There are several different types of opioids. Prescription opioids are prescribed by doctors to treat moderate to severe pain (CDC, 2018a). Examples include oxycodone (OxyContin®), hydrocodone (Vicodin®), codeine, morphine, and many others (National Institute on Drug Abuse [NIDA], 2016). Fentanyl, another type of prescribed opioid, is more potent than the opioids mentioned above. Fentanyl is approved for treating severe pain, such as is found in advanced cancer. Unfortunately, fentanyl can be illegally made and distributed. Heroin is also an illegal opioid that has drastically contributed to the opioid epidemic.

In the 1990s, when pharmaceutical companies reassured the medical community that patients would not become addicted to prescription opioid pain relievers (HHS, 2017), healthcare providers increased the prescription of opioids. This increased prescription led to widespread misuse of both prescription and nonprescription opioids before it became clear that these medications were highly addictive. Furthermore, some patients who could not afford the prescribed opioids resorted to using cheaper illegal opioids, such as fentanyl or heroin.

In the United States, the misuse of opioids has affected both males and females across different age groups with diverse social, racial, and economic backgrounds with devastating consequences (AARP, 2015; Cicero et al., 2014). People who were not characteristically identified as being at risk for opioid addiction are now the new face of this epidemic. The opioid epidemic is no longer confined to dark alleys in urban neighborhoods. The most significant surge is among groups that have historically lower rates of opioid abuse: women, White Americans,

and middle-class households (AARP, 2015; Cicero et al., 2014; Dart et al., 2015; Maxwell, 2011; Rose, 2018).

The Centers for Disease Control and Prevention (CDC, 2018b) estimated that the total economic burden of prescription opioid misuse alone in the United States is $78.5 billion per year. This includes the costs of healthcare, lost productivity, addiction treatment, and criminal justice involvement (Curtin et al., 2017; Florence et al., 2016). Although most people take prescription medications responsibly, an estimated 54 million people (more than 20% of those aged 12 years and older) have used such medications for nonmedical reasons at least once in their lifetime. The reasons for the high prevalence of prescription drug misuse vary by age, gender, and other factors, but may include factors such as ease of access, misinformation about the addictive properties of prescription opioids, and the perception that prescription drugs are less harmful than illicit drugs. As mentioned earlier, misuse of opioids has affected many nontraditional opioid abusers with an aggravating risk factor among young adults.

**Opioid Use by Young Adults**

In the United States, the Substance Abuse and Mental Health Services Administration (SAMHSA) uses the annual National Survey on Drug Use and Health (NSDUH) to collect data on the scope and prevalence of substance use, misuse, and related disorders, as well as utilization of substance disorder treatment among Americans aged 12 years and older. The annual survey provides tables with general statistics for the United States as a whole, as well as tables for subpopulations. Stakeholders vested in substance abuse prevention and treatment such as the SAMHSA, the National Institute of Health (NIH), and the CDC, the National Institute on Drug Abuse (NIDA), law enforcement, and health providers use this research to inform policy, treatment, and prevention.

The most recent data from NSDUH collected by SAMHSA illustrate that young adults have continued to misuse opioids and have unmet needs in relation to effective drug treatment (McCance-Katz, n.d.). For example, 2.5 million of those aged 18 to 25 years continue to misuse prescription pain relievers, 214,000 have used heroin, and 665,000 have used cocaine (SAMHSA, 2018). In addition, the 2017 NSDUH data showed that transitional age youth (18 to 25 years) as described by SAMHSA have increasing rates of serious mental illness, major depression, and suicidality when compared to 2015 data (SAMHSA, 2018).

According to NIDA (2016), young adults ages 18 to 25 years are the biggest abusers of prescription opioid pain relievers, attention deficit hyperactivity disorder (ADHD) stimulants, and anti-anxiety drugs. About one out of every six American young adults, or 16.3%, battled a substance use disorder in 2014 (Center for Behavioral Health Statistics and Quality, 2015), the highest percentage of any age group. Also, heroin addiction among young adults in this age bracket has doubled in the past 10 years (NIDA, 2016).

The young adult is not clearly defined in the literature. There is no precise age distinction for when an adolescent becomes a young adult and when a young adult becomes an adult. Various terms were noted in the literature to describe young adults. Terms such as *late adolescents*, *youth*, *early adult*, and *emerging adults* are often used interchangeably and with arbitrary age ranges. For example, the U.S. Census described young adults as being ages 18 to 34 years in some correspondence (U.S. Census Bureau, 2017), the Affordable Care Act describes young adults as 18 to 26 years, and SAMHSA uses the age range of 18 to 25 years. Also, young adults were often grouped with adolescents or with adults when discussed in research and policy. In the annual NSDUH survey, young adults are categorized as 18 to 25 years old; thus, this was the definition adopted in the current study.

Regardless of how young adulthood is defined, it is consistent in the literature that young adulthood is a unique time period fraught with many challenges and opportunities, a significant time when adolescents transition into adulthood. Young adults are generally expected to become financially independent, establish romantic relationships and perhaps become parents, and assume responsible roles as productive and engaged members of the community. As with all transitional periods across the lifespan, there are biological, physiological, psychological, cultural, environmental, and social changes and structures that may influence how well effective transition and maturation occur.

There is evidence that young adult health issues, in particular opioid use and misuse, may start in adolescence (HHS, Office of the Surgeon General, 2018) and misuse of opioids in adolescence may place a young adult at a higher risk for opioid misuse (Neinstein & Irwin, 2013; Park et al., 2006, 2014; Spitsbergen, 2017). Despite this knowledge, the health issues of young adults have received little attention compared with those of adolescents and adults. Critical health issues among young adults include reproductive health, injury, substance use, mental health, violence, obesity, and access to health care (Park et al., 2006). Even though young adult health issues parallel those of adolescence, young adults fare worse than adolescents in many areas such as rates of injury, homicide, and substance use, which peak in young adulthood. Compared to adolescents, for example, young adults have higher rates of substance use, including alcohol, tobacco, and marijuana use and drinking and driving, as well as higher rates of obesity, sexually transmitted infections, motor vehicle crash mortality, and homicide (Park et al., 2014).

An additional concern is that young adults are known to have the lowest rate of health insurance compared to other age groups (Centers for Medicare and Medicaid Services [CMS],

Center for Consumer Information & Insurance Oversight, n.d.). About 30% of young adults are uninsured, representing more than one in five of the uninsured. This rate is three times higher than the uninsured rate among children (CMS, Center for Consumer Information & Insurance Oversight, n.d.). Young adults also have the lowest rate of access to employer-based insurance. As young adults transition into the job market, they often have entry-level jobs, part-time jobs, jobs in small businesses, and other employment that typically comes without employer-sponsored health insurance. The uninsured rate among employed young adults is one third higher than that of older employed adults. Therefore, the health of young adults is at risk. Contrary to the myth that young people do not need health insurance, one in six young adults has a chronic illness such as cancer, diabetes, or asthma, and nearly half of uninsured young adults report problems paying medical bills (CMS, Center for Consumer Information & Insurance Oversight, n.d.).

The emergence of the opioid crisis highlights the need for social and institutional support to help young adults transition into competent, fully functional, successful adults. A holistic systematic approach is needed to understand and respond to the unique circumstances and needs of today's young adults. The findings of the current study shed light on the needs of opioid-dependent young adults.

**The Nursing Challenge**

In this investigation, the phenomenon under study was opioid use among young adults. I sought to uncover the experience of opioid use among young adults. A better understanding of this experience can inform nurses' work with persons at risk for opioid use problems. Researchers have shown that some healthcare professionals have a negative and stigmatizing attitude toward people with addictions (Henderson, 2018; Howard, 2015; Livingston et al., 2012). There may be a lack of faith that people with opioid dependence can recover. Some

healthcare providers also report fear of violence, manipulation, and low motivation as hindering factors in the treatment of people with addiction (van Boekel et al., 2013). Patients reported that healthcare professionals lacked adequate training and support when working with them. The negative attitudes of staff contributed to patients' experiences of decreased empowerment and decreased determination of treatment efficiency (van Boekel et al., 2013).

Nurses are in a unique position, in that they are often the first point of contact with clients in treatment centers. It is essential that nurses not be task-oriented exclusively and participate in their clients' care in a comprehensive manner that is patient-centered, individualized, and empathetic. Understanding the needs of opioid-dependent young adults may assist in helping to provide nursing care in a skilled, competent, and holistic way. It is imperative that nurses participate in the emerging research on opioid dependency.

**The Experience of Opiate Use: A Nursing Approach**

As stated previously, there is an opioid epidemic in the United States, and young adults are particularly at risk. Having declared a public health emergency in 2017, HHS has announced a five-point strategy to combat the opioid crisis. This strategy includes better addiction prevention, treatment, and recovery services, better data collection, better pain management, better targeting of overdose-reversing drugs, and better research. HHS is supporting research on pain and addiction to inform clinical practices, reduce opioid prescribing, and combat the opioid crisis. Many studies have been done on opioid use among adults with a few studies done on adolescents. These show a promising preliminary trend of a decrease in opioid usage.

The dominant social view of persons using drugs is one of stigma and shame and the dominant scientific view on drug abuse is one of a public health problem, biochemistry, or psychopathology. Unlike these views, an existential phenomenological view starts with the first-hand experience of persons using drugs in their own words. Young adults are abusing opioids at

an alarming rate with devastating consequences. It is, therefore, necessary to explore the lived experience of opioid use among young adults.

**Significance to Nursing**

Through this study, I uncovered the unique presentations of opioid use among young adults. There is an opioid epidemic in the United States, and young adult deaths from opioid overdoses are on the rise. As stated earlier, since the opioid epidemic has been declared a public emergency, there is an urgency for research to better understand opioid use and treatment. Once afflicted, clients seek care in the many diverse health care centers with nurses in a unique position in that they are often the first point of contact with patients. It is imperative that nurses be aware, involved in opioid usage research, and skilled in handling patients who use opioids.

**Purpose of the Study**

The purpose of this study was to explore, describe, and understand the lived experience of opioid use as talked about by young adults. Participants were asked what it is like using opiates. All of the participants were between ages of 18 and 25 years old and had acknowledged using opiates more than occasionally (more than 3 times per month) and for more than 6 months. The participants indicated their current age, at what age they first used opiates, and whether they used opiates more than occasionally for at least 6 months. The participants do not have to be currently using opiates, and they can be on buprenorphine or methadone. Only persons fluent in speaking and reading English and who were willing to sign informed voluntary consent were included. Persons who appeared to be intoxicated or reported using any psychoactive drug on the day of the interview were excluded.

I analyzed the themes and essences that arise for any insight into how young adults are affected by opioid usage. This study may supply nurses, parents, teachers, and other healthcare providers with valuable information on the psychosocial, environmental, and economic

determinants of opioid use and its consequences. This information could be used to expand or enact new policies and to develop or continue existing interventions to improve the health, safety, and well-being of opioid-dependent young adults.

## Research Question

The research question that guided this study was: What is the lived experience of using opiates? I selected van Manen's (1990) interpretive phenomenological design to explore this phenomenon.

## Assumptions

Assumptions are the explication of presupposition or unfolding ontology regarding the elements or meaning of an experience such as opioid use (van Manen, 1990). This way of knowing relies upon a few basic assumptions, or what is already known about the phenomenon. My assumptions and biases are based on the fact that as a nurse, I have taken care of patients who have struggled with opioid use, and I have some family members who have misused opioids. From these personal and professional experiences and a review of the research, it is understood that many people start with prescription opiates and progress to heroin, and that opioid use disorder is associated with considerable suffering for the person, family, and society, but recovery is possible.

## Summary

Chapter I described the phenomenon of interest for this phenomenological study, which is to examine the lived experience of opioid use among young adults. The aim and justification of the study were discussed, along with implications for nursing practice. Chapter II contains a brief literature review of the phenomenon of interest.

# CHAPTER II: LITERATURE REVIEW

## Introduction

The rates of opioid use, OUDs and opiate overdose deaths among the young adult population are on the rise. In addition, there is a lack of studies exploring their lived experiences with opioid use, the need to bridge the gap between young adult opioid use and effective treatment needs is apparent. The purpose of this study was to increase the current understanding of the experience of young adult opioid users. I hoped that the results of the current study would guide further research and lead to effective methods to treat opioid dependency in young people.

In order to investigate the phenomena of opioid usage, I reviewed what previous researchers have discovered regarding the phenomenology of using opiates. The literature review for Chapter II was collected from a variety of sources utilizing current databases and numerous search terms in locating current articles, books, and dissertations. Search engine databases including CINAHL complete, PsychInfo, Medline, ERIC, Social Sciences, and PsycARTICLES were used to locate the research published on the phenomenology of opioid use. Key search terms included but are not limited to *opiates*, *drugs*, *drug addiction*, *opioid addiction*, *opioid dependence*, *opioid use*, *young adults*, and *phenomenology*. Once the literature review was conducted, four key topic areas were identified. The following section elaborates on these main areas.

## Literature Review of Opioid Use in the United States

Research related to the lived experience of opioid use in young adults is limited. Most existing research has focused on identifying trends and growth in opioid use as well as risk factors for opioid use, both legal and illegal. A majority of these studies have been quantitative and used standardized survey instruments to identify trends and motivating reasons for opioid

use (Han et al., 2017; International Narcotics Control Board, 2009; Maxwell, 2011; McHugh et al., 2015; Wilkerson et al., 2016).

***Trends***

There are many ways to track trends and motivations for opioid use, but as stated previously, data collected by SAMHSA utilizing the NSDUH are widely utilized to inform research studies. Han et al. (2017) conducted a study to evaluate the prevalence of prescription opioid use, misuse, and use disorders and motivations for misuse among U.S. adults based on the 2015 NSDUH data. They reported that 72,600 eligible civilians, noninstitutionalized adults, were selected for the NSDUH, and 51, 200 completed the survey. The results estimated that in 2015, 91.8 million (37.8%) U.S. civilian, noninstitutionalized adults used prescription opioids; 11.5 million (4.7%) misused them; and 1.9 million (0.8%) had a use disorder. Among adults with prescription opioid use, 12.5% reported misuse; of these, 16.7% reported a prescription opioid use disorder. The most commonly reported motivation for misuse was to relieve physical pain (63.4%). Misuse and use disorders were most commonly reported in adults who were uninsured, were unemployed, had low incomes, or had behavioral health problems. Among adults with misuse, 59.9% reported using opioids without a prescription; 40.8% obtained prescription opioids for their most recent episode of misuse for free from friends or relatives. The main limitation was that the study was cross-sectional and used self-reported data.

Other studies have analyzed different types of programs to track trends in opioid analgesic abuse and mortality in the United States. For example, Dart et al. (2015) analyzed five programs from the Researched Abuse, Diversion, and Addiction-Related Surveillance (RADARS) System to describe trends between 2002 and 2013 in the diversion and abuse of all products and formulations of six prescription opioid analgesics: oxycodone, hydrocodone, hydromorphone, fentanyl, morphine, and tramadol. These programs gather data from drug-

diversion investigators, poison centers, substance abuse treatment centers, and college students (Dart et al., 2015). Data in the Drug Diversion Program records the drugs involved in cases opened by law-enforcement agencies investigating prescription-drug diversion in 49 states utilizing standardized reports from law enforcement agencies. The Poison Center Program records the substances involved in poison-center cases classified as intentional abuse from electronic medical records in 49 regional U.S. poison centers in 46 states (91.5% of the total U.S. population). The information on record is provided by patients, acquaintances, or healthcare providers. Using standardized questionnaires, the Opioid Treatment Program and the Survey of Key Informants' Patients (SKIP) Program query new patients upon admission to substance abuse treatment about the medications that they have abused in the previous 30 days. Using a web-based approach, the College Survey Program asks self-identifying college students about their nonmedical use of prescription drugs during the previous 30 days. In general, RADARS System programs reported large increases in the rates of opioid diversion and abuse from 2002 to 2010, but then the rates flattened or decreased from 2011 through 2013. The rate of opioid-related deaths rose and fell in a similar pattern. Reported nonmedical use did not change significantly among college students.

In an earlier study by Maxwell (2011), data from surveys, emergency room visits, treatment admissions, overdose deaths, and toxicology laboratory findings were collected to examine trends in opioid use. The surveys and emergency department visits showed that use was lowest among young teenagers and highest among older teenagers and young adults, with significant increases among those aged 55 years and older. The length of time between initial use of an opioid other than heroin and admission to treatment was shown to be shortening.

### *Young Adults*

In young adult opioid use research, the pattern is similar, in that it focuses on identifying risk factors and motivations for opioid use rather than the lived experience of young adult opioid users (Drazdowski, 2016; McCabe et al., 2014; Parks et al., 2017; Rozenbroek & Rothstein, 2011). Most studies looking at the trends and motivators for opioid use were conducted among undergraduate college students who were assessed for nonmedical use of prescribed drugs (NMUPD) (Drazdowski, 2016; McCabe et al., 2014; Rozenbroek & Rothstein, 2011). Nonmedical use of prescribed drugs occurs when individuals use medications that were not prescribed to them, use their prescribed medications in higher quantities, or take medications for purposes other than prescribed (NIDA, 2016).

In an online survey of 527 university students from 4-year institutions ages 18 to 25 years, Lord et al. (2011) found that most young adults used prescription opioids not for the intended purpose but for other reasons. In this study, the three major reasons why students used NMUPDs were to relax (72%), get high (68%), and have fun (65%). Other reasons stated for misusing prescription opioids were to experiment, cope with depression or anxiety, manage chronic pain, improve concentration, improve energy, perform better at school, stay up at night, counteract other drugs, increase alertness, and perform better at work.

In another study, some authors from the previous study investigated opioid use among 950 PharmD students training to become pharmacists in a college of pharmacy in the United States (Lord et al., 2011). Similar to the findings in the general population of American college students, these PharmD students used opioids to have fun (31%), relax (29%), and to manage chronic pain (23%). In this study more students reported using prescription opioids to manage chronic pain (23%).

This research on trends of the opioid epidemic has also been instrumental in illustrating the changing demographics of opioid use. For example, in the mixed-methods study of Cicero et al. (2014), the researchers analyzed the claim that heroin abuse had migrated from low-income urban areas with large minority populations to more affluent suburban and rural areas with primarily white populations and also analyzed the relationship between the abuse of prescription opioids and the abuse of opioids. These authors used structured, self-administered surveys to gather retrospective data on past drug use patterns among patients entering substance abuse treatment programs across the country who received a primary (DSM-IV) diagnosis of heroin use/dependence ($n$ = 2797). In addition, data were analyzed from unstructured qualitative interviews with a subset of patients ($n$ = 54) who completed the structured interview. Approximately 85% of treatment-seeking patients approached to complete the Survey of Key Informants' Patients Program did so. Respondents who began using heroin in the 1960s were predominantly young men (82.8%; mean age, 16.5 years) whose first opioid of abuse was heroin (80%); however, more recent users were older (mean age, 22.9 years) men and women living in less urban areas (75.2%) who were introduced to opioids through prescription drugs (75.0%). Whites and non-Whites were equally represented in those initiating use prior to the 1980s, but nearly 90% of respondents who began use in the last decade were White. Although the "high" produced by heroin was described as a significant factor in its selection, this opiate was often used because it was more readily accessible and much less expensive than prescription opioids (Cicero et al., 2014).

In some cases, the aforementioned research studies raised more questions than they answered because the standardized survey instruments did not give the context for opioid use. A participant asked whether they abuse opioids may answer affirmatively. The response indicates

that the participant has used opioids, without providing a context as to why opioids were used. In addition, although the research has been helpful in identifying the growth in opioid use as well as risks for opioid use, there has been no consensus on the assessment of risk for opioid abuse (Minozzi et al., 2013).

## Qualitative Research

Currently, there is a resurgence in the literature to explore the complexities of opioid use in the participant's own words via qualitative research. This qualitative research is diverse in its aim, the population studied and the targeted opioids. For example, the qualitative studies on prescription opioid abuse explored motives for opioid prescription abuse, initiation into prescription use and or prescription abuse, and general opioid treatment experiences.

### *Motives for Prescription Drug Misuse*

In a mixed-method study, Rigg and Ibañez (2010) examined the motivations for engaging in the nonmedical use of prescription opioids and sedatives among street-based illicit drug users, methadone maintenance patients, and residential drug treatment clients aged 18 to 60 years. In addition, they examined associations between prescription drug abuse motivations and gender, age, race/ethnicity, and user group; and associations between specific motivations and prescription drug abuse patterns. Quantitative surveys ($n$ = 684) and in-depth interviews ($n$ = 45) were conducted with a diverse sample of prescription drug abusers in South Florida between March 2008 and November 2009. The three most common motivations reported were "to get high," "to sleep," and "for anxiety/stress."

Using a very different approach, Merlo et al. (2013) explored the reasons for prescription drug misuse among physicians referred to a physician health program for monitoring due to substance-related impairment. In this study, a total of 55 physicians (94.5% male, mean age 53 years old, 71.7% White, 20.8% Latino, 7.5% other) who were being monitored by their state

professional health program due to substance-related impairment participated in guided focus group discussions. Participation was anonymous. Discussions were transcribed from nine separate focus groups that lasted 60 to 90 minutes each. The researchers conducted the qualitative analyses utilizing the grounded theory method (Strauss & Corbin, 1990) to examine themes. All participants were diagnosed with substance dependence, and 69.1% of them endorsed a history of misusing prescription drugs. Participants documented five primary reasons for prescription drug misuse: (a) to manage physical pain, (b) to manage emotional/psychiatric distress, (c) to manage stressful situations, (d) for recreational purposes, and (e) to avoid withdrawal symptoms.

In another study, Rigg and Murphy (2013) explored the etiology of prescription opioid abuse (POA). Their sample of prescription opioid abusers in substance abuse and treatment programs gave narrative accounts of the circumstances surrounding their POA onset. The total sample ($N$ = 90) included Black/African American ($n$ = 9), White ($n$ = 70), and Hispanic/Latino heterosexual participants ($n$ = 11) ranging in age from 18 to 51 years (mean = 31 years). A total of 52 men and 38 women comprised the final sample. A little over half of the sample (57%) possessed a high school diploma (or equivalent); a small number (9%) reported acquiring a college degree; and an even smaller number were attending or had recently (within the past 3 years) attended college (8%). One third (33%) of the participants had recently experienced housing instability, such as living in a shelter, and a large majority of the participants (82%) came from a substance-abusing family, with at least one parent or sibling who abused drugs or alcohol. Audiotapes of in-depth interviews were transcribed, coded, and thematically analyzed.

After analyses, Rigg and Murphy (2013) identified the presence of four trajectories leading to POA: the South Florida effect, male influence, the cocaine context, and prescribed

addiction. The South Florida effect had to do with the perception that the heroin in Florida was of poor quality and hard to acquire, with the result that certain individuals transitioned to prescribed opioids. Some female participants reported transitioning to prescribed opioid abuse after seeing their significant others abuse prescribed opioids (male influence). Others used prescribed opioids to moderate the high or dangerous effects of cocaine use (cocaine context), and some participants started abusing opioids after obtaining them for legitimate medical reasons, such as postoperative pain relief).

***Initiation***

Other studies explored the initiation into opioid use (Daniulaityte et al., 2006; Harocopos et al., 2016; Lankenau et al., 2012). In a mixed-method study, Lankenau et al. (2012) described patterns of initiation into prescription opioid misuse among intravenous drug users (IDUs) ages 16 to 25 years. Young IDUs who had misused a prescription drug at least three times in the past 3 months were recruited during 2008 and 2009 in Los Angeles ($n$ = 25) and New York ($n$ = 25). Informed by an ethno-epidemiological approach, descriptive data from a semi-structured interview guide were analyzed both quantitatively and qualitatively. These researchers found that initiation into prescription opioid misuse was facilitated by easy access to opioids via participants' own prescription, family, or friends, and occurred earlier than misuse of other illicit drugs, such as heroin. Nearly all transitioned into sniffing opioids, most injected opioids, and many initiated injection drug use with an opioid. Motives for transition to sniffing and injecting opioids included obtaining a more potent high and/or substituting for heroin; access to multiple sources of opioids was common among those who progressed to sniffing and injecting opioids (Lankenau et al., 2012).

As the prevalence of opioid analgesic (OA) misuse and associated harms has increased in the United States, the prevalence of heroin use and rates of unintentional overdose have risen

concurrently (Harocopos et al., 2016). Researchers have begun to explore the relationship between opioid analgesic misuse and heroin use. A study by Harocopos et al. (2016) explored the context of heroin initiation among persons with histories of opioid misuse in New York City. In-depth interviews were conducted with individuals with histories of OA abuse between August 2013 and January 2015. Participants ($n$ = 31) ranged in age from 18 to 44 years (median = 22); six identified as female and 25 as male. The majority ($n$ = 30) identified as non-Hispanic White and heterosexual. All participants had stable housing at the time of the interview, and all were high school graduates. The participants described several key points of transition along their trajectories from OA misuse to heroin initiation. There was a progression from using dual-entity pills (pills containing both an opioid compound, either oxycodone or hydrocodone, and acetaminophen) to single-entity OAs (pills containing only one opioid with no other active ingredient). A common reason for this change given by the participants was to protect their organs from internal damage. The third transition was from oral single-entity intake to intranasal OA administration; the fourth transition was from intranasal OA to heroin use. The majority of participants discussed the transition to single-entity pills and intranasal administration as leading to increased frequency of use and, consequently, physical opioid dependence, which contributed to the use of heroin. The development of physical dependence was seen as a big contributing factor in using heroin and overcoming any existing heroin stigma in order to control opioid withdrawal symptoms.

Some studies show that part of the motivation to use prescribed opioids stems from a perception that prescribed opioids produce a good, dependable, “safe” high because unlike heroin, the dose is known with certainty and the pill is labeled clearly—thus, it is thought, greatly reducing the risk of overdose (Back et al., 2011; Daniulaityte et al., 2006, 2012;

Lankenau et al., 2012; Mars et al., 2014; Rigg & Murphy, 2013). In addition, the medications are legal, which may translate to fewer legal problems for possession with intent to abuse or distribute (Cicero & Ellis, 2017).

***Treatment***

As the devastating consequences of opioid misuse increase, researchers are interested in finding out how patients being treated for opioid misuse seek treatment and experience the general healthcare system (Andraka-Christou & Capone, 2018; Barry et al., 2010; Gilbert, 2011; Henderson, 2018; McMurphy et al., 2006; Spitsbergen, 2017). Gilbert (2011) used a qualitative phenomenological case study design to explore the lived experiences and unique treatment needs of the young adult heroin user. The six participants in the study, who ranged in age from 18 to 24 years, were diagnosed with opiate (heroin) dependency and actively involved in an out-patient treatment setting. Data were collected using semi structured interviews and then analyzed using qualitative, case study methods of coding to uncover themes. The research question that guided the study was: "What are the lived experiences and unique treatment needs of young adult heroin users engaged in treatment?" Upon conclusion of all data collection and analysis the emerging themes were identified; they included social support, consequences, accountability and responsibility, drug testing, regaining a life and goals, family relationships, and trust. The concept of social support was the predominant theme that emerged. Participants felt as though their ability to maintain abstinence was directly related to their access to social support among a similar peer group of the same age.

Utilizing an ethnographic perspective, Henderson (2018) sought to explore the experience that opioid addiction patients have within the framework of emergency care. The central field site selected for this study was the ED of an urban trauma-level research hospital. The researcher sought to document the process of care for those in opioid crisis and the

challenges healthcare providers face in facilitating this care. The research utilized participant observation to focus on patients who arrived in the ED in acute opioid crisis and the hospital personnel that administered treatment to them. In addition to participant observation and qualitative analysis, 15 interviews with ED staff were conducted along with three in-depth life history interviews with three participants in order to achieve a more holistic view of addiction.

Henderson (2018) described the participant demographics as being thoroughly anonymized. Healthcare providers were described as running the gamut regarding ethnicity and gender, while the opioid-addicted participants were described as being mostly female and Caucasian. The findings of this study suggested that stigma permeates the interactions drug-addicted patients have with healthcare professionals, which may have a negative impact on their decision to seek further treatment. Overdose victims reported experiencing stigmatized reactions, lack of access to resources, and inadequate follow-up care during healthcare crises. Providers reported experiencing constraints regarding time with the patient in crisis and lack of funding options and pathways to utilize for extended care once patients were discharged from the ED.

Spitsbergen (2017) utilized a retrospective approach to explore the experiences of 26 young adults (18 to 25 years old) participating in various 12-step recovery programs in a Midwestern metropolitan region who had achieved continuous sobriety. Twenty-five participants were Caucasian and one was Black non-Hispanic. All participants were recruited from Alcoholics/Narcotics Anonymous meetings. This author used grounded theory methodology to gather and analyze data of participants' recollections of their adolescent addiction, treatment, and recovery histories. Analysis was conducted to create an explanatory model of how drug of choice influences levels of life impairment, readiness for treatment, and recovery processes in young adults who began using these substances during adolescence. Overall, participants' accounts

frequently included descriptions of severe reckless use, severe consequences, increased levels of isolation, elevated levels of depression, and suicide attempts. When users began using at younger ages the result was increased levels of impairment, frequency of incidental bouts of intense moods, and suicide attempts. All participants experienced relapse at some point in their lives. Many relapsed as soon as treatment concluded, and most participants had issues with depression well beyond 90 days of sobriety (Spitsbergen, 2017).

In summary, research has been conducted on opioid dependency in various ways. As pointed out previously, many researchers have focused on identifying trends and growth in opioid use as well as risk factors for opioid use. Most studies have been quantitative and used standardized survey instruments to identify trends and motivating reasons for opioid use (Han et al., 2017; Maxwell, 2011; McHugh et al., 2015; Wilkerson et al., 2016). The limited qualitative research on opioid dependency has explored motives for opioid prescription abuse, initiation into prescription use and or prescription abuse, and general opioid treatment experiences. Although the demographics of patients in the reviewed studies varied, most studies were conducted on older adults. There is a need for research on the phenomenology of the lived experience of young adults using opiates.

# CHAPTER III: METHODOLOGY

The phenomenological methodology of van Manen (1990) was used to explore the phenomenon of opioid use among young adults in this study. According to van Manen, phenomenology is a systematic process of uncovering and describing the internal meaning and structure of an event as it is lived in one's everyday existence, in one's lifeworld (van Manen, 1990). It is a way in which to study the human experience and issues that present themselves to humans within the context of specific experiences (van Manen, 1990). As not much was known about the lived experiences of young adults, I aimed to illuminate their particular experiences.

Phenomenology has been defined as a systematic process of uncovering and describing the internal meaning and structure of an event as it is lived in one's everyday existence, in one's lifeworld (van Manen, 1990). It is a way in which to study the human experience and issues that present themselves to humans within the context of specific experiences (van Manen, 1990). Phenomenology is not only a research method that is employed by qualitative researchers, but also a philosophy (Dowling, 2007). As a philosophy, the ideas of phenomenology draw heavily on the writings of German mathematician Edmund Husserl. Later, philosophers such as Martin Heidegger, Maurice Merleau-Ponty, and Max van Manen expanded on Husserl's ideas. The purpose of this qualitative phenomenological study was to describe and understand the lived experience of opioid use among young adults aged 18 to 25 years.

## Rationale for Selection

An essential component of nursing scholarship is an examination of the philosophical basis of knowledge development (Packard & Polifoni, 2002). As a discipline, nursing is concerned with understanding the human being as a holistic individual. Phenomenology has become a dominant means in the pursuit of knowledge development in nursing and presents "credible displays of living knowledge for nursing" (Jones & Borbasi, 2004, p. 99; Munhall,

2007). Phenomenology was chosen for this study because the training, expertise, and third-person posture of traditional medicine and psychological research marginalize ill persons. Phenomenology seeks to ameliorate this epistemic injustice (Carel & Kidd, 2014).

In this study, I recruited, gained the consent of, and interviewed young adult people who admitted to having used opioids in order to gain an understanding of their lived experience. As the researcher, I served as the instrument through which the participants were able to tell their stories, recollect, reflect, and share their experiences. Therefore, a phenomenological approach was chosen for this study. According to van Manen (1990), the phenomenological researcher uses inquiry and allows the participants to tell their experiences. Through a phenomenological inquiry, I sought to illuminate and reveal the phenomenon of the experience of opioid use among young adults.

**Philosophy of Phenomenology**

Phenomenology arose as a philosophy in Germany before World War I and has since occupied a prominent position in modern philosophy. The word *phenomenon* comes from the Greek *phainesthai,* meaning "to flare up," "to show itself," or "to appear" (Moustakas, 1994). Thus, the motto of phenomenology is *Zu den Sachen,* which means both "to the things themselves" and "let's get down to what matters!" (van Manen, 1990, p. 184). As a research tool, phenomenology is based on the academic disciplines of philosophy and psychology and has become a widely accepted method for describing human experiences. It is a qualitative research method that is used to describe how human beings experience a certain phenomenon.

A phenomenological study attempts to set aside biases and preconceived assumptions about human experiences, feelings, and responses to a particular situation. It allows the researcher to delve into the perceptions, perspectives, understandings, and feelings of those people who have actually experienced or lived the phenomenon or situation of interest.

Therefore, phenomenology can be defined as the direct investigation and description of phenomena as consciously experienced by people living those experiences. Phenomenological research is typically conducted using in-depth interviews of small samples of participants. By studying the perspectives of multiple participants, a researcher can begin to generalize what it is like to experience a certain phenomenon from the perspective of those who have lived the experience.

***Edmond Husserl (1859–1938)***

Phenomenology has its roots in a 20th-century philosophical movement based on the work of the philosopher Edmund Husserl. As such, Husserl is considered to be the founder of phenomenology. A transcendental phenomenologist, his main focus was on the pure description of the lived experience (Annells, 1996). This theorist's concept of the lifeworld refers to the direct experience of the everyday world in which the individual lives (van Manen, 1990). Husserl's phenomenology came to mean the description of phenomena as lived and constituted and experienced through consciousness. Through phenomenological reduction, Husserl (1931) asserted the elimination of all preconceived notions whereby a subject may come to know an essence directly; this is known as bracketing. Bracketing purifies the consciousness that is seen as intentional and necessary to achieve credibility and rigor and reduce bias. Intentionality refers to the internal experience and an inseparable connectedness of being conscious to the world (van Manen, 1990); therefore, essences are dependent on consciousness (Husserl, 1931).

It is this focus on seeing the full essence of things that is at the heart of phenomenological inquiry. In the current study, the human phenomenon of interest was opiate use among young adults within the context of their lived experiences. In the current study, I asked what young adults using opiates think, feel, and live, and how can such insight translate into effective help. It is within this ontological perspective that I attempted to understand complex, shared experiences

of opiate use with the broader goal of uncovering, developing, or supplementing treatment practices or policies that may be more effective than standard treatment.

***Martin Heidegger (1889–1976)***

Heidegger, who was also born in Germany, was concerned with human experience as it is lived. Heidegger differs from Husserl in his views of how the lived experience is explored, advocating the utilization of hermeneutics as a research method founded on the ontological view that lived experience is an interpretive process (Racher & Robinson, 2003). *Being in Time*, published in 1927, proposes that consciousness is not separate from the world of human existence; in it, Heidegger argues for an existential adjustment to Husserl's writings that interprets essential structures, such as basic categories of human experience, rather than pure, cerebral consciousness (Polkinghorne, 1983). Influenced by the Danish thinker Soren Kierkegaard (1813–1855), who is generally regarded as the founder of existential philosophy (Valle et al., 1989), Heidegger was one of the first thinkers to combine existential matters with phenomenological methodology.

Heidegger's focus was ontological. He believed that the primary phenomenon that concerns phenomenology is the meaning of *being* (presence in the world) (Cohen & Omery, 1994). To ask for the being of something is to ask for the nature or meaning of that phenomenon (van Manen, 1990). Heidegger also used the phrase *being-in-the-world* to refer to the way human beings exist, act, or are involved in the world (van Manen, 1990). He argued that understanding is a reciprocal activity and proposed the concept of *hermeneutic circle* to illustrate this reciprocity. The hermeneutic circle is viewed as one between preunderstanding and understanding, which Alvesson and Skoldberg (2000) labeled “the circle of alethic hermeneutics” (p. 57) to differentiate it from the original so-called hermeneutic circle (i.e., the part related to the whole) of objectivist hermeneutics.

***Maurice Merleau-Ponty (1908–1961)***

Merleau-Ponty, an existential phenomenologist, expanded on Husserl's ideas by focusing on the importance of the perception of experiences in the context of the individual's situation (Merleau-Ponty, 2008). Merleau-Ponty saw the existence of people in a pregiven world whereby they return to the very thing, in search of essences, seeing this as part of the lived and experienced world that has not been reflected upon. His phenomenology focused on the importance of perception and the individual's situation in the world through experience (Merleau-Ponty, 2008). Like Husserl, Merleau-Ponty's emphasis was on phenomenological description rather than interpretation, and he advocated for phenomenological reduction as a way to reach an original awareness. Several of this author's themes are critical to the philosophical foundation of this study and include the lived experience, embodiment, and primacy of perception.

Among these three these is the concept of consciousness, which Merleau-Ponty (2008) defined as sensory awareness and response to the environment. He saw consciousness as the state in which one relates to the world and allowed for description of one's lived experiences with the world, encouraging people to see the world as new, to rediscover it as if experienced for the very first time. The second theme is embodiment. This entails that through one's body, one has access to the world, and it is through perception that it is possible to know both interior and exterior worlds. The body is the anchor (Merleau-Ponty, 2008), and although the conditions of the world may limit the body, they do not determine it. People are in charge of determining their bodies through their own choices. Embodiment gives meaning to the space around itself. It is through consciousness and embodiment that people are aware of being in the world and gain access to the world. The third theme, primacy of perception, proposes to rediscover the first experience. Merleau-Ponty defined primacy of perception as the experience of perception of the

moment when things, truths, and values are constituted. He saw perception as the thing that forms and increases the awareness of the experience or reality that provides direct experience to the phenomena and the world.

Merleau-Ponty believed that through one's life experiences, it is possible to find meaning in and understand life itself. His philosophy is a perfect fit for my study given that he views humans as experiencing the world through the body, which is the most appropriate philosophical underpinning for this qualitative nursing research. Through consciousness and embodiment, young adults are aware of their being, their lived experience, and their perception in this world. Exploring the phenomenon of opiate use among young adults through specific human perceptions was my goal in the current study.

***Max van Manen***

Max van Manen, a Canadian social scientist and educational philosopher, described phenomenology as the difference between a research methodology and a research method. He referred to research methodology as the philosophical framework, the fundamental assumptions, and the characteristics of a qualitative approach. He described the research method as the techniques and procedures utilized to conduct the research (van Manen, 1990).

van Manen's (1990) phenomenological (existential-descriptive-hermeneutic) method is greatly influenced by Merleau-Ponty (existential), Husserl (descriptive), and Heidegger (interpretive) and consists of six research activities. Based on its recent development and the structure it provides for analyzing data, van Manen's phenomenological method was selected for this study. The six research activities are mentioned here but their specific application to this study are described in greater detail in the next chapter. The research activities included:

1. Turning to a phenomenon that seriously interests us and commits us to the world.
2. Investigating experience as we live it, rather than as we conceptualize it.

3. Reflecting on the essential themes that characterize the phenomenon.
4. Describing the phenomenon through the art of writing and rewriting.
5. Maintaining a strong and oriented pedagogical relation to the phenomenon.
6. Balancing the research context by considering parts and whole.

**Summary**

The primary goal of this study was to capture the essence of young adults who use opiates through describing the phenomenon and gaining a deeper understanding of their experience (van Manen, 1990). Utilizing a phenomenological method assisted me in attaining this goal. After conducting the interviews and getting the results, I selected an appropriate nursing theorist to organize the findings. This chapter began with a description and rationale of the research design chosen for this study. It included the discussion of Husserl's work as the roots of phenomenology, the utilization of the philosophy of Merleau-Ponty, and the six phenomenological research activities of van Manen. The next chapter focuses on the application of van Manen's phenomenological research activities and the steps that I took to conduct the research study.

## CHAPTER IV: METHODOLOGY APPLIED

Qualitative research aims to uncover the perceptions of individuals experiencing a particular phenomenon. In this chapter, I discuss how I applied van Manen's (1990) phenomenological method of research to explore the lived experiences of young adults who use opiates. Specifically, I outline the steps that guided me in collecting and analyzing the data, with the aim of describing and understanding the meaning and essence that comprise the experiences of young adults with opiate use.

### Research Activities

According to the research process of van Manen (1990), the researcher needs to follow six activities or steps. The first step in van Manen's (1990) phenomenological method is "turning to a phenomenon which seriously interests us and commits us to the world." This describes a phenomenon that I, the researcher, am interested in and committed to. The lived experience of a young adult with opiate usage has always been a phenomenon of my interest because I have had family members who have used opioids as young adults, and I have also taken care of young adult patients who have used opioids. In my work as a nurse, I felt that not enough time was spent really understanding the patients' or my family members' experiences with opiate use once their immediate medical needs were met. I felt that there was more that could be learned about their experiences that would assist in developing opiate treatment strategies. I hope that my desire as a nurse to get a better understanding of the experience of these young adults will benefit nursing as a profession, as well as other disciplines.

The second step, "investigating experience as we live it rather than as we conceptualize it," means to be aware and be a part of the participant's world. Phenomenological research aims at establishing a renewed contact with the original experience. This orients the researcher to stand in the fullness of life and in the midst of the participant's world, thereby actively exploring

the participant's lived experience in all its modalities and aspects (van Manen, 1990). Being a nurse who has worked in New York City metropolitan hospitals has put me in contact with many patients struggling with opiate use and has made me aware of their world. This research was conducted through face-to-face interviews, which provided participants an opportunity to describe their experiences in their own words and from their own perceptions. As the researcher, I planned to listen without bias and to be present to hear their lived experience.

The third step is "reflecting on the essential themes which characterize the phenomenon." Phenomenological research makes a distinction between appearances and essences. The insight into the essences of a phenomenon involves a process of reflecting, appropriating, clarifying, and making explicit the structure of meaning of the lived experience (van Manen, 1990). As the meaning of lived experiences is usually hidden or veiled (van Manen, 1990), I plan to transcribe the conversation of each participant verbatim and immerse myself in the data to reveal and unveil the themes and essences of young adults' experiences with opiate use. Reflecting and organizing the emerging themes can illuminate the essences of their experiences.

The fourth step of "describing the phenomenon through the art of writing and rewriting" deals with bringing something to speech along with the application of language and thoughtfulness (van Manen, 1990). Through interviewing young adults and then reflecting on their words, I was able to rewrite, rethink, reflect, and recognize (van Manen, 1990) the emerging themes, thereby allowing the experience of the young adults to be seen.

"Maintaining a strong and oriented pedagogical relation to the phenomena" is the fifth step, the purpose of which is to establish and maintain a strong relationship with the phenomenon in order to avoid speculation, detours, and narcissistic reflections (van Manen, 1990). My goal was to remain oriented to the research question, the phenomenon, and the human experience.

The idea is to wander with intention, to not settle for wishy-washy speculations or superficialities and falsities (van Manen, 1990). During the interview process, I asked open-ended questions to allow the participants to describe their experience. To ensure that participants remained focused on the phenomenon, I sensitively drew participants back to their experience when they diverged on different tangents. This helped in maintaining a commitment to the integrity of the study.

The final step to van Manen's (1990) research activities is "balancing the research context by considering parts and whole." In searching for the "whatness" of the phenomenon, one may lose sight or get stuck in the end of phenomenological research (van Manen, 1990). If and when this occurs, van Manen suggested stepping back at several points to look at the total, at the contextual givens, and how each of these parts contribute to the whole. During data analysis, it is important to keep an open mind and to observe how the data flow and the themes emerge.

**Aim of the Study**

The aim of this study was to describe and understand the lived experience of young adults who use opiates. The participants were asked to share their experiences and what their experiences mean to them. The themes and essence that were revealed from this research provided insight for nursing to offer support based on the understanding of what is important for these young adults at this time in their lives.

**Sample and Setting**

A purposive sample for this qualitative research was obtained. Purposeful sampling in qualitative research means that the researcher selects individuals who have experienced the same phenomenon and can therefore purposely inform the researcher in understanding the research problem (Creswell, 2007; Polit & Beck, 2004). I recruited a purposeful sample of young adults with a history of opiate use from the urban areas of New York City. Phenomenological research tends to necessitate a very small sample of participants. The participants for this study included

young adults aged 18 to 25 years who have had a history of opiate use within the past 5 years. The participants were English speaking and cognitively stable, alert, and oriented to time, place, and person. The setting for this study was a quiet, private location that is convenient for each participant. Because in-depth interviews were the data collection tool for this study and the participants may have been in a vulnerable state, a quiet and private space allowed them to feel sufficiently comfortable to share their experience.

**Recruitment**

Institutional Review Board (IRB) approval was obtained from the Graduate Center at the City University of New York (CUNY). Upon IRB approval, the recruiting process began by contacting agencies, such as churches, gyms, schools that may provide information to find potential candidates. The recruitment process was via research flyer postings around the city, street distribution of flyers and word-of-mouth (people who had heard of the study). If potential participants were identified and required more information, I gave them the option of speaking with me via the phone or meet with them to give more details.

**Protection of Human Subjects**

Young adults are considered a vulnerable population because they are more vulnerable to coercion than older adults and present with more than a minimal risk. IRB approval was obtained from the Graduate Center at CUNY. Upon the identification of potential participants, each was screened to determine whether they met the inclusion criteria. Those that did had the research purpose, aim, goals, and advantages/benefits and disadvantages of participating in the study explained to them and clarified. Potential participants were informed that participation in the study was strictly voluntary, and that they could withdraw from the study at any time without being penalized. Once eligible individuals expressed a desire to participate, they were given an

informed consent to sign. A date, time, and place convenient to participants was identified, and the interview was scheduled.

Each participant was deidentified by assigning a pseudonym that maintained their anonymity. All participant data—including recordings, transcriptions, encryptions, and other pertinent information—were secured in a locked cabinet. A password was also assigned to my computer.

**Data Collection**

After participants are identified, data collection began with an interview. All interviews took place in a private office in mid-town Manhattan. At the time of the interview, informed consent was obtained, a demographic questionnaire was completed, and the face-to face in-depth interview took place. Each interview lasted between 30 minutes to 60 minutes. An in-depth interview is defined as a process whereby a researcher asks questions to a participant who responds with thoughts, perspectives, and narratives based on the person's lived experiences (deMarrais & Tisdale, 2002).

Each interview was audiotaped by two tape recorders. One tape recorder was used as a back-up in the event of equipment failure. Each interview began with a uniformly general lead question: "Tell me about your experience using." Subsequent interview questions were guided by the responses of the young adult participant. I explored and sought clarification during the interview process and asked clarifying questions such as "What does that mean?" or "Can you give me an example?" I was mindful to allow the participant time to speak without interruption.

Participants were revisited for a second interview if necessary, as suggested by van Manen (1990). van Manen recommended going back to the interviewee to discuss the ongoing record of the interview transcript. All participants had the opportunity to review their transcript for accuracy and to verify that the emerging themes reflect their experiences as they told them. If

there was a need for clarification or further questions, a second interview was scheduled to address these issues.

**Data Analysis**

The data were analyzed using van Manen's (1990) phenomenological method. At the end of the interviews, after data saturation had been reached, each interview was transcribed verbatim. I then dwelled in the raw data and text. Each interview was read line-by-line, several times, seeking words and phrases that describe the phenomenon being explored. Phrases capturing the phenomenon were identified, placed into categories, and reviewed for emerging themes. These themes are the experiential structures that make up the experience (van Manen, 1990). It is within these essential themes that the essence of the young adults' experience emerged.

**Rigor**

Rigor in qualitative research is achieved when the study is believable, accurate, and useful to other people beyond the participants (Roberts & Priest, 2006). Lincoln and Guba (1985) suggested criteria aimed at maintaining rigor through credibility, dependability, transferability, and confirmability. Rigor is useful for establishing consistency of the study methods over time and provides accuracy in representation of the studied population (Thomas & Magilvy, 2011).

Seeking approval and clarification from each young adult for accuracy of the transcript and description of their experience is a way to maintain rigor and credibility. Should discrepancies have arisen, reinterviewing the participant would have been necessary. Credibility, the faithful depiction that allows others to recognize the interpreted experiences of the participants in a study, was achieved through prolonged engagement (Lincoln & Guba, 1985).

A good phenomenological study is one that someone can nod to (van Manen, 1990). According to van Manen, there are three phenomenological approaches in doing this: (a) the

researcher looks at the holistic or sententious approach; (b) analysis occurs through selective highlighting; and (c) analysis is done through a detailed, line-by-line approach. I utilized all three ways of analysis to adhere to van Manen's recommendations and illuminate the phenomenon of the lived experiences of young adults with opiate use. Once the interviews were transcribed, I coded the interviews in reference to the conversations. In reading and reflecting on the interviews, I highlighted and underlined each section of the interview, writing codes in the margins, grasping the essences or phrases that captured the meanings of the section. I made an effort to summarize the overall meaning of the interview by coding sentence-by-sentence—or, as van Manen stated, line-by-line. These codes were grouped in relation to each interview. After this process of analysis is done, the codes were listed and grouped together according to their underlying meanings. According to van Manen, these codes then create meanings of the themes to surface that capture ideas and recurrent themes throughout the interviews.

**Limitations**

A major limitation with qualitative research is that it is not generalizable to the general public as quantitative research is. This is due to the small sample. This limitation, however, does not negate or minimize the benefits of qualitative research, as qualitative research allows for a deeper and richer understanding of a phenomenon that can easily be missed with quantitative research (Thomas & Magilvy, 2011). Another possible limitation to this study was that some young adults may have been resistant and withdraw from participating due to being overwhelmed with emotions and concerns about their current situation. I reinforced that they could withdraw from the study at any time and a list of local support groups was provided. As the researcher, I remained sensitive and nonjudgmental so as to gain the trust of participants and maintain rapport through the interview process.

## Summary

This chapter contained a detailed discussion of the six research activities of van Manen (1990) and their applicability to this study. I outlined the steps that I took to recruit and interview participants. The processes for data collection, data analysis, and the maintenance of patient confidentiality and study rigor were also discussed.

## CHAPTER V: FINDINGS

The purpose of this chapter is to present the findings of this phenomenological study of the experience of opioid use. The findings include themes that were identified from the meaning units in the comments that were transcribed from audiotaped interviews of the participants. The participants ranged in age from 18 to 25 years old. As per the inclusion criteria, each of the participants admitted that they used opiates at least three times per month for more than 6 months. The audio-recorded interview data were transcribed verbatim and reread while listening to the audio recording until major themes could be identified in all of the participant's comments using van Manen's (1990) phenomenological research method. After careful review of each interview transcript, I engaged in an iterative process of identifying meaning units from all the interviews in order to pinpoint the four essential themes.

### Participants' Stories

#### *Participant 1 (P1): Mike*

Participant 1 said he first took oxycodone when it was offered to him by a coworker to help him deal with his back pain. This participant said, "*I've always had back problems…and somebody introduced me to that pill…'cause we were working, and when you do physical labor, your body breaks down after a while…I used the pill one time, and then I felt good. You know, I was able to do the regular job, no pain, no nothing, and it had been a while since I felt like that*." Participant 1 said he had become addicted to them because he built up a tolerance and needed larger doses to get the same level of relief from pain: "*It starts out slowly, but then your body builds a tolerance. It is like drinking alcohol or whatever, anything else. Your body now gets used to it, and then you go, 'I need more*.'" Participant 1 said his addiction to opioid painkillers led to taking heroin because of the cost: "*You know, it's $20 [for the pills], or you could go get a bag of heroin, which is like $10. And it does the same effect*."

Participant 1 said he recognized that his substance use was problematic but that initially he was too ashamed to ask for help, even though he knew that his addiction to heroin was nearly impossible to escape from without some form of assistance: "*It's hard to tell family that you are a drug addict, or you need help. It is the same thing. Most people are gonna feel shameful, they're gonna just keep it in themselves, but it's not gonna get any better*." After entering a recovery program, Participant 1 went on methadone maintenance as part of a methadone program, and eventually switched to Buprenorphine, but he said switching was a bad withdrawal and he still has pain. He said that addiction to the heroin substitutes, like methadone or Buprenorphine was not much different from addiction to heroin. Participant 1 said he was able to enter into recovery through the strength he derives from his religious beliefs; paraphrasing from one of the 12 steps, he said, "*I believed in a higher power, and I just let Him guide me, take me from there. And I just got stronger and stronger from there*."

***Participant 2 (P2): Joe***

Participant 2 described his home environment as one where opioid use was common, he said his father was a heroin addict, he recalled several occasions when he came home from school he used to find his dad "*hunched over the toilet"* in the dark with *"a needle in his arm*." Despite knowing plenty of people whose lives he saw as ruined by drug use, he said he began taking opioids because of peer pressure and a desire to make new friends. "*You get influenced by friends. I wanted friends, they were hanging out, and they would party. There would be girls and stuff like that. And I remember somebody offered me some pills*." Participant 2 thinks that he became addicted because the opioids helped him forget traumatic memories: "*Where I came from, there was a lot of trauma, pain. I knew people who was murdered. [When I took opioids,] I was just finally released and free. It just felt good just to be free and laughing*." After these experiences feeling relief from traumatic memories, he began seeking opioids, and said his

behavior demonstrated to him that he was addicted: "*I was like, 'Wow, I want to feel that feeling again.' And that started the thing where, suddenly, I was on the hunt for it, and I would always get it, because we [friends] always had parties*." Participant 2 said the experience of becoming addicted: "*creeps up on you. People don't realize how easy it can be to get hooked*." After he began using opioids regularly, Participant 2 suffered torn ligament playing football, and received a prescription for oxycodone that further enabled the progression of his addiction.

Participant 2 was in college at the time the use began. Opioid use led to a sharp decline in his grades, and he began feeling pressure from his teachers, which he initially dealt with by taking more opioids. Participant 2 said that he ended up being expelled from school because of his poor grades and he was caught dealing drugs on campus to support his own use. After his ligament healed he no longer could get the prescriptions for oxycodone, so he began stealing money from his mother to buy substances. The sense of losing control finally caused Participant 2 to appreciate that his drug use was a severe problem: "*I remember I crawled back to where I was staying in the dorm. I had lost a whole day, and I could not tell you what happened. I was hunched over the toilet, was just barfing and throwing up, just sick and horrible. By this time, I had had many wild nights, but this was the first time I thought I had a problem*." He said by this time his father had recovered from his heroin addiction with the help of a methadone program, and helped him to escape addiction: "*Without preaching to me directly, he would talk about how he wished he could get his time back. How he might do some things differently, you know. Physically, emotionally, this [withdrawal] was the worst time for me, but something about seeing my Dad trying to do better helped me*."

***Participant 3 (P3): Sally***

Participant 3 said she began using opioids while selling them to finance her film production career: "*I was pursuing a career in film production, and I was trying to make money*

*on the side. In addition, basically, it took me down a bad path of becoming addicted to what I was selling. I was addicted for about 3 years*." Participant 3 recognized that the drug abuse was a problem after taking an unknown pill and having a bad reaction that included becoming psychotic after several consecutive days without sleep. After this experience, Participant 3 said, "*I felt scared. It got to the point where now I am meeting people and taking unknown substances and staying up all night, you know what I mean... It just really, really, really got bad, like I could not live without this drug [oxycodone] at some point. Like I started doing more oxy pretty much every day*."

Participant 3 said she engaged in sex for money to support her drug use: "*I went down a really dark, dark road, to like selling myself, not on the street corner, like for $5, but just getting with other people if the price was right*." Participant 3 recognized that her behavior had become very dangerous and that she needed help: "*That was what made me stop, because it was a lot of close calls where I could have been in jail or dead*." Participant 3 recovered from addiction with the help of attending Narcotics Anonymous meetings and by recognizing that her opioid use was a means of dealing with traumatic flashbacks and memories: "*I guess my bottom was realizing that you're kind of like hiding trauma. You know what I mean. When I think about it, like the real, real start of me even taking oxy was because I got out of a 5-year, abusive relationship*."

***Participant 4 (P4): Jim***

Participant 4 said he started using opiates in college, where they were readily available, but did not become addicted during that period. Participant 4 said his addiction began while in social isolation because of the COVID-19 pandemic. He said he was staying home continually with nothing to occupy his time. Participant 4 said his addiction progressed because using opioids helped in dealing with psychological pain: "*I think that I had a tendency to do drugs like opioids and stuff because it will let you sort of forget everything that you're feeling. I guess it's*

*just a lot of psychological shit and situations that I was uncomfortable with, and heroin just took it all away, made me feel good*." He said that many of his friends used drugs, and heroin was readily available.

Participant 4 realized that his substance use was serious after he researched how to process his own opium from unwashed poppy seeds. Using this process he began making his own opium that was stronger and cost less. He said, "*I did that for a bit, but then I realized that I was really getting very addicted, so I wanted to get off it again, and that's when I found the Addiction Institute of New York at Mount Sinai*." Participant 4 also said he made the decision to quit using opioids because of his job, which he valued: "*I was working, and I realized that in order to hold a job and not mess it up—I had a decent job—I needed to get in a Methadone program*." Participant 4 continued to attend meetings to aid his recovery, and that he liked to take any opportunity he could find to warn potential opioid abusers about the dangers of experimenting with addictive substances: "*I like to tell people some of my experience to sort of help them not do drugs. People do drugs, and everybody thinks they can beat it, everybody thinks they are more powerful than the drugs when you start, right? In addition, the fact of the matter is, nobody is more powerful than the drugs. Sooner or later, it's going to get you*."

***Participant 5 (P5): Monique***

Participant 5 started to use oxycodone when her girlfriend offered it to her, and she continued to use it because it helped her to deal with her anxiety: "*I suffer from severe social anxiety. Looking back, I think this [addiction] really started or became worse when my family moved to the U.S. Now, I can clearly tell you that the smoking and drinking tried to cover that up. For some strange reason, oxy did an even better job for me*." After trying oxycodone for the first time, Participant 5 appreciated the psychological relief she felt: "*I felt good after I took it. Nothing crazy happened. In fact, I felt like I had figured out some shit when I took a break from*

*the world. It was nice not to worry about anything*." Like other participants, Participant 5 did not expect or intend to become addicted: "*I just felt good. It felt like a heavy burden had been lifted. No worries at all...My plan was to use just sometimes...Maybe 5 months in, I realized that it had become a habit. I did not even see it coming. My girlfriend and I joked about how we needed our 'adult cocktail' every day now*."

Participant 5 realized that she was addicted when using was taking over her life during the COVID-19 pandemic: "*For me, things got bad when I couldn't sleep, and I started to feel depressed. I did not want to do anything anymore. I just wanted to stay home, use, and sleep*." The unhappiness and physical illness associated with her addiction caused P5 to realize that she needed to change: "*My life sucked. It was not normal and I wanted to be normal, to have a regular day without using or being depressed...I really wanted to heal. I was tired of feeling sick and feeling bad all the time*." Participant 5 contacted her doctor and began a course of buprenorphine, which she used to stop oxycodone while she also attended Narcotics Anonymous meetings. As she recovered, Participant 5 had insights into the incompatibility of addiction with her life goals, and these insights renewed her determination to stop using opioids: "*For me, as I struggled back into my skin, into my mind, and learned to be comfortable again, I realized that life was short. That I had goals. That I may want to have kids one day and that using was not helping me get there. I was wasting time and my life*."

**Essential Themes**

The themes represent the essences of what was said by the participants about their experiences of using opioids. The researcher undertook a process of uncovering the essences and then bringing them up a level of abstraction to identify the themes from the transcribed interview narratives of the participants using van Manen's six-step phenomenological method. The six processes from the method as they were used in this study were as follows:

1. Turning to the Phenomenon: This step involved examining the comments of the participant's comments captured in the transcribed interviews for meaning units about their experience of using opiates.
2. Investigating Experience as We Live It Rather than as We Conceptualize It: In this step, I again listened to the audio-recordings of the interviews with the participants while rereading their transcripts and list of meaning units to uncover the unique story of each participant about using opiates.
3. Reflecting on the Essential Themes Which Characterize the Phenomenon: In this step, while rereading the participant's stories about using opiates and reviewing the meaning units, I identified the essential themes of the narrative of text collected from all of the participants. These themes represent the essence of the participants' experience.
4. Describing the Phenomenon in the Art of Writing and Rewriting: This step consisted of exploring and describing the essential themes in the language of the participants in the way that best expresses their experience. These themes reflect the meaning of the experience of using opiates for the participants. This meaning is expressed by carefully selecting key quotes of the participants that capture the meaning of each theme and of the overall meaning statement, which creates a composite story about using opiates.
5. Maintaining a Strong and Oriented Relation to the Phenomenon: I continued to write about these themes and their meaning for these participants in order to answer the research question.
6. Balancing the Research Context by Considering Parts and the Whole: During this process, the themes are organized into a coherent statement, which captures the meaning of the structure of the lived experience of using opiates uncovered in this study and

considers this finding in light of the extant literature on the topic to discuss the unique contribution from this study.

This section of Chapter IV is a presentation of the essential themes and the meaning units that composed them. Under the heading for each of the four essential themes, discussion and evidence from the stories of the participants are presented. Table 1 contains the four essential themes and a sample quote related to each.

**Table 1**

*Essential Themes and Sample Quotes*

| Essential Theme | Sample Quote |
|---|---|
| Starting opioids to alleviate stress or pain | "*I was just finally released and free. It just felt good just to be free and laughing*." (P2) |
| Getting trapped in addiction | "*It just really, really, really got bad, like I couldn't live without this drug*." (P3) |
| Recognizing the problem of addiction | "*My life sucked. It wasn't normal and I wanted to be normal, to have a regular day without using or being depressed*." (P5) |
| The painful, precarious escape from addiction | "*I had used opioids for so long that I was really uncomfortable with nothing in my system*." (P4) |

### *Theme 1: Starting Opioids to Alleviating Stress or Pain*

While most participants initially tried opioids recreationally, Participant 1 used it to alleviate back pain that interfered with his ability to function at work. Soon after their initial use, all participants reported that they began to use it regularly for relief of pain or uncomfortable feelings, which they felt when they sustained from its use. For example, Participant 1 described

the drug as "*a getaway*": "*My story involves having back pain that turned into using pills, and then spiraled it somewhere else*."

Participant 2 considered his drug use as related to his childhood experiences and environment he grew up in: "*Growing up in kind of a rough neighborhood, and in a very rough building, where there was a lot of alcohol and drug abuse, low-income housing, I think that was part of the influence*." Initially, P2 resisted the influences of this past and current environment, because his mother was adamantly against drug use and anything that resembled his father's behavior and addicted to heroin: "*I wanted to make [my mother] proud of me. I prided myself on not smoking [marijuana] as my cousins and or being a [heroin] addict like my dad. I kept telling myself using was just a terrible thing. Drugs ruin lives. I was better than that. All that sort of thing*." Participant 2 started using opioids when he went away to college, and was outside of his mother's supervision, and under peer pressure to experiment with drugs.

He said his opioid use continued after he found out how well it alleviated his psychological pain: "*Where I came from, there was a lot of trauma, pain. I mean, I knew people who was murdered. I was just finally released and free. It just felt good just to be free and laughing and things of that nature*." A sports injury later resulted in P2 receiving a steady and legal supply of oxycodone from his doctor: "*They were giving me oxycodone for pain! So, now I was getting it legit*." Participant 2 emphasized how effective, pleasant, and immediate were the effects of narcotic as compared to other pain medications: "*Once I got it, I was just buzzing, and it was just like the most intense, amazing, interesting fun time, just laughing and relaxing. Everyone is laughing having a good time. So just being on that good, good, good feeling was something that I never felt before*." He was soon pursuing that pleasurable feeling of enjoyment and relief, he was actively seeking the drug: in his words, "*I was on the hunt for it*."

Participant 3 said she was dealing oxycodone and MDMA (three, 4-methylenedioxy-methamphetamine) which is also known as ("mollies"), at dance clubs at night to make extra money to support her ambition to become a film producer: "*My experience with opioids came because I used to sell them. I had some friends that would supply it... It basically it took me down a really bad path of becoming addicted to what I was selling*." Later, when she was in recovery from her opiate use disorder, she became more aware that her regular use of oxycodone was a way to alleviate her uncomfortable feelings related to her history of interpersonal trauma: "*I guess my bottom was realizing that you're kind of like hiding trauma...When I think about it like the real, real start of me even taking oxy was because I got out of a 5-year, abusive relationship*."

Participant 4 said he had tried opioids as a teenager, but he does not think he became addicted until several years later: "*I first tried opioids; I guess I was about 18 or 19, in college. And I liked it very much, but I didn't get into it, and I didn't develop an addiction till I had graduated college and I was working already*." Participant 4's addiction became obvious to him during the COVID-19 pandemic, when he was remaining quarantined and wanted relief from boredom and psychological pain: "*I think that I sort of had a tendency to do drugs like opioids and stuff because it will let you sort of forget everything that you're feeling. You know I guess it's just a lot of psychological shit and situations that I was uncomfortable with and heroin just took it all away, made me feel good*."

Participant 5 experienced uncomfortable feelings and moods when she entered college because she came from a "*tight-knit immigrant family with parents who do not understand what it is like to be an outsider at school. Very religious. Very strict. They had no idea what my daily struggles looked like. Just trying to fit in*." She initially tried opioids when a friend offered a pill

to her to alleviate insomnia and stress: "*Nothing special was going on the day that I tried oxy. My girlfriend's boyfriend gave her some and she asked me if I wanted to try it. She said it helped her relax and it had helped her sleep. She felt good like everything was okay in the world*."

Participant 5 reported that she had severe social anxiety that began when her family immigrated to the United States, and that she had previously used marijuana and alcohol to feel more confident, particularly when she was attending school in the U.S., where "*You are labeled dumb if you are not speaking and if you don't call attention to yourself*." Participant 5 found oxycodone to be the most effective substance for dealing with her anxiety: "*The smoking and drinking tried to cover the [anxiety] up. For some strange reason, oxy did an even better job for me...So, to cope, I used. It was not a conscious decision. It just kinda happened*." The essential theme that appeared across all of the participants' accounts was that their initial use of opioids was occasional, but eventually became regular users because they found opioids to be an effective means of managing either pain or uncomfortable feelings.

***Theme 2: Getting Trapped***

All of the participants said their use became a trap, a condition of confinement that progressed subtly and outside of their awareness until it was firmly binding. All of the participants reported that they experienced a period of heavy opioid use but still did not realize they were addicted or that their use was problematic. For P1, the progression to being trapped by the drug use was associated with an increased tolerance for the drug that resulted in his taking larger amounts to achieve the same level of relief: "*You start building a tolerance, and that's how that issue [addiction] started*." He also said that he did not recognize it at the time, but he was developing tolerance and increasingly dependent on the substance: "*Your body now gets used to it, and then you go, 'I need more.' So, the more you need, the more you take...so that you don't get sick*." Participant 1 that this went on for some time but did not think he had lost control

of his use pattern because he was able to function normally. "*I didn't let it overtake me to the point where I was just completely out there...So, you know, I knew what I was doing was starting to go wrong, but I just tried to fight it*."

Participant 2 described his progression to addiction as unexpected and subtle: "*When you least expect it, your soul may get stolen from you. You lose good judgement. I was just having a good time. I did not expect to get in trouble...It creeps up on you. People don't realize how easy it can be to get hooked*." He also, at least initially denied being addicted, both to himself and to his deeply saddened mother: "*I was an addict at this point even though I wouldn't admit that to anyone. I kept denying it. In addition, I kept saying, 'Oh, no, no, I wasn't dealing or anything. I'm just hanging' out.* "'

For Participant 3, addiction progressed subtly from regular use to dependence: "*I proceeded to take it to just to relax. And the addiction got really, really severe, to the point where I would be doing it like for 4 or 5 days straight*." Participant 3 said her perception of reality and social acceptability was becoming distorted to the point where she was using in front of other who were nonusers: "*My reality of what was appropriate and what was not became so warped that I just started doing it in front of people in the open*." She remembered one instance that particularly troubled her in retrospect, "*I remember I was at a family barbecue, and I was so deranged in my mind that I just pulled [opioids] out in front of some kids and popped some. I never thought I would do something like that*." To other people, she lied about what she was taking: "*If someone asks, you can say its Aspirin, like for a headache*." She said she was telling herself that her opioid use was not like taking other drugs like smoking crack or using heroin: "*In my thinking, I was like, okay, it's not crack. It's not like heroin. Like, all you have to do is casually take a pill, put it on your hand and take it*." Participant 3's use progressed because she

still did not see it as a problem, until "*It just really, really, really got bad, you know, like I couldn't live without this drug at some point. Like I started doing more oxy pretty much every day*." She said the subtle process of becoming addicted was like part of the trap: "*You just get into the trap of it all. In addition, that is what it is. They call it a trap for a reason. Like, so drug dealing, 'trapping,' [slang for dealing drugs], that's the same shit*."

Participant 4 also did not realize that his opioid abuse had become such a big problem because he saw it as normal: "*I started using it, it was like a social phenomenon, so many people were using it, but not everybody got hooked and developed a really debilitating addiction. I did, though*." To avoid the legal pitfalls of illicit drug use, he went to doctors to get prescriptions for painkillers: "*I started going to doctors and getting the prescriptions for opioid pills like Percocet, Morphine, there was a bunch of 'em. It's crazy, but it wasn't hard for anyone to get anything you wanted*." In part, Participant 4 was able to deny to himself that his use was problematic because he remained functioning and did not face social pressure to stop: "*I was able to work and basically hold a job when I had to and talk my way out of situations...My family was none the wiser until later. I moved out of my parents' house when I was 18, so they didn't really know what was going on*."

Participant 5 enjoyed the relief from stress that she experienced when using opioids and made the bargain with herself that she would only use them occasionally, when she felt particularly bad. "*I just felt good. It felt like a heavy burden had been lifted. No worries at all...I figured it would not hurt to feel like that occasionally when I was feeling low. My plan was to use just sometimes, like how I used to smoke just to get the edge off*." Previously, P5 used to drink alcohol until drunk and smoked marijuana to deal with life's problems and uncomfortable feelings, but oxycodone became her primary substance of abuse, and she quickly became a

habitual user: "*If I didn't get oxy, I found myself drinking and smoking more, but now these things no longer had the same effect. The drinking was good to make me get tipsy for a while, but I hated the hangovers. Nothing worked quite like the oxy. So, just like that, I got a habit*."

Thus, the essential theme across all participants was that their use progressed to addiction quickly and subtly. None of the participants reported that they were indifferent to being addicted; instead, they reported that as their use became heavier their thinking provided logical reasons for their use of drugs and excuses for why it was not bad. Their use of opioids progressed without their realizing it from experimental, to regular use, to habituation, in other words, being trapped. All of the participants reported that they eventually were addicted heavy users before they realized that their use of opioids had become such a problem.

***Theme 3: Recognizing Addiction***

All of the participants reported that at some point they became aware that their pattern of use represented an addiction, they realized that their use was a problem. Participant 2 realized his use was out of control when he found himself budgeting for drugs: "*When you're planning, that's when you know, this is bad. You get $100, then you are like, 'Okay, I got to put $40 aside to get the pill.' That is when things are bad. That's when things are really getting bad, out of control*." Participant 1 realized he was addicted to opioids and heroin when he saw how insane his behavior had become: "*I really spiraled, 'damn, this is crazy*.*"*" Participant 2 tried to compensate for the effects of the drug use by using more: "*I started doing terrible at school. All my grades went down, and I was getting lot of, just, pressure from the teachers, but did that make me want to stop? Naw, just made me want to do some more stuff and all I cared about was feeling good*." Participant 2 realized he was addicted when he began to black out for hours at a time: "*I had lost a whole day and I couldn't tell you what happened. I was hunched over the toilet, was just*

*barfing and throwing up, just sick and horrible. By this time, I had had many wild nights, but this was the first time I thought I had a problem*."

Participant 3 realized she was addicted after two very dangerous incidents. The first was when she took an unknown substance in a stranger's house and was so high she could not leave for 3 days. The second was when she was riding with two friends in a car with a large amount of oxycodone strapped to her body when the car was pulled over by the police. The two male officers searched the males in the car and arrested them. They did not search her, because they did not have a female officer with them, so she was let go. After these events, P3 said, "*That was what made me stop, because it was a lot of close calls where I could have been in jail or dead*."

Participant 4 realized he had become addicted when he started processing unwashed poppy seeds in his home: "*I did that for a bit and I realized that I was really getting very addicted again, so I wanted to get off it again*." Although P4 remained functional while using drugs addictively, he realized his use was escalating and that this job was in jeopardy unless he got control of his use: "*I was working and I realized that in order to like hold a job and not mess it up, I had a decent job, and I decided to get on a Methadone program*."

Participant 5 faced pressure to quit opioids after her mother caught her using them: "*I passed out a couple of times, which is how my mom found out. The other times, my friends took care of me, but this one time, I was home, and my mom came home, and I was passed out on the bed. I had taken some pills and proceeded to drink some vodka, too, all because I wasn't feeling right*." She finally made the decision to quit because of how ill she felt all of the time and realized she was failing to pursue her goals: "*My anxiety increased. Sometimes, I would be up at night texting, binge watching Netflix for hours and not getting anything done. I just felt bad. My habit just helped me sleep, but I did not feel right. I felt bad all the time. I did not want to feel*

*like this all the time. My appetite was gone and sometimes, I felt nauseous. My life sucked*." She said reflected on how unhappy she was and recalled stories she read online about the consequences of addiction: "*I was worried enough about it to want to stop*."

Thus, the essential theme that emerged across all participants' accounts was that at some point they realized they were addicted to using opioids in an unsafe and deleterious pattern of use. This realization involved recognizing they had a problem. Participants described this recognition as a shift to a comprehensive perspective, through which they stopped thinking only about their short-term needs as substance abusers and began to think in terms of how much drug use had changed them and how it was interfering with their long-term goals, as well as their health and safety.

***Theme 4: The Painful, Precarious Escape from Addiction***

All of the participants reported that they had recovered from addiction and were not currently using. The participants also suggested that their escape from addiction was still precarious and that they needed to be continually vigilant to ensure they did not relapse. Participants described recovery as painful because of the intense physical symptoms of withdrawal.

Participant 1 described the pain of withdrawal as torture: "*You have to fight it; you have to let that sweat it out of you, which means it's like 7 days of torture. Some people go 3 days, 4 days, by 7 days, before it will be out your system, and then you could be normal again. But it is like pain*." Because withdrawal was so painful, Participant 1 relapsed several times after stopping his opioid use for only 1 or 2 days: "*My thing was just trying to fight it out like, try to sweat it out your body. But that's just hard, 'cause you may end up, you could do probably a day, a day and a half, and then you end up collapsing [relapsing] that second day. So, I'd go a day and a half, and try again*." Participant 1 attributed his eventual success to his strong religious faith, which he

continued to rely on as a means of preventing a future relapse: "*I try to pray every day, and just ask for guidance, and just to make better decisions. And that's all I try to do*."

Participant 2 also reported that withdrawal was painful. He was able to get through it by spending time with his father, a former heroin user who did not judge him for becoming addicted to opioids: "*Spending time with my Dad helped me out. I saw the bigger picture...Without preaching to me directly, he would talk about how he wished he could get his time back. How he might do some things differently*." He described the pain of withdrawal as involving physical and emotional pain, and that time as the worst time in his life. Of the precarious nature of recovery, Participant 2 said that it required continual vigilance to avoid relapse: "*I am grateful even worse things didn't happen to me. Now, I am just trying' to maintain...I am in this weird head space now on my own, just trying' to maintain...You got to be on guard, 24/7*."

Participant 3 reported that to stay off opioids, she also had to avoid taking other substances that might lower her inhibitions and cause her to let down her guard: "*I know if I go and take oxy, I'm going to go on a binge. Like, I have an addictive personality. It got so bad that I had to stop drinking. I had to stop smoking cigarettes. I had to stop doing all of that because it leads me down back to [relapsing on opioids]*." Participant 4 had heard that getting off opioids was difficult after heavy use, so he decided to get into a methadone program: "*I wasn't crazy about it [quitting] because I had heard it was very, very hard to get off, but I needed something to stabilize me so I could go to work every day, sort of lead an almost normal life. So, I got on [methadone] and I stayed on that for about a year*." He also was aware of the precarious nature of his recovery, that when he would try to get off methadone he would be vulnerable to relapse: "*It was pretty touch and go. I had used opioids for so long that I was really uncomfortable with nothing in my system*." One of the ways he avoided relapsing was by refusing to ruminate over

regrets about the opportunities he may have lost because of his opioid use: "*I've often thought about if I didn't do it, what would I have done? These days I try and avoid thoughts like that because they are not fun*."

Participant 5 also said withdrawal was painful: "*It was hell. It was hard. I cannot tell you that it was easy. To this day, I don't know how I managed to get clean for real*." She described the difficult process of quitting opioids to one of struggling back into her old self: "*For me as I struggled back into my skin, into my mind and learned to be comfortable again, I realized that life was short. That I had goals*." Participant 5 described the pain and discomfort of withdrawal as follows: "*Nothing was real. Nothing was natural. Your skin does not feel comfortable. I tried praying, meditation, deep breathing. Nothing worked. Meditation just got me all jittery. I would feel worse afterwards*." She got buprenorphine from her doctor and attended online NA and AA meetings to help her quit and stay clean. Of the precariousness of her recovery, she stated, "*As an addict, you are always tempted. My life is still stressful. I am still anxious, and I still get depressed*." To maintain her recovery and avoid relapse, she also focused on the misery she had experienced during her addiction and on how much better her life was as a nonuser: "*I focus on how far I have come and what I want to accomplish. I never want to get back to that low, depressed, desperate, antsy place. That loss of control, not feeling like you have a choice is death. I never want to feel like that again*."

All of the participants described the process of escaping from addiction as painful because of the intense physical and psychological distress they experienced during withdrawal. The participants expressed no regret about quitting their use of opioids, and all expressed gratitude that they were able to quit successfully. The process of quitting opioid remained precarious. All of them were acutely aware that they might relapse at any time. For many, their

uncomfortable feelings and pain that they had when they began using opioids returned. To avoid relapse, they focused on their long-term goals, they expressed gratitude for their recovery, and were open and honest about their experiences while they were using.

**Summary**

Four essential themes were identified in the process of doing this phenomenological inquiry with five participants who talked openly about their opioid use, addiction, and recovery. The participants described their lived experiences of opioid use as beginning with casual, illicit use, typically recreational. Their experimental use progressed to regular use when they found that opioids alleviated their physical and psychological pain from injuries, stress, and trauma. The participants all described their addiction to opioids as developing quickly but subtly, without their realizing their increasing dependence on the substance. Participants rationalized their heavy use to themselves and to others. All participants' experiences included a moment of realization or recognition that their use of opioids had become problematic and that they needed to quit for the sake of their health and well-being. For all of the participants, withdrawing from opioids was painful, and avoiding relapse required continual vigilance.

# CHAPTER VI: DISCUSSION

The language in the public discourse on the opioid use problem has been complicated by the multiple terms used to describe it, including *opioid addiction*, *opioid dependence*, and *opioid use disorder*. In the context of this study, addiction was defined as a chronic brain disease that shares similarities with other illnesses that can be characterized by neurobiological, genetic, behavioral, developmental, psychosocial, and environmental factors that may influence their development and manifestations (American Society of Addiction Medication [ASAM], 2011). Greater clarity of meaning and understanding was needed to address this major health problem and facilitate treatment, recovery, and relapse prevention.

The purpose of this study was to explore, describe, and understand the lived experience of opioid use as described by young adults. Participants were asked what it is like to use opiates. All of the participants were between the ages of 18 and 25 and acknowledged using opiates more than occasionally (more than three times per month) and for more than 6 months. The participants were asked their current age, at what age they first used opiates, and whether they used opiates more than occasionally for at least 6 months. The participants did not have to be currently using opiates, and they could be on buprenorphine or methadone. Only persons fluent in speaking and reading English who were willing to sign informed voluntary consent were included in the sample. Persons who appeared to be intoxicated or reported using any psychoactive drug were excluded on the day of the interview.

In this study, the phenomenological method of van Manen (1990) was used to explore the participants' lived experience of opioid use. According to van Manen, phenomenology is a systematic process of uncovering and describing an event's internal meaning and structure as it is lived in one's everyday existence, in one's lifeworld (van Manen, 1990). It is a way to study the human experience and issues that present themselves to humans within the context of specific

experiences (van Manen, 1990). Not much is known about the lived experiences of opiate use among young adults, so I hoped to illuminate their particular experiences. I analyzed the themes and essences that arose for any insight into how young adults are affected by opioid usage. The findings of this study may supply nurses, parents, teachers, and other healthcare providers with valuable information on the psychosocial, environmental, and economic determinants of opioid use and its consequences. This information could then be used to expand or enact new policies, as well as to develop or continue existing interventions to improve opioid-dependent young adults' health, safety, and well-being.

A total of four themes emerged, including (a) starting opioids to alleviate stress or pain; (b) getting trapped in addiction; (c) recognizing the problem of addiction; and (d) the painful, precarious escape from addiction. All participants except Participant 1 initially tried opioids recreationally. Participant 1 initially tried opioids to alleviate chronic back pain that interfered with work. Participants likened addiction to a trap or a condition of confinement that progressed subtly and outside of their awareness until it was firmly binding. All five participants reported that at some point after they became addicted, heavy users of opioids, they realized that their use was problematic and that they were addicted. All five participants reported that they had successfully recovered from addiction and were not currently using opioids.

The remainder of this chapter includes a discussion of the findings in comparison to the existing body of literature. An interpretation of the findings is presented, as well as the limitations of the study. The findings from this study are also described in their relevance to the newly identified theoretical statement on the meaning of lived experience of using opiates. The findings and theoretical statement are discussed in connection with the work of Viktor Frankl. Therefore, this chapter identifies the theoretical framework that underlies the interpretation of

findings and provides implications for this research through the lens of the identified theory. Recommendations are then provided for future research and practice. The implications of these findings to practice, research, theory, and social change are then considered. The chapter concludes with a summary and outline of key points.

## Interpretation of the Findings

The findings are structured by the themes that were derived from the thematic analysis. These include: starting opioids to alleviate pain, getting trapped in addiction, recognizing the problem of addiction, and the painful escape from addiction. Each of these themes is discussed below.

### *Starting Opioids to Alleviate Stress or Pain*

The first theme to emerge from the data was *starting opioids to alleviate stress or pain*. All participants except Participant 1 initially tried opioids recreationally. Participant 1 initially tried opioids to alleviate chronic back pain that interfered with work. After trying an opioid for the first time, all participants began to use it regularly because of the relief of pain or stress they experienced while the drug's effects lasted. These findings align with the literature presented in Chapter II. In a mixed-method study, Rigg and Ibañez (2010) examined the motivations for engaging in the nonmedical use of prescription opioids and sedatives among street-based illicit drug users, methadone maintenance patients, and residential drug treatment clients ages 18 to 60 years. In addition, they examined associations between prescription drug abuse motivations and gender, age, race/ethnicity, and user group, as well as associations between specific motivations and prescription drug abuse patterns. Quantitative surveys ($n$ = 684) and in-depth interviews ($n$ = 45) were conducted with a diverse sample of prescription drug abusers in South Florida between March 2008 and November 2009. The three most common motivations reported were “to get high,” “to sleep,” and “for anxiety/stress.”

Using a very different approach, Merlo et al. (2013) explored the reasons for prescription drug misuse among physicians referred to a physician health program for monitoring due to substance-related impairment. In this study, a total of 55 physicians (94.5% male, mean age 53 years old, 71.7% White, 20.8% Latino, 7.5% other) were being monitored by their state professional health program due to substance-related impairment and participated in guided focus group discussions. Participation was anonymous. Discussions were transcribed from nine separate focus groups that lasted 60 to 90 minutes each. The researchers conducted the qualitative analyses utilizing the grounded theory method (Strauss & Corbin, 1990) to examine themes. All participants were diagnosed with substance dependence, and 69.1% of them reported a history of misusing prescription drugs. Participants documented five primary reasons for prescription drug misuse: (a) to manage physical pain, (b) to manage emotional/psychiatric distress, (c) to manage stressful situations, (d) for recreational purposes, and (e) to avoid withdrawal symptoms. These findings align with another study by Rigg and Murphy (2013) exploring the etiology of prescription opioid abuse (POA). In this study, prescription opioid abusers in substance abuse and treatment programs provided narrative accounts of their POA onset circumstances. Thus, it is apparent that addiction largely emerges as a result of one's desire to alleviate stress or pain. The physical and psychological dependency on the drug then occurs and reaches a point in which it is no longer controllable.

Among adults with prescription opioid use, evidence has shown that 12.5% reported misuse; of these, 16.7% reported a prescription opioid use disorder (Rigg & Murphy, 2013). The most commonly reported motivation for misuse was to relieve physical pain (63.4%). Misuse and use disorders were most commonly reported in adults who were uninsured, were unemployed, had low incomes, or had behavioral health problems. Among adults with misuse,

59.9% reported using opioids without a prescription; 40.8% obtained prescription opioids for their most recent episode of misuse for free from friends or relatives. The main limitation was that the study was cross-sectional and used self-reported data. The current findings help expand on this limitation by demonstrating the experiences of those with addiction and offer greater insight into how and why such addiction occurs.

The results of this study also help expand on the literature pertaining to reasons why addictions occur. In an online survey of 527 university students from 4-year institutions aged 18 to 25 years, Lord et al. (2011) found that most young adults used prescription opioids not for the intended purpose but for other reasons. In this study, the three major reasons why students used NMUPDs were to relax (72%), get high (68%), and have fun (65%). Other reasons for misusing prescription opioids were to experiment, cope with depression or anxiety, manage chronic pain, improve concentration, improve energy, perform better at school, stay up at night, counteract other drugs, increase alertness, and perform better at work.

In another study, the authors investigated opioid use among 950 pharmacist students training in a college in the United States (Lord et al., 2011). Similar to the findings in the general population of American college students, these pharmacist students used opioids to have fun (31%), relax (29%), and manage chronic pain (23%). In this study, more students reported using prescription opioids to manage chronic pain (23%). The current study confirmed that addictions rarely form because of simply a desire to use the drug itself. Instead, they occur primarily for a desire to remove pain or stress that prevents relaxation.

There are many ways to track trends and motivations for opioid use, but as stated previously, data collected by SAMHSA utilizing the NSDUH is widely utilized to inform research studies. Han et al. (2017) conducted a study to evaluate the prevalence of prescription

opioid use, misuse, and use disorders and motivations for misuse among U.S. adults based on the 2015 NSDUH data. They reported that 72,600 eligible civilians, noninstitutionalized adults, were selected for the NSDUH, of which 51,200 completed the survey. The results estimated that in 2015, 91.8 million (37.8%) U.S. civilian, noninstitutionalized adults used prescription opioids, 11.5 million (4.7%) misused them, and 1.9 million (0.8%) had a use disorder.

As demonstrated in the current study, opioid use appears to be a growing problem in the United States and is one of the most common sources of addiction. Among adults with prescription opioid use, 12.5% reported misuse; of these, 16.7% reported a prescription opioid use disorder. The most commonly reported motivation for misuse was to relieve physical pain (63.4%). Misuse and use disorders were most commonly reported in adults who were uninsured, were unemployed, had low incomes, or had behavioral health problems. Among adults with misuse, 59.9% reported using opioids without a prescription; 40.8% obtained prescription opioids for their most recent episode of misuse for free from friends or relatives. The main limitation was that the study was cross-sectional and used self-reported data. The results from the current study help expand on these findings by offering insight into the lived experiences of those with addictions. The following section contains a discussion of the second theme that emerged from this study, which was the concept of becoming trapped in one's addiction.

### *Getting Trapped in Addiction*

The second theme to emerge from the data was *getting trapped in addiction*. Participants likened addiction to a trap or a condition of confinement that progressed subtly and outside of their awareness until it was firmly binding. All five participants reported that they experienced a period of heavy opioid use when they did not realize they were addicted or that their use was problematic. Other studies have analyzed different programs to track trends in opioid analgesic abuse and mortality in the United States. For example, Dart et al. (2015) analyzed five programs

from the Researched Abuse, Diversion, and Addiction-Related Surveillance (RADARS) System to describe trends between 2002 and 2013 in the diversion and abuse of all products and formulations of six prescription opioid analgesics: oxycodone, hydrocodone, hydromorphone, fentanyl, morphine, and tramadol. The programs gather data from drug-diversion investigators, poison centers, substance abuse treatment centers, and college students (Dart et al., 2015).

The findings of this study offer expanded insight into large quantitative datasets documenting drug use rates and frequencies in the United States; for example, data in the Drug Diversion Program records the drugs involved in cases opened by law-enforcement agencies investigating prescription-drug diversion in 49 states utilizing standardized reports from law enforcement agencies. The Poison Center Program records the substances involved in poison-center cases classified as intentional abuse from electronic medical records in 49 regional U.S. poison centers in 46 states (91.5% of the total U.S. population). Patients, acquaintances, or healthcare providers provide the information on record. Using standardized questionnaires, the Opioid Treatment Program, and the Survey of Key Informants' Patients (SKIP) Program, new patients upon admission to substance abuse treatment were queried about medications they had abused in the previous 30 days.

Using a web-based approach, the College Survey Program asks self-identifying college students about their nonmedical use of prescription drugs during the previous 30 days. In general, RADARS System programs reported large increases in opioid diversion and abuse rates from 2002 to 2010, but then the rates flattened or decreased from 2011 through 2013. The rate of opioid-related deaths rose and fell in a similar pattern. Reported nonmedical use did not change significantly among college students. After analyses, Rigg and Murphy (2013) identified the presence of four trajectories leading to POA: the South Florida effect, male influence, the

cocaine context, and prescribed addiction. In the current study, it was also clear that numerous contextual factors were associated with addictions and characterized the lived experiences of those struggling with such issues.

Additionally, the current study results help clarify ethnographic research conducted related to opioid addictions in the United States. Utilizing an ethnographic perspective, Henderson (2018) sought to explore the experience that opioid addiction patients have within the framework of emergency care. The central field site selected for this study was an urban trauma-level research hospital's emergency department (ED). This researcher sought to document the process of care for those in the opioid crisis and the challenges healthcare providers face in facilitating this care. The researcher utilized participant observation to focus on patients who arrived in the ED for an acute opioid crisis and the hospital personnel who administered treatment. In addition to participant observation and qualitative analysis, 15 interviews with ED staff were conducted and three in-depth life history interviews with three participants to achieve a more holistic view of addiction. The results from this study are also in alignment with those of Spitsbergen (2017), who utilized a retrospective approach to explore the experiences of 26 young adults (18 to 25 years old) participating in various 12-step recovery programs in a Midwestern metropolitan region who had achieved continuous sobriety. Twenty-five participants were Caucasian, and one was Black non-Hispanic. All participants were recruited from Alcoholics/Narcotics Anonymous meetings. The study used grounded theory methodology to gather and analyze data of participants' recollections of their adolescent addiction. The findings of this study offer an extension of these findings by demonstrating how users can become trapped in addictions without necessarily having a strong desire to use drugs and simply seeking to remove or alleviate pain and stress. The following subsection elaborates on the third major

theme in this study, which pertains to how individuals recognize problems associated with their addictions.

### *Recognizing the Problem of Addiction*

The third theme to emerge from the data was *recognizing the problem of addiction*. All five participants reported that at some point after they became addicted, heavy users of opioids, they realized that their use was problematic and that they were addicted. These findings reflect literature showing how the recognition of problems associated with addiction appears to reflect a stage in which it is recognized that action may be needed to regain control over this state of physical dependency. In many cases, as reported by the literature, legal problems may serve as a catalyst for the desire to remove addiction from one's life. In addition, the medications are legal, which in some cases may translate to fewer legal problems for possession with intent to abuse or distribute (Cicero & Ellis, 2017). Once addiction occurs, however, individuals may be more inclined to use harder drugs or obtain prescription medications illicitly for cost reasons or because they cannot receive the quantity of the medication that they seek to support their dependency.

What used to be a problem primarily seen in adults in urban areas and minorities is now seen in populations that were not routinely associated with opioid dependencies, such as White Americans, women, and the middle class. The most alarming increases in opioid misuse, both legal and illegal, have been among young adults aged 18 to 25 years. Much of the literature has been focused on adults who were afflicted with opioid dependency (Cicero & Ellis, 2017). The dominant social view of persons using drugs is stigma and shame, and the dominant scientific view on drug abuse is a public health problem, biochemistry, or psychopathology. Unlike these views, an existential-phenomenological view starts with the first-hand experience of persons using drugs in their own words. Young adults are abusing opioids at an alarming rate with

devastating consequences. The results of this study help offer further insight into the lived experiences of opioid-dependent young adults and illustrate ways in which nurses may be able to help them recognize their problems earlier before severe health and legal issues manifest. The following section discusses the fourth theme to emerge from this data, which pertains to the process by which users begin to escape from addiction.

### *The Painful, Precarious Escape from Addiction*

The fourth and final theme to emerge from the data was coined *the painful, precarious escape from addiction*. All five participants reported that they had successfully recovered from addiction and were not currently using opioids. The participants suggested that their escape from addiction was precarious in the sense that they needed to be continually vigilant to ensure they did not succumb to the temptation of resuming opioid use. The participants also described the experience of recovery as painful because of the intense symptoms of physical withdrawal. These findings help extend the literature presented in Chapter II regarding factors that may be involved in the treatment of addiction and the provision of support for those who recognize they have a chemical dependency problem. For example, in a mixed-method study, Rigg and Ibañez (2010) examined the motivations for engaging in the nonmedical use of prescription opioids and sedatives among street-based illicit drug users, methadone maintenance patients, and residential drug treatment clients aged 18 to 60 years. The three most common motivations reported were "to get high," "to sleep," and "for anxiety/stress." These findings reflect those of the current study and may present important implications for the recovery of those with addictions.

It is also important to discuss the study findings in relation to gender and race. Though the study was limited, the participants were diverse (See appendix D). Since 1999, the demographics of opiate misuse have slowly changed. For example, female opioid overdose deaths have increased at a faster pace than male deaths – 1,608% for females versus 1,076% for

males (CDC, 2021). Opiate misuse has also increased in non-traditional populations (women, white Americans and middle-class households). In addition, minorities have reported differences in inadequate access to treatment for opioid disorders (Anderson et al., 2009; Singhal et al., 2016). Some minorities have also reported that they have been unable to get opiates when needed for other legitimate medical reasons.

In my study, there were more male users than female users. Along racial lines, there were 2 white participants, 2 black participants and one participant who identified as other. None of the participants reported any issues with being able to get treatment once they were ready. Each participant had help and could easily get help when needed. In fact, unlike some of the literature, none of the participants reported feeling marginalized by healthcare providers. One interesting finding was that at the height of the pandemic, Participant 4 (male and white) was able to easily get opioids to misuse by telling his primary providers that he had medical problems. All the other participants were acquiring their opioids via dubious means. Because the sample is limited, inferences cannot be made. However, there has been some literature on implicit bias stipulating that certain demographics have an easier access to opiates for treatment (Burgess et al., 2014; Chapman et al., 2013).

**Relevance to Theoretical Framework**

In order to connect the findings of this study with a theoretical and a practical approach, I will discuss the findings in light of Victor Frankl's theory of meaning or logotherapy. Since the formation of psychotherapy as a clinical profession, its development has been accompanied by efforts to provide empirical evidence for its theoretical assumptions and its efficiency, and many researchers have been interested in the progression of logotherapy as a psychotherapeutic tool (Batthyány, 2011). Perera (2020) provided a useful outline of Victor Frankl's theory, covering

the basic tenets of logotherapy as outlined in the following paragraphs. Born in 1905, Frankl grew up learning the theories of Sigmund Freud and Alfred Adler (Encyclopædia Britannica, 2019). In 1942, his life abruptly changed when Frankl and his family were deported to a Nazi concentration camp. While struggling to survive in the Nazi camp, drawing from his experiences as well as observations, he developed the theory of logotherapy which claimed that through a search for meaning in life, individuals can endure and overcome suffering.

Frankl coined the term logotherapy based on his belief that the search for meaning even amidst suffering can constitute a potential solution to human suffering. Logotherapy literally means therapy through meaning. Frankl believed that humans are motivated by something called a "will to meaning," which corresponds to a desire to seek and make meaning in life (Frankl, 1984, p. 125).

At the heart of Frankl's philosophy are three essential properties (Rajeswari, 2015), including that every person possesses a healthy core, the main focus is upon enlightening a person to their own inner resources, and providing them with the tools to use their internal core, and while life offers purpose and meaning, it does not assure happiness or fulfillment.

One of the important components is finding meaning. According to Graber (2004), Finding meaning or the will to meaning is the primary motivation for living….the meaning that an individual finds is unique to each person and can be fulfilled only by that one person….Frankl emphasized that the true meaning of each person's life is something that must be discovered by activity in the world through interaction with others, not solely through introspection…..Challenging a person with a potential meaning to fulfill evokes the will to meaning. (p. 65)

Logotherapy holds that human beings are driven to find purpose and meaning in life. It offers three distinct ways whereby one can discover meaning in life (Devoe, 2012), including creative value by creating a work or accomplishing a task, experiential value by receiving something from the world through appreciation and gratitude. By fully experiencing something or loving someone, and attaining value by adopting a certain attitude toward inevitable suffering. Frankl held that life includes suffering, and that a human being's ultimate freedom lay in responding correctly to the given circumstances, including those which have engendered pain.

As do all forms of psychotherapy, logotherapy possesses a set of underlying assumptions which cannot be conclusively proven (Reitinger, 2015). These assumptions include that human beings are made up of body (*soma*), mind (*psyche*), and spirit (*noos*). Frankl held that while humans have a body and a mind, the spirit is who they are, in terms of identity and essence. While Frankl's theory was not derived from theology, his assumption herein departs from an atheistic materialism and shares striking similarities with certain religious views.

One assumption is that life has meaning even in the most miserable circumstances. This assumption represents an acknowledgement of a higher order in the world—an order that transcends mere human laws. Consequently, even an objectively terrible situation can offer meaning. "If there is a meaning in life at all, then there must be a meaning in suffering. Suffering is an ineradicable part of life, even as fate and death. Without suffering and death human life cannot be complete" (Frankl, 1984, p. 88).

Logotherapy proposes that humans have a will to meaning, which means that seeing meaning in pain can prepare the individual for suffering. This assumption embodies a significant departure from one's will to achieve power and pleasure. It posits that the discovery of meaning is one's primary motive for living. The will-to-meaning is "the basic striving of man to find

meaning and purpose" (Frankl, 1969, p. 35). Under all circumstances, individuals are free to activate the will to discover meaning. The salutary amendment of one's attitude toward inevitable suffering can enable one's will to discover meaning under any circumstance. This assumption draws heavily upon Frankl's own experiences in the Nazi camps. An individual's response determines the meaningfulness of the individual's decision. By heeding the values of society or following one's conscience, one can find meaning in their decisions. This assumption is associated with the meaning of the moment in practical daily living, rather than ultimate meaning.

In response to the various demands of life, human beings experience unique situations. Additionally, they are constantly seeking meaning. In practice, logotherapy involves therapeutic goals to awaken the client's sense of responsibility and meaning, to help the client discover their true identity and place in the world, to help the client pursue what really matters in life, and to make life better for self and others. Three techniques used in logotherapy include dereflection, paradoxical intention, and Socratic dialogue.

Dereflection, which is based on self-transcendence, seeks to redirect one's attention from oneself or one's own goals toward others. This technique posits that when one is self-absorbed and is struggling with issues in one's life, one can significantly improve one's situation by altering one's focus and being concerned about those around. For instance, if one is struggling with one's finances, the logotherapist might ask the patient to focus more on the people for which they are working to provide, rather than constantly thinking of how the problem is affecting themselves. Paradoxical intention is employed primarily to overcome fear by anticipating the very object of one's fear. For instance, with humor and ridicule, one may wish for the very thing of which one is afraid in order to remove fear from one's intention. This

practice would likely result in symptom reduction as well. Socratic dialogue employs a method of self-discovery to demonstrate to the patient that the solution to the patient's problem is within them. The logotherapist would use the patient's words, by listening carefully for patterns, to help the patient discover new meaning in their own words.

In addition to the above three, attitude modification can be implemented. This technique is primarily focused on altering one's attitude toward a situation rather than amending one's conduct. A patient who has suffered a loss might be directed to adopt a new attitude toward the misfortune so as to process the situation better. Frankl believed in turning tragedy into triumph and past guilt into life-changing progress. Drawing primarily from his personal experiences, his approach aimed at enabling individuals to tap into their own inner resources to transform adversity. By today, however, more than mere anecdotes testifies to its efficacy. A vast array of theoretical and empirical research has been conducted on logotherapy (Schulenberg et al., 2008). In 2016, a systematic assessment of evidence related to logotherapy was conducted, and the following were among its findings (Thir & Batthyány, 2016): (a) a tendency of patients with disorders to have a lower meaning of life; (b) a correlation between the search for and the presence of meaning and satisfaction in life; and (c) a relationship between the search for and the presence of meaning and resilience.

Some critics have accused Frankl of using his time in the Nazi concentration camps to advance his specific brand of psychotherapy (Reitinger, 2015). Additionally, some have contended that Frankl's support came only from religious leaders. Moreover, existentialist psychologist Rollo May argued that logotherapy resembled authoritarianism because the therapist seemingly dictated solutions to the client (May, 1969). In his criticism, however, May did not clarify whether he was critiquing Frankl's approach as a therapist himself or an aspect

that characterized logotherapy itself. Frankl, in fact, contended that logotherapy teaches the patient to be responsible. Furthermore, although Frankl's logotherapy has enjoyed acceptance from many religious communities, it has not been completely rejected by the scientific community. On the contrary, as shown above, logotherapy—sometimes in combination with other approaches—is still practiced today. Finally, while it can be granted that Frankl may not have discovered logotherapy without his experiences in the Nazi camps, there is no evidence to even faintly suggest that Frankl proactively sought out his torturous ordeal so he could be credited with a novel brand of psychotherapy (Perera, 2020).

This study uncovered that opioid use is a threat to human freedom and creates a feeling of being trapped. As previously stated, participant 2 described it as *"your soul may get stolen from you"* and "*it's like your best friend holding you hostage"*, statements which were unique from the literature to describe the experience of opioid usage. The results from this study have numerous implications because of the four themes which emerged; starting opioids to alleviate stress or pain; getting trapped in addiction; recognizing the problem of addiction; and the painful, precarious escape from addiction. For example, all participants in the current study except Participant 1 initially tried opioids recreationally. They did not do so because it brought them any significant form of meaning or purpose. Participant 1 initially tried opioids to alleviate chronic back pain that interfered with work. For individuals who are at this stage of usage, psychotherapeutic concepts such as meaning-making via Frankl's logotherapy may not yet be of benefit.

Participants likened addiction to a trap or a condition of confinement that progressed subtly and outside of their awareness until it was firmly binding. This finding reflects how substances began to create more meaning in these participants' lives. Addiction and the

acquisition of the substance of choice became central to these participants' lives, and their sense of meaning from other activities that were previously enjoyable began to decline. At this stage, Frankl's logotherapy may be of significant benefit to individuals with addictions and / or undergoing recovery. For example, through the application of logotherapy and techniques like paradoxical intention, those experiencing addiction can be led to address anxieties and obsessions through self-distancing from these emotions and humorously exaggerating their effects. Additionally, dereflection can be used to help draw attention away from their symptoms of addiction. According to Frankl, hyper-reflection can result in stagnation and inaction.

Frankl also used Socratic dialogue and the modification of attitudes by asking questions that could help the client discover their own meaning. This would be of benefit to individuals undergoing addiction, who would be questioned to determine what meaning substance use brings and whether there is anything that would potentially be more meaningful. It would be of benefit to utilize Frankl's perspective in order to produce self-knowledge and awareness in the case of addiction, and to foster the reflexivity needed in order to understand one's own sources of meaning and whether or not addiction is detracting from that. All five participants reported that at some point after they became heavy users of opioids, they realized that their use was problematic and that they were addicted. Thus, it is clear that individuals who suffer from addiction possess self-awareness and generally do understand the negative impacts of their addictions; however, they simply believe that the benefits of substance use outweigh any negative outcomes. All five participants reported that they had successfully recovered from addiction and were not currently using opioids. Thus, it is also possible that through psychotherapy, such as Frankl's logotherapy, recovery from addiction is possible.

One of the reasons that recovery is possible, according to the perspective of Viktor Frankl and his logotherapeutic framework, is that practitioners can help clients discover what is meaningful to them in life and the extent to which addiction is detracting from things that would truly make them happy and fulfilled. According to Frankl, meaning is the central motivational factor and force in all of mental health. For example, participant one struggled with finding meaning and became very religious as part of his recovery. He stated *"I feel like I had to get afflicted, for me to be smarter, and be wiser. So... And that's in the Bible too, like, you know, you've to get afflicted... Like, like the Most High has to afflict you, He has to make me go to something. And then once you go to that, like say, if, once you hit rock bottom, He's gonna pick you back up, and you just gotta ride with him from there on".* Thus, the discovery of meaning is key to therapeutic progress using this approach. The results of the current study demonstrate the importance of meaning in the recovery from addiction. Additionally, the findings demonstrate the role that psychotherapy can play in the recovery from addiction. The following section contains a discussion of the major limitations that were present in this study.

**Limitations of the Study**

Although findings from this study are believed to make a substantial contribution to the understanding of addiction, some limitations are present in this research that warrant consideration. First, a major limitation with qualitative research is that it is not generalizable to the general public as quantitative research is. This is due to the small sample size and the lack of random sampling of the population. This limitation, however, does not negate or minimize the benefits of qualitative research, as qualitative research allows for a deeper and richer understanding of a phenomenon that can easily be missed with quantitative research (Thomas & Magilvy, 2011). Another possible limitation to this study might be due to the sensitive nature of the phenomenon under study. Some young adults chose not to participate in the study because

they became overwhelmed with emotions and concerns about their lived experience with opiate use disorder. Thought it was reiterated that support services were available and they could withdraw at any time, some young adults were not comfortable. As the researcher, I remained sensitive and nonjudgmental in order to gain the trust of participants and maintain rapport through the interview process.

The age range of the participants was limited to between 22 to 25 years age, it would be interesting to see if younger participants have similar comments and concerns. Because of these limitations, some caution may be warranted with interpreting the results of this study.

**Recommendations**

In consideration of the findings of this study and the aforementioned limitations, several recommendations can be made for research and practice. First, it is recommended that researchers adopt study designs with larger samples and make use of random sampling to improve the generalizability of the results. Additionally, longitudinal research that examines addiction processes over time is warranted to understand how addiction evolves and changes. The findings of this study offer important insight into the potential stages of addiction. It would be interesting to determine whether those who become addicted undergo relatively similar processes. Such research may have important implications for the treatment of addiction and the prevention of addiction for nurses who can recognize any signs in patients.

This research may be also be beneficial for participants who are immigrants. Studies using logotherapy on immigrant populations are still scarce. Participant 5 experienced uncomfortable feelings and moods when she entered college because she came from a *"tight-knit immigrant family with parents who do not understand what it is like to be an outsider at school. Very religious. Very strict. They had no idea what my daily struggles looked like. Just trying to fit in."* Logotherapy approaches may help the person to deal with the existential concerns of

freedom, isolation, and meaninglessness. According to Frankl, freedom is an existential concern as every person should be able to determine who and what they are, while isolation is the reality that there is a gap in existence between the person and others in the society. Addressing these existential concerns requires effective interventions intended to empower people to find meaning in work, suffering, and relationships. Immigrants may be free to pursue meaning from their experiences and how they have responded to the experiences

` From a practical standpoint, there is a need to conduct intervention research based on these themes, which may help in preventing or treating addiction. As these findings help to illustrate the lived experiences of individuals with addiction, there is a necessity to generate understanding as to how they can be applied to practice within the context of nursing. It is also recommended that the findings of this study be incorporated into the development of screening tools that can help nurse practitioners recognize signs and symptoms of addiction in order to guide early interventions.

**Implications**

The phenomenon under study was opioid dependency among young adults, and there are several implications of this research for nursing practice, research, and theory. The results uncovered the unique presentations of opioid dependence among young adults. There is an opioid epidemic in the United States, and young adult deaths from opioid overdoses are on the rise. As stated earlier, because the opioid epidemic has been declared a public emergency, there is an urgency for research to better understand opioid dependency and treatment. Once afflicted, clients seek care in the many diverse health care centers with nurses in a unique position in that they are often the first point of contact with patients. It is imperative that nurses be aware, involved in opioid dependency research, and skilled in handling opioid-dependent patients.

The emergence of the opioid crisis highlights the need for social and institutional support to help young adults transition into competent, fully functional, successful adults. A holistic, systematic approach is needed to understand and respond to today's young adults' unique circumstances and needs. This study helps shed light on the needs of opioid-dependent young adults.

Having declared a public health emergency in 2017, HHS has announced a five-point strategy to combat the opioid crisis. This five-point strategy includes better addiction prevention, treatment, and recovery services, better data collection, better pain management, better targeting of overdose-reversing drugs, and better research. HHS is supporting research on pain and addiction to inform clinical practices, reduce opioid prescribing, and combat the opioid crisis. Many studies have been done on opioid-dependent adults, with a few studies on adolescents. These show a promising preliminary trend of a decrease in opioid usage.

The dominant social view of persons using drugs is stigma and shame, and the dominant scientific view on drug abuse is a public health problem, biochemistry, or psychopathology. Unlike these views, an existential-phenomenological view starts with the first-hand experience of persons using drugs in their own words. Young adults are abusing opioids at an alarming rate, with devastating consequences. It is, therefore, necessary to explore the lived experience of opioid-dependent young adults.

Nurses are in a unique position in that they are often the first point of contact with clients in treatment centers. Because of its emphasis on reshaping thoughts and choosing one’s attitude and perspective on events, Logotherapy, can be an option which nurses may incorporate when managing patients. Almost 2,000 papers have been published about logotherapy’s effectiveness, and because of the evidence supporting both logotherapy and the importance of living with

meaning and purpose, around 60 formal mental health assessments have been created and are in use based on logotherapy's principles (Schulenberg et al., 2008). Vested institutions may consider utilizing some of these tools in their practices as part of the initial screening process when treating patients. It is essential that nurses are not task-oriented exclusively and participate in their clients' care in a comprehensive, patient-centered, individualized, and empathetic manner. Understanding the complex needs of opioid-dependent young adults may assist in helping to provide nursing care in a skilled, competent, and holistic way. Nurses must participate in the emerging research on opioid dependency.

**Conclusion**

The purpose of this chapter was to provide a discussion of the findings, their significance, and their relevance to literature and theory presented in Chapter II. An interpretation of the findings was presented first, drawing back to the seminal research and evidence pertaining to addiction identified in the literature review. The findings of this study generally aligned with the large body of evidence documenting problems with addiction and the causes in the United States. As demonstrated in Chapter II, addiction often emerges from a desire to alleviate stress or pain and quite often results from prescription medication. From a nursing standpoint, results from this study highlight the responsibility of practitioners to identify signs of addiction and monitor prescriptions that are offered to individuals who may be particularly susceptible or prone to addiction.

The main limitations of the study were then discussed. These primarily pertained to the small and potentially self-selecting sample, which reduces the extent to which findings can be generalized to the target population. The depth and richness of data were selected in favor of generalizability in the current study. The present limitations were considered acceptable based on the nature and design of the research. Additionally, these findings generally agreed with previous

research that has included larger, random samples. Recommendations were then provided for future research and practice. There remains a clear need to understand the process of addiction, particularly as this relates to prescription drugs. Understanding this topic should lead to an improved ability to recognize addiction and intervene as early as possible. The implications of these findings to practice, research, theory, and social change were then considered. The study results have important implications for nursing practice and the understanding of addiction risk and its pathways. It is clear from these findings that there are consistent themes that define the process of addiction. This information is critical for guiding nursing practice regarding both identifying addiction and helping patients manage physical dependency.

## Appendix A

**THE CITY UNIVERSITY OF NEW YORK**
*CUNY Graduate Center*
*PhD Nursing Program*

## CONSENT TO PARTICIPATE IN A RESEARCH STUDY

**Title of Research Study:** *The Lived Experience of Using Opiates Among Young Adults*

**Principal Investigator:** *Catherine Mbewe, RN, MS*
*Student*

**Faculty Advisor:** *Steven Baumann, RN, PhD, GNP, PMHNP*
*Professor*
*Hunter College*

**Research Sponsor**: N/A

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You are being asked to participate in a research study because you have used opiates within the past 5 years.

**Purpose:**
The purpose of this research study is to explore your perceptions of your experience as a young adult with a history of opiate use. We will do this study through individual face to face interviews. Not many studies have been conducted on the experiences of young adults with opiate use. The investigator will analyze the themes and essences that arise for any insight into how young adults are affected by opioid usage. The themes that emerge from the interview will add to the body of literature on the experiences of young adults with opiate use. This information could then be used to expand or enact new policies and to develop or continue existing interventions to improve the health, safety, and well-being of opioid-dependent young adults. We are seeking your consent to participate in this study.

**Key Information:**

- We are seeking your consent to participate in this research study on opiate use in young adults. Your participation is completely voluntary and you can decide to stop the interview at any time.
- The purpose of this research study is to explore your perceptions of your experience as a young adult with a history of opiate use. This research will involve a face to face interview

that will take anywhere from 30 to 60 minutes. If you consent to participate in this research study, we will ask you to do the following:

- Complete a demographic questionnaire which includes your gender, age and borough of residence and history of opiate use. The questionnaire has 15 short questions and takes 5 minutes to complete. The completion of the questionnaire will take place in a location comfortable to you. We will then read the interview guide script before we actually start the interview. The main interview question will be: "Tell me about your experience using." Follow up questions may be:
  "What do you mean by that?" "Can you give me an example?"
- The interview will be audio recorded. The interview will be in a location that is comfortable to you.
- There is a slight chance that one or more of the questions asked may make you feel uncomfortable. You can choose not to answer a particular question. Your standing as a CUNY student (if applicable) will in no way be affected by your decision to participate or not to participate or by any comments you make during the interview. Please be assured that the interview is confidential and individuals will not be identified in any analyses or reports. You will be asked to sign this consent form, but your name will not be included on any assessment form or linked to your answers.
- You may not benefit personally from being in this study. However, we hope that there will be a greater body of knowledge on the experiences of young adults with opiate use. This study may supply nurses, parents, teachers, and other healthcare providers with valuable information on the psychosocial, environmental, and economic determinants of opioid use and its consequences. This information could then be used to expand or enact new policies and to develop or continue existing interventions to improve the health, safety, and well-being of opioid-dependent young adults.
- You may choose to not participate in this research study. This study involves only one visit today, however, you are welcome to review the transcript at a later time if you feel that it is necessary. You are free to leave the study at any time.

**Procedures**

If you volunteer to participate in this research study, we will ask you to do the following:
Provide us your thoughts related to the following topics;

1. Complete a demographic questionnaire which includes your gender, age and borough of residence and your history of opiate use. This information assists us in screening you for the study to ensure that you meet the inclusion criteria. If you are eligible for this study, this screening data in the questionnaire will be kept in a secure password protected cabinet that only approved research staff will have access to. This data will not identify you by name. If you are ineligible, this screening data will be destroyed immediately. The questionnaire has 15 short questions and takes 5 minutes to complete. The completion of the questionnaire will take place in a location comfortable to you.
2. If you have already been screened over the phone and are eligible for the study, we will now collect the rest of the demographic data.
3. We will then read the interview guide script before we actually start the interview.
   The main interview question will be:
   a. Tell me about your experience using

Follow up questions may be:

b. What do you mean by that?
c. Can you give me an example?

The interview will be audio recorded and may take 30 to 60 mins. The interview will be in a location that is comfortable to you.

You are free to skip any questions that you prefer not to answer.

At any time in the study, you may decide to withdraw from the study. If you withdraw, no more information will be collected from you. When you indicate you wish to withdraw, the interview will be concluded and you are free to leave the interview location.

**Audio Recording**

The interview will be audio recorded by 2 recording devices to accurately capture the comments of all participants. 2 devices are being used in the event that one recorder malfunctions. Audio recording is required for participation in the interview. If you do not wish to be recorded, you cannot participate in this study. After the interview, the recording will be transcribed without personal identifying information and then will be deleted from the recording devices.

**Time Commitment**

Your participation in this research study is expected to last for 30 to 60 minutes

**Potential Risks or Discomforts**

There is a slight chance that one or more of the questions asked may make you feel uncomfortable. You can choose not to answer a particular question. Your standing as a CUNY student (if applicable) will in no way be affected by your decision to participate or not to participate or by any comments you make during the interview.

Please be assured that the interview is confidential and individuals will not be identified in any analyses or reports. You will be asked to sign this consent form, but your name will not be included on any assessment form or linked to your answers.

**Potential Benefits**

You may not benefit personally from being in this study. However, we hope that there will be a greater body of knowledge on the experiences of young adults with opiate use. This study may supply nurses, parents, teachers, and other healthcare providers with valuable information on the psychosocial, environmental, and economic determinants of opioid use and its consequences. This information could then be used to expand or enact new policies and to develop or continue existing interventions to improve the health, safety, and well-being of opioid-dependent young adults.

**Alternatives to Participation**

You may choose to not participate in this research study. This study involves only one visit today, however, you are welcome to review the transcript at a later time if you feel that it is necessary. You are free to leave the study at any time.

**Payment for Participation**
You will not be paid to take part in this study.
As a thank you for your time, you will receive a Dunkin Donuts gift card (worth a total of $15) upon completion of the interview.

**New Information**
You will be notified about any new information regarding this study that may affect your willingness to participate in a timely manner.

**Confidentiality**
We will make all best efforts to maintain confidentiality of any information that is collected during this research study, and that can identify you. We will disclose this information only with your permission or as required by law. We will protect your confidentiality by keeping your responses separate from this consent form and any identifying information. Additionally, only approved research staff will have access to the audio recordings.
Recordings will be kept in a password protected cabinet folder only accessible to approved research staff. Recordings will be transcribed and transferred to a password protected server. The research team, authorized CUNY staff, and government agencies that oversee this type of research may have access to research data and records in order to monitor the research. Research records provided to authorized, non-CUNY individuals will not contain identifiable information about you. Publications and/or presentations that result from this study will not identify you by name. Data will not be stored or distributed for future research studies

**Participants' Rights**
Your participation in this research study is entirely **voluntary**. If you decide not to participate, there will be no penalty to you, and you will not lose any benefits to which you are otherwise entitled. Your participation or non-participation in this study will in no way affect your employment or student status at CUNY (if applicable). You can decide to withdraw your consent and stop participating in the research at any time, without any penalty.

**Questions, Comments or Concerns**
If you have any questions, comments or concerns about the research, you can talk to one of the following researchers:

Catherine Mbewe, RN, MS
PhD Nursing Program
CUNY Graduate Center
646-228-1950

Steven Baumann, RN, PhD, GNP, PMHNP
Professor
Hunter College
516-294-4001

If you have questions about your rights as a research participant, or you have comments or concerns that you would like to discuss with someone other than the researchers, please call the CUNY

Research Compliance Administrator at 646-664-8918 or email HRPP@cuny.edu. Alternatively, you may write to:

CUNY Office of the Vice Chancellor for Research
Attn: Research Compliance Administrator
205 East 42nd Street
New York, NY 10017

**Participant Signature for Audio Recording**

If you agree to audio recording, please indicate this below.

_____ I agree to audio recording

_____ I do **NOT** agree to audio recording

**Signature of Participant:**

If you agree to participate in this research study, please sign and date below. You will be given a copy of this consent form to keep.

_____
Printed Name of Participant

_____ _____
Signature of Participant Date

**Signature of Individual Obtaining Consent**

_____
Printed Name of Individual Obtaining Consent

_____ _____
Signature of Individual Obtaining Consent Date

## Appendix B

**Protocol Number: TEMP-2019-0922**
**Interview Guide**

**WELCOME:**

Thank you for agreeing to be part of this interview today. I really appreciate your time and willingness to participate in this research study.

**INTRODUCTIONS:**

My name is Catherine Mbewe and I am a doctoral student at the CUNY Graduate Center PhD Nursing Program. I will be facilitating the interview discussion.

PURPOSE OF INTERVIEW:

I would like to talk briefly about the purpose of our discussion today. I am interested in your perceptions of your experience with opiate use as a young adult. I am interested in how your involvement in opiate use has impacted you both on a personal level as well as on a professional level. Not many studies have been conducted on the experiences of young adults with opiate use. To that end, I am exploring your unique experience.

You are being interviewed because you have met the inclusion criteria for this study. The themes that emerge from our interview discussion will add to the body of literature on the experiences of young adults with opiate use. The interviews will be confidential. Your insights will be very valuable as I complete this study. This interview will last anywhere from 30 minutes to one hour.

GUIDELINES:

I would like to inform you of some simple guidelines that I would like you to follow.

1. There are no right or wrong answers.

I want to hear your opinions, experiences and thoughts.

2. What you say here, stays here (confidentiality)

Please do not hesitate to share your experiences. You have my assurance that this is a strictly confidential discussion. However, you are free to skip any question or end the interview if you are not comfortable.

3. The interview will be audio-recorded with 2 recorders

Participation is strictly confidential. I will not identify you by your name in the final report.

Recording the conversation helps me in further analysis. I will destroy the audio recordings after I have analyzed the content of our discussion.

Do you have any questions or concerns before we begin?

Main research question:

1. Tell me about your experience using

Supportive questions:

2. What does that mean?
3. Can you give me an example?

Thank you for the meaningful discussion.

## Appendix C

RESEARCH FLYER

ARE YOU A PERSON WHO:

- Is aged 18 to 25 years old?
- Wants to participate in research on the health status of young adults?
- Wants to contribute on research among young adults?

***If You Answered Yes to ALL of those Questions, Your Help is Needed!***

**A CUNY Graduate Center Doctoral Student would like you to participate in an interview about your health status.**

**Your Participation will:**

- Lend Insight into the real experiences of young adults and their health practices
- Assist in learning more about how to help young people to be healthy
- Provide knowledge and possible direction for further research and treatment approaches
- Provide immediate data that may be used to help young people who may have health concerns

RESEARCH FLYER

**If you are interested in participating in this research study, please contact Catherine Mbewe at cmbewe@gradcenter.cuny.edu or call 646-228-1950**

If you are accepted for this study, you will receive a $15 Dunkin Donuts gift card as a thank you for your participation at the completion of the interview. The interview may take anywhere from 30 mins to 1 hour.

## Appendix D

Demographic Data

| Participant | Pseudonym | Race | Sex | Age | Residence |
|---|---|---|---|---|---|
| 1 | Mike | Black | Male | 23 | Manhattan |
| 2 | Joe | Black | Male | 22 | Manhattan |
| 3 | Sally | White | Female | 24 | Staten Island |
| 4 | Jim | White | Male | 25 | Manhattan |
| 5 | Monique | Other | Female | 24 | Brooklyn |

## Appendix E

THE CITY UNIVERSITY OF NEW YORK

*CUNY Graduate Center*
*PhD Nursing Program*

## FACE TO FACE SCRIPT

**Title of Research Study:** The Lived Experience of Using Opiates Among Young Adults

**Principal Investigator:** Catherine Mbewe MS, RN

Student

Hi, my name is Catherine Mbewe. I am a doctoral student at the CUNY Graduate Center PhD Nursing Program. I am conducting research on young adults aged 18 to 25 years old who have used opiates within the past 5 years. I am looking for participants who have used opiates more than occasionally (more than 3 times a month) and for more than 6 months. You do not have to be currently using opiates and can be on Suboxone or Methadone.

The purpose of the study is to provide insight into the unique experiences of young adults who use opiates. In addition, this study will provide relevant information that may provide knowledge and possible direction for further research and treatment approaches for young adults who use opiates.

Face to face interviews will be conducted at a time that is convenient for you and may last from 30 minutes to 1 hour. At the end of the interview a $15 gift card will be given to you for your participation.

If you are interested in participating, please contact me at 646-228-1950 or cmbewe@gradcenter.cuny.edu so that we can set up a time for me to provide you with all the relevant information such as the informed consent.

If you have any additional questions regarding the study, please do not hesitate to contact me.

Thank you and I look forward to hearing from you.

Catherine Mbewe MS, RN,
Principal Investigator and Study Coordinator
CUNY Graduate Center
PhD Nursing Program
Phone: 646-228-1950
Email: cmbewe@gradcenter.cuny.edu

## Appendix F

**THE CITY UNIVERSITY OF NEW YORK**
*CUNY Graduate Center*
*PhD Nursing Program*

**ELIGIBILITY SCREENING SCRIPT**

**Title of Research Study:** The Lived Experience of Using Opiates Among Young Adults

**Principal Investigator:** Catherine Mbewe MS, RN
Principal Investigator and Study Coordinator

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Thank you for your interest in our research. This research study will explore the lived experience of young adults aged 18 to 25 years old who currently use opiates or have used opiates within the past five years. I would like to read you a questionnaire to determine whether you are eligible to participate in this research.

The screening will take about *5 minutes*. I will read you a questionnaire with some questions about demographics and drug use. You do not have to answer any questions you do not wish to answer or are uncomfortable answering, and you may stop at any time. Your participation in the screening is voluntary.

We will make our best efforts to keep your answers confidential. No one except for the research team will have access to your answers. The screening information will be used to assess whether you meet the eligibility criteria. *If you do not qualify for the study*, the answers will be destroyed. If you qualify for the research, decide to participate, and you sign the research informed consent form, the answers will be kept with the research record.

Would you like to continue with the screening?

Instruction: If yes, continue with the screening. If no, thank the person and hang up.

How old are you? Are you currently using opiates or have you used opiates within the past 5 years? Did you use opiates more than occasionally (more than 3 times a month) and for more than 6 months?

Thank you for answering the screening questions.

Instruction: If eligible: Thank you for answering our questions. You are eligible to participate in our study. If you are interested in participating in this study, the next step is to set up a time and day that is convenient to you in order for you to sign the informed consent and to participate in the study. Even though you are eligible, you have the right to change your mind and not participate at

any time. What date and time is convenient for you? If you do not have the date and time now, you may call me Catherine Mbewe, the principal investigator at 646-228-1950. Do you have any questions? Thank you.
If additional screening is required: Thank you for answering our questions. At this time, we are not able to determine whether you meet the eligibility criteria because you are not able to answer all of our questions. If you are still interested in this study, you may call me, Catherine Mbewe at 646-228-1950 for another screening. Do you have any questions? Thank you for taking the time to answer our questions.

If ineligible: Thank you for answering our questions. You are not eligible to participate in our study because you do not meet the eligibility criteria for this study. Thank you for taking the time to answer our questions. Do you have any questions? Have a good day.

Do you have any questions about the screening or the research? I am going to give you a couple of telephone numbers to call if you have any questions later. If you have questions about the research screening, you may call 646-228-1950.

If you have questions about your rights as a research participant, or if you wish to voice any problems or concerns to someone other than the researchers, please call CUNY Research Compliance Administrator at 646-664-8918 or email hrpp@cuny.edu.

Thank you again for your willingness to answer our questions.

## Appendix G

RESOURCES:

To get help and stop using:

| | |
|---|---|
|  | If you or someone you know is struggling with addiction, you can always call New York City's 24/7 mental health crisis and access line at 1-888-NYC-WELL (1-888-692-9355), text "WELL" to 65173, or visit nyc.gov/nycwell |

**Everybody needs help sometimes. Whatever you are dealing with, you don't have to do it alone.**

*NYC Well is New York City's free, confidential support, crisis intervention, and information and referral service for anyone seeking help for mental health and/or substance misuse concerns, available 24 hours a day, 7 days a week, 365 days a year. NYC Well is staffed by trained professionals who can help you find the services that best meet your needs.*

**Call NYC Well**

English: 1-888-NYC-WELL (1-888-692-9355), Press 2
Call 711 (Relay Service for Deaf/Hard of Hearing)

Español: 1-888-692-9355, Press 3

中文: 1-888-692-9355, Press 4

Interpreters are available for 200+ languages. Stay on the line, and you will be connected with a counselor who can connect you to translator services.

NYC Well Counselors are trained to accept calls from hearing impaired individuals using Video Relay Services

**Text NYC Well**

Text WELL to 65173

A service for NYC residents, available 24/7/365. **Text anytime!**

For English, when prompted text 1
For Spanish, when prompted text 2
For Chinese, when prompted text 3

**Chat with a Counselor Now**

If you need support and prefer to chat, NYC Well Chat is here 24 hours a day, 7 days a week, 365 days a year. https://nycwell.cityofnewyork.us/en/get-help-now/chat-with-a-counselor-now/

**In danger or need immediate medical attention? Call 911 now**

**At any hour of any day, in almost any language, from phone, tablet or computer, NYC Well is your connection to get the help you need. We can provide:**

- **Suicide prevention and crisis counseling**
- **Peer support and short-term counseling via telephone, text and web**
- **Assistance scheduling appointments or accessing other mental health services**
- **Follow-up to check that you have connected to care and it is working for you**

**Crisis**

- A crisis is a time of intense difficulty, distress or trouble. A crisis can be personal, a family crisis, or related to some other event in your life.
- **If you are in a crisis, call one of our counselors: 1-888-NYC-WELL (1-888-692-9355).**

**Emergency**

- An emergency is a situation that requires immediate attention.
- **If someone is at immediate risk of hurting themself or someone else or is in immediate danger because of a health condition or other situation: Call 911 immediately.**

**OTHER RESOURCES:**

- SAMHSA ♣ National Helpline: 1-800-662-HELP (4357) or 1-800-487-4889 (TDD, for hearing impaired)
- ♣ Behavioral Health Treatment Services Locator (search by address, city, or ZIP Code): https://findtreatment.samhsa.gov/
- ♣ Buprenorphine Treatment Practitioner Locator (search by address, city, or ZIP Code): https://www.samhsa.gov/medication-assistedtreatment/physician-program-data/treatment-physician-locator

- ♣ Single State Agencies for Substance Abuse Services: https://www.samhsa.gov/sites/default/files/ssa-directory.pdf

**HOSPITALS specializing in young adults:**

Brooklyn Hospital Center - 9B Detox Unit
121 Dekalb Avenue, Brooklyn, NY 11201 **718-250-8900 x8096**

**Services For:**
Adult men, Adult women, LGBTQ, Seniors, Young adults, Veterans

- **Payment Assistance:** Medicare, Medicaid, TRICARE, State insurance
- **Medication-Assisted Treatment for:** Opioids/Heroin, Mental Health

Montefiore Medical Center - Wellness Center at Melrose
260 East 161st Street, C-Level, Bronx, NY 10451 **718-993-3397**

**Services For:**
Service members, Adult men, Adult women, Court referrals, LGBTQ, Military families, Past domestic violence, Past sexual abuse, Past trauma, Mental health disorders, HIV/AIDS, Seniors, Young adults, Veterans

- **Payment Assistance:** Sliding fee scale, Medicaid, State insurance
- **Medication-Assisted Treatment for:** Alcohol, Opioids/Heroin

Saint Lukes Roosevelt Hospital
1000 10th Avenue, Floor 8, New York, NY 10019 **212-523-8943**

**Services For:**
Adult men, Adult women, LGBTQ, Past domestic violence, Past sexual abuse, Past trauma, Mental health disorders, HIV/AIDS, Seniors, Young adults, Veterans

- **Payment Assistance:** Medicare, Medicaid, State insurance
- **Medication-Assisted Treatment for:** Alcohol, Opioids/Heroin, Mental Health

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