A Qualitative Study of Counseling Students’ Attitudes Toward the Use of Medication Assisted Treatments with Opioid Dependent Clients

Bethany L. Ackerman
A QUALITATIVE STUDY OF COUNSELING STUDENTS’ ATTITUDES TOWARD THE
USE OF MEDICATION ASSISTED TREATMENTS WITH OPIOID DEPENDENT CLIENTS

A Dissertation
Submitted to the School of Education

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In partial fulfillment of the requirements for
the degree of Doctor of Philosophy

By
Bethany L. Ackerman

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Bethany L. Ackerman

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Bethany L. Ackerman

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A QUALITATIVE STUDY OF COUNSELING STUDENTS’ ATTITUDES TOWARD THE USE OF MEDICATION ASSISTED TREATMENTS WITH OPIOID DEPENDENT CLIENTS

Approved by:

____________________________, Chair
William Casile, Ph.D.
Associate Professor of Counselor Education
Duquesne University

____________________________, Member
David L. Delmonico, Ph.D.
Professor of Counselor Education
Duquesne University

____________________________, Member
Matthew Bundick, Ph.D.
Associate Professor of Counselor Education
Duquesne University
ABSTRACT

A QUALITATIVE STUDY OF COUNSELING STUDENTS’ ATTITUDES TOWARD THE USE OF MEDICATION ASSISTED TREATMENTS WITH OPIOID DEPENDENT CLIENTS

By

Bethany L. Ackerman

Dissertation supervised by Dr. William Casile

Counseling students’ perceptions of medication assisted treatment for opioid addition was explored. This study sought to understand how the students’ attitudes and beliefs regarding the use of medication assisted treatments developed, and also how these attitudes and beliefs may affect client care and professional career choices. Specifically, this study examined how their professional counselor education experiences played a role in the formation/development of these attitudes and beliefs.

This qualitative study was conducted with six counseling students who participated in semi-structured, individual interviews. At the time of the study, all of the students were currently enrolled in a CACREP-accredited counselor education program and were currently participating in their fieldwork experience. The data was analyzed using Thematic Analysis informed by Cognitive Behavioral Theory in order to determine how students’ educational
experiences and personal experiences affect the development of their attitudes and beliefs regarding the use of medication assisted treatment for the treatment opioid dependence and the clients who use this treatment option. This study found that the students’ perceptions of clients who chose medication assisted treatment appeared to be influenced by their perception of medication assisted treatment as formed in response to both their professional education and their personal experiences. Specifically, it appears that the participants’ limited exposure to medication assisted treatment during their formal education and training negatively affected their perception of medication assisted treatment as a treatment modality. However, this study also found that their attitudes toward MAT did not appear to negatively impact students’ attitudes toward providing care and treatment for these clients. The potential implications for practice and suggestions for future research are provided.
DEDICATION

This dissertation is dedicated to my son, Lucas. Always remember to follow your dreams.

I love you.
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“A journey of a thousand miles begins with a single step,” and this journey was not a journey I made alone. On this journey, I was blessed with many individuals who helped me along the way and I want to take this opportunity to thank them.

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CHAPTER I: INTRODUCTION

Opioid dependence is an increasing epidemic in the United States, and recently resulted in the current United States President declaring the opioid epidemic a national public health emergency (Merica, 2017). Despite this declaration, there continues to be limited treatment options to address the growing opioid epidemic. There are currently two primary treatment options: abstinence-based treatment and medication assisted treatment, which is also known as harm reduction. Two of the more common medication assisted treatment options are Methadone and Suboxone.

Approximately two million people in the U.S. are dependent on or abuse opioids, including heroin and prescription opioids. Of these two million, it is estimated that approximately 21 to 25% of all substance abusers have been involved in Methadone treatment and an additional 32,000 individuals have received Suboxone treatment for opioid dependence (Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality, 2013). Methadone has long been recognized as an effective treatment for opioid dependence (Schwartz, et al., 2008; Aletraris, Edmond, Paino, Fields, & Roman, 2016). Methadone is used to prevent withdrawal symptoms for opioid dependent individuals and so that the clients no longer experience peaks of euphoria or the adverse effects of withdrawal once they are stabilized on Methadone (Douaihy & Kelly, 2013). In addition to Methadone, Suboxone is a more recently developed treatment for opioid dependence that was approved by the U.S. Food and Drug Administration (FDA) for office-based treatment of opioid dependence in 2002. Suboxone was developed in part due to the need for an alternative medication that did not have the strict laws and treatment regulations associated with Methadone (Jaffe & O’Keefe, 2003; Walsh & Eissenberg, 2003).
Despite the addiction statistics noted above, counselor education programs accredited by the Council for Accreditation of Counseling and Related Educational Programs (CACREP) continue to provide limited education to counseling students regarding substance abuse treatment, and in particular regarding medication assisted treatment. The CACREP requirements do not require that students be taught about medication assisted treatment specifically. With the growing opioid epidemic, however, this lack of educational exposure exposes a potential weakness, as counseling students are more likely to see clients addicted to opioids than ever before. Additionally, by not exposing students to the medication assisted treatment modality, programs increase the likelihood of maintaining underlying stigma and limiting the number of counselors available to treat clients with opioid dependence. Despite CACREP not requiring specific additions to education, approximately 82% of CACREP programs have incorporated substance abuse training into their curriculum. However, only 30% require students to take one or more courses in substance abuse training. (Whittinghill, Carroll, & Morgan, 2004) Within these substance abuse courses, approximately 24% of students were taught about Methadone and 5% were educated about Suboxone in their respective counseling program (Madison, Bethea, Daniel, & Necaise, 2008).

Students’ limited educational exposure to addictions and medication assisted treatment specifically has the potential to affect their perception of this treatment modality and the clients who choose to use this treatment option. The negative attitudes of providers towards the use of medications used to treat opioid dependence have been identified as a potential barrier for treatment by professionals and clients (Smye, Browne, Varcoe, & Josewski, 2011). Clients in Methadone Maintenance Treatment (MMT) report that they often feel misunderstood, looked down upon, and stigmatized by addictions counselors (Conner & Rosen, 2008). Even though
evidence-based treatment for Methadone and Suboxone has been proven effective for the
treatment of opioid dependence, the use of these medications remains a point of contention
among providers (Matusow, et al., 2013; Fitzgerald & McCarty, 2009; Atlas, 1982).

This disagreement, and the conflicting opinions and attitudes among counselors regarding
the use of medication for the treatment of opioid dependence, have significant consequences for
the client with an addiction to opioids who is seeking treatment. Development of negative
professional attitudes toward the efficacy of using these types of medications, even in light of the
evidence to support their efficacy, may affect a client’s willingness to enter treatment,
development of the therapeutic relationship, the personal self-perception of the client, and the
therapist’s perception of the client (Conner & Rosen, 2008; Hunt, Lipton, Goldsmith, Strug, &
Spunt, 1985-86). This study seeks to explore the origin and development of counselors’ attitudes
and beliefs towards the use of medication assisted treatment.

Statement of the Problem

Counselors who treat individuals prescribed medication assisted treatments may have
varying views about the medications despite the research supporting their effectiveness
(Knudsen, Ducharme, Roman, & Link, 2005; Rieckmann, Daley, Fuller, Thomas, & McCarty,
2007; Fitzgerald & McCarty, 2009; Rieckmann, Kovas, McFarland, & Abraham, 2010). While
the thoughts and beliefs regarding the use of medication assisted treatment have been reported
for counselors and other healthcare providers who provide medication assisted treatment,
(Conner & Rosen, 2008; Knudsen, Ducharme, Roman, & Link, 2005; Rieckmann, Daley, Fuller,
Thomas, & McCarty, 2007; Fitzgerald & McCarty, 2009; Rieckmann, Kovas, McFarland, &
Abraham, 2010), there is a lack of research regarding the attitudes and beliefs of counseling
students towards this treatment approach. As a result, there is an inadequate understanding of the relationship between counseling students’ experiences and how they might develop either positive or negative attitudes and beliefs surrounding the use of medication assisted treatments as part of a treatment protocol for opioid addictions. Furthermore, little is known about the implications these attitudes and beliefs have on the behaviors of these counselors in their treatment practices.

While many factors may have influenced where or how such perceptions developed, it is possible that limited education about or exposure to the use of these medications can play a significant role in the counseling student’s development of negative attitudes and bias against the use of this approach to addiction treatment. The 2016 Council for Accreditation of Counseling and Related Educational Programs (CACREP) standards are vague in their requirements for addictions and counseling education; the requirements appear to be dependent on the specialty or major within a counselor education program. The standards for the Clinical Mental Health and School Counseling specialties only briefly mention addictions while the Marriage, Couple, and Family Specialty does not mention addiction education as part of the curriculum requirements. None of the specialties specifically address harm reduction education, or in particular medication assisted treatment, as being a required topic in the education of counselors. (Council for Accreditation of Counseling and Related Educational Programs, 2015). Additionally, there appears to be a lack of literature regarding the perceptions of counseling students and counseling professionals’ attitudes and beliefs about the use of medication assisted treatment for the treatment of opioid dependence and how it affects outcomes for individuals seeking recovery from opiate addiction. This failure to ensure that these topics are adequately addressed in the counselor-in-training’s professional preparation may contribute to their limited knowledge and
may negatively influence their beliefs and attitudes about harm reduction programs. Also, this lack of educational experiences regarding this treatment modality may have implications for how treatment is provided and, eventually, the client’s success.

The treatment of addictions is a complex and long-term process that often requires many years of various types of treatments before recovery can be achieved. A significant factor that has been shown to influence the efficacy of a treatment modality is the therapeutic relationship (Conner & Rosen, 2008; Hunt, Lipton, Goldsmith, Strug, & Spunt, 1985-86). While the thoughts and beliefs regarding the use of prescription Methadone and Suboxone have been reported for counselors who provide medication assisted treatment, the lack of research on the attitudes and beliefs of counseling students towards this treatment approach presents a gap in developing an understanding of the development of these attitudes and beliefs. Additionally, it is unclear if and how educational experiences affect the development of positive or negative beliefs towards the use of medication assisted treatment for the treatment of opioid dependence, and the implications these attitudes and beliefs have on the behaviors of counselors’ career choices and treatment practices is also unclear.

**Purpose and Research Questions**

The purpose of this qualitative study is to examine, describe, and understand how the attitudes and beliefs of counseling students regarding the use of medication assisted treatments develop and how these attitudes and beliefs may affect client care and professional career choices. This study will specifically examine how students’ professional counselor education experiences played a role in the formation/development of these attitudes and beliefs.
A thorough review of the literature related to the development of attitudes and beliefs of counseling students toward the use of medication assisted treatment for opioid addicted clients revealed a dearth of research activity. Therefore, the primary research questions that guide this study are:

1. “What are the attitudes and beliefs of counseling students towards clients who use medication assisted treatments for the treatment of opioid dependence?”

2. “How do the attitudes and beliefs of counseling students regarding the use of medication assisted treatments for the treatment of opioid dependence affect their perceptions of individuals using these treatment options?”

3. “How do pre-professional counselor education experiences affect the attitudes and beliefs of counselors regarding the use of medication assisted treatments as a treatment option?”

4. “What other experiences influence the counselor-in-training’s development of attitudes and beliefs towards clients who use medication assisted treatments as a treatment option?”

5. “How do these attitudes and perceptions influence the counselor’s provision of client care?”

6. “How do these attitudes and perceptions influence the counselor’s professional career choices?”

**Significance of the Study**

There have been several studies that analyze the attitudes and beliefs of counselors who treat clients using medication assisted treatments; however, there is a limited understanding of the development of these attitudes and beliefs and how students’ educational experiences may have contributed to these developments. This study is significant because it will provide insight into the development of these attitudes and beliefs, and how students’ personal and educational
experiences may have positively or negatively affected their attitudes and beliefs towards the use of medication assisted treatments as a treatment option, as well as their career choices and treatment practices.

The examination of the development of the attitudes and beliefs of counseling students and how their educational experiences may have contributed to these developments will allow for a better understanding of how counselor training programs affect the attitudes and beliefs of counseling students regarding the use of medication assisted treatments as a treatment option. Additionally, examining these attitudes and beliefs will assist the counseling community in understanding any stigma that exists around the use of medication assisted treatments and aid in developing ways to assist counselors in overcoming any possible negative beliefs towards the use of these treatment options.

**Theoretical Framework**

This study uses the basic principles of Cognitive Behavioral Theory to understand human behavior. In Cognitive Behavioral Theory, the stimulus influences the development of thoughts and feelings, which then affect behaviors (National Alliance on Mental Illness, 2014). This theory as applied in this study suggests that the stimulus, a client addicted to opioids who uses medication assisted treatments as part of a treatment protocol, stimulates thoughts and feelings in the counselor who, based on these thoughts and feelings, will form attitudes and beliefs that will in turn influence their behavior toward the client and in their career decision-making process.

The beliefs and attitudes of counseling students regarding individuals who are either enrolled in or have previous experience with medication assisted treatments can influence their professional experience as a counselor by influencing how they treat clients in the medication
assisted treatment programs. The attitudes and beliefs counseling students develop about a particular treatment modality could also limit their career choices and employment opportunities. If their attitudes and beliefs about the use of medication assisted treatments are negatively biased, a counseling student may not be able to work effectively with clients engaged in these types of addictions treatment. Furthermore, they may choose not to work in therapeutic situations where they would be required to work with clients in medication assisted treatment programs, thus limiting their career opportunities. If counselors develop inaccurate and negative perceptions of the use of medication assisted treatments for the treatment of opioid dependence, they may behave differently towards individuals who have chosen this form of treatment protocol or they may avoid working with this client population altogether, again limiting their career opportunities.

This study examined the underlying thoughts and feelings counseling students had in response to clients using medication assisted treatments for opioid dependence as well as the treatment modality. By exploring and understanding how counseling students develop attitudes and beliefs toward clients who have chosen to use medically assisted treatment approaches, this study will help to illuminate how these participants’ responses to such clients might impact their career choices and their ability to form effective therapeutic relationships and provide appropriate treatment.

**Summary of Methodology**

This study is a qualitative study designed to explore the attitudes and beliefs that counseling students develop regarding the use of medication assisted treatments as a treatment option for opioid dependence. An individual’s experiences and interpretations become
intertwined into one and, until an individual brings these experiences to conscious awareness, it is difficult to understand how such experiences affect their worldview and, in essence, their attitudes and beliefs towards a particular phenomenon (Patton, 2002). A qualitative study focuses on the meaning people make of their experiences and how that process influences their behavior (Creswell, 2013). This study explores how counseling students’ personal and educational experiences with the medically assisted treatment might influence their treatment and career decision-making process.

**Definitions of Key Terms**

**Addict**: A person who meets the DSM V criteria for Substance Use Disorder or Opioid Use Disorder.

**Counselor-in-training**: In this study, a counselor-in-training must be in the process of completing a master’s or doctoral degree in counselor education from a CACREP accredited program and currently enrolled in their fieldwork experience.

**Client or individual in treatment**: A person who is addicted to opioids and is currently or has used Methadone or Suboxone as part of a medication assisted treatment.

**Medication Assisted Treatment (MAT)**: Medication assisted treatment, also known as harm reduction treatment, is a method of addictions treatment that uses medication to assist an opioid dependent individual in obtaining and maintaining abstinence from opioids. For the purposes of this study, medication assisted treatment will be limited to treatment that uses prescription Methadone and Suboxone to assist opioid dependent individuals in obtaining and maintaining abstinence.
**Methadone:** Methadone is an opioid blocker used for the treatment of opioid dependence. It is dispensed as a pill or liquid. Methadone is available legally by prescription from a specially trained physician and is usually dispensed in a clinic or at a private practice.

**Suboxone:** Suboxone, also known as Buprenorphine, is a prescription medication combination of buprenorphine and naloxone, which is used for the treatment of individuals addicted to opiates. It is dispensed as a pill or a sublingual film, and usually prescribed by a specially trained physician as part of a private practice or as a part of group practice or in a clinic.
CHAPTER II: REVIEW OF THE LITERATURE

Introduction

The opioid epidemic continues to increase rapidly. Despite an elevated awareness of the problem, however, there continues to be limited understanding of the overall problem and the treatment options available to individuals affected by opioid dependence. This section will explore the relevant literature related to opioid dependence in the United States, available treatment options, stigma, and the current educational standards of CACREP accredited universities, as well as how it all applies to this study.

Opioid Dependence in the United States

The growing epidemic of opioid dependence in the United States continues to be a problem that affects all aspects of an addicted individual’s life and treatment. According to the Substance Abuse and Mental Health Administration (SAMHSA), the number of individuals in the U.S. who used heroin alone increased from 373,000 users in 2007 to 669,000 users in 2012 (Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality., 2013; Jaslow, 2013). It is estimated that approximately two million people in the U.S. are dependent on or abuse opioids, including heroin and prescription opioids. Of these two million, it is estimated that, in 2011, approximately 21 to 25% of all substance abusers in treatment received Methadone; or, approximately 306,000 individuals were involved in Methadone treatment for opioid dependence. An additional 32,000 individuals received Suboxone treatment from either a private Suboxone prescribing doctor or a treatment program for opioid dependence (Substance Abuse and Mental Health Services Administration, Center for...
Due to the large numbers of opioid dependent individuals in the United States, opioid dependence has a significant impact on the social, medical, and economic situation in the United States (Mark, Woody, Juday, & Kleber, 2001; Rosenheck & Kosten, 2001). According to a study by Mark, Woody, Juday, & Kleber (2001), it was estimated that the annual cost of heroin addiction was, at best guess, between $19.6 to $33.4 billion U.S. dollars in 1996. This estimate includes the cost of unemployment, lost productivity, incarceration, crime, policing, legal services, social services, substance abuse treatment, and medical treatment. Of this estimated amount, approximately $862 million was spent on substance abuse treatment and approximately 23% (or $4.5 billion) was spent on healthcare costs. One can assume that this amount was significantly higher in 2016 due to the ever-increasing costs of healthcare services, addictions treatment, and inflation. With the large numbers of individuals involved in treatment and the extensive financial costs of treating these individuals, there is also an increased need for an understanding of the providers and their attitudes towards the effectiveness of treatment. Based on the personal, social, and economic costs involved in the epidemic, it is likely that counselors in every aspect of the counseling community have encountered in their practice someone with addiction.

In addition to the high cost of addiction, there is the high risk of potential overdose and death to be considered. In 2007, there were approximately 27,000 unintentional drug overdoses in the United States. Since 2003, more overdose deaths have involved opioid analgesics than heroin and cocaine combined. This can be partially accounted for by an increase in the number of prescriptions for a class of prescription drugs called opioid analgesics. A majority of health
care providers receive minimal education regarding addiction and might indecently prescribe drugs that contribute or encourage addiction (Paulozzi, et al., 2012). While a lack of education may be contributing to these statistics, the stigma related to addiction and addiction treatment is another possible factor involved in these statistics.

While the risk of overdose is great with heroin and prescription drugs, if Methadone or Suboxone is used for addiction treatment, the risk of overdose decreases. Methadone and Suboxone treatments protect against death by overdose in heroin addicts. Additionally, the majority of Methadone and Suboxone overdoses that do occur are not due to legally prescribed prescriptions, but to those obtained as a result of diversion (Bell, Butler, Lawrance, Batey, & Salmelanen, 2009).

**Treatment Options For Opioid Dependence**

While there have been multiple attempts made to manage addiction in general, the severity of and unique challenges associated with opioid dependence have generated specific treatment responses. In addition to the more general approaches to addiction, such as abstinence-based counseling and self-help support groups, specialized harm reduction techniques, including medication assisted treatment, have been developed as treatment options for opioid addicted clients. The main difference between abstinence-based treatment and harm reduction treatment is found in their separate definitions of progress. In abstinence-based treatment, the goal is to maintain complete abstinence from the addictive substance. In harm reduction programs, the goal is to decrease the risk to the client and decrease their amount of overall use while they continue to explore the negative consequences of their behavior.
One type of harm reduction program is a needle exchange program. Needle exchange programs were developed in the mid-1980s to stop the spread of blood-borne illnesses such as HIV and Hepatitis C among IV drug users. In addition to providing individuals the opportunity to exchange used needles for sterile needles, they may offer referrals to other treatment options (Logan & Marlatt, 2010). Woodak and Cooney (2006) conducted a comprehensive review of over 45 studies, from 1989 to 2002, and found that these programs are a safe, effective, and cost-effective option. Despite their being proven to be an effective option, however, the United States federal government implemented a ban on federal funding being used to support these programs. As a result of the increasing opioid epidemic, the ban was lifted in 2016, which allowed agencies to seek federal funding to cover some of their administrative costs, but not the syringes themselves (Ungar, 2016).

Safe injection sites for illegal drugs is another harm reduction approach. At these locations, opioid dependent individuals can use clean equipment and inject their own drugs while having access to medical personnel and referrals to treatment options. There are approximately 100 safe injection sites operating in the world, and mainly in European countries where they are frequently publicly funded (Logan & Marlatt, 2010; Drug Policy Alliance, 2018). Despite this being a practice which is relatively accepted in European countries, there are currently no publicly funded safe injection sites in the United States, where this topic continues to be a controversial subject. In 2017, Seattle, Washington announced plans to develop the nation’s first safe injection sites; however, to date, it has not occurred (Whelan, 2018).

Medication assisted treatment is another form of harm reduction treatment. In medication assisted treatment, an individual is given a medication to assist with the effects of opioid dependence and withdrawal. Two of the most common MAT approaches are Methadone
and Suboxone treatments. These two forms of treatment have been proven to be safe and effective treatment options for opioid dependence (Schwartz, et al., 2008; Aletraris, Edmond, Paino, Fields, & Roman, 2016).

**Stigma and Methadone**

Methadone was first used in the treatment of opioid addiction more than 40 years ago. The purpose of Methadone is to prevent withdrawal symptoms for opioid dependent individuals and help clients avoid experiencing peaks of euphoria or the adverse effects of withdrawal once they are stabilized on Methadone (Douaihy & Kelly, 2013). It has long been recognized as an effective treatment for opioid dependence (Schwartz, et al., 2008; Aletraris, Edmond, Paino, Fields, & Roman, 2016). It has also been associated with lower crime rates, increased employment, and decreased medical co-morbidities (Rosenblum, Magura, & Joseph, 1991). Despite Methadone being recognized as an effective treatment, however, a study by Aletraris, Edmond, Paino, Fields, & Roman (2016) found that approximately 20% of counselors were unfamiliar with its effectiveness. Methadone was also perceived by the counselors in this study to be the least desirable of the available MATs.

Since Methadone first came into use, it has had a love-hate relationship with many areas of society, including addicts, addiction professionals, the medical community, and the legal community. In the legal community, the most common reason that Methadone is not offered as a treatment option in court is because it is not permitted or endorsed by the courts. In some cases, as many as 52% of courts have not supported Methadone as a treatment option for opioid dependent individuals (Matusow, et al., 2013). Many individuals see methadone as a drug substitute and a crutch that does not allow individuals to fully recover from their addiction. This
belief often contributes to individuals in treatment feeling ostracized by their family, friends, peers, and treatment providers, and this feeling of being ostracized by others often creates a barrier to treatment (Matusow, et al., 2013; Humphreys, Noke, & Moos, 1996; Schwartz, et al., 2008; Conner & Rosen, 2008; Kayman, Goldstein, Deren, & Rosenblum, 2006).

Additionally, Methadone is perceived by some addicts in the drug community to be an easy way out or inferior to being on the street. There are several myths, elements of misinformation, and misperceptions regarding the use of Methadone, all of which influence access to treatment (Hunt, Lipton, Goldsmith, Strug, & Spunt, 1985-86). One of the largest influences on treatment is the stigma associated with entering Methadone treatment. Stigma has a large impact on the emotional and psychological well-being of an individual. It also has a significant impact on the recovery efforts of individuals dealing with addiction (Earnshaw, Smith, & Copenhaver, 2013; Fitzgerald & McCarty, 2009; Conner & Rosen, 2008; Matusow, et al., 2013; Hunt, Lipton, Goldsmith, Strug, & Spunt, 1985-86).

The sources of stigma for individuals in Methadone treatment are often multi-layered. The individual often faces stigma from family members, peers, courts, employers, health care workers, society in general, 12-step programs, and addiction treatment providers themselves (Earnshaw, Smith, & Copenhaver, 2013; Humphreys, Noke, & Moos, 1996; Fitzgerald & McCarty, 2009; Conner & Rosen, 2008; Rieckmann, Daley, Fuller, Thomas, & McCarty, 2007; Hunt, Lipton, Goldsmith, Strug, & Spunt, 1985-86). Many of these stigmas are based on society’s overall perception of drug use in general and not necessarily on Methadone treatment. Some of these stigmas include the belief that Methadone addicts are simply substituting one drug for another, unemployed, and on welfare, and without any desire to enter recovery.
While society may have a negative perception of Methadone treatment, clients in Methadone Maintenance Treatment (MMT) report that they often feel misunderstood, looked down upon, and stigmatized by addiction counselors (Conner & Rosen, 2008). Several factors appear to influence the acceptance of Methadone as a treatment option. These elements include education level, treatment setting, and personal use history (Rieckmann, Daley, Fuller, Thomas, & McCarty, 2007; Humphreys, Noke, & Moos, 1996; Conner & Rosen, 2008; Caplehorn, Hartel, & Irwig, 1997; Aletraris, Edmond, Paino, Fields, & Roman, 2016). This stigma also has the potential to influence the effectiveness of any care given. When a person feels they are being stigmatized, they often are resistant to being open in regard to their concerns and behaviors, and this in turn effects the therapeutic relationship.

**Stigma and Suboxone**

Stigma towards harm reduction approaches is not limited to Methadone. Another form of harm reduction treatment, Suboxone, also presents with concerns about stigma. While Methadone has been used to treat opioid dependence for over 40 years, Suboxone is a newer medication used for the treatment of opioid dependence. Suboxone was developed in part due to the need for an alternative medication that did not have the complexities and strict regulations associated with Methadone (Jaffè & O’Keefe, 2003; Walsh & Eissenberg, 2003). Suboxone is becoming a popular choice for clients seeking assistance with opioid-dependence. The popularity of Suboxone over Methadone appears in part because it is often less restrictive than Methadone. Suboxone can sometimes be prescribed by a doctor instead of the need for going to a clinic, which does not require the same level of commitment in regard to daily dosing, does not require the same level of counseling, and comes with less stigma than Methadone (Thomas, et
Suboxone was approved by the FDA for office-based treatment of opioid dependence in 2002. Physicians are able to prescribe Suboxone after they attend an 8-hour class and obtain a waiver from the Substance Abuse and Mental Health Services Administration (SAMSHA) and also obtain a special DEA number (Thomas, et al., 2008; Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality, 2013). Even though Suboxone may be prescribed privately by a physician, it is recommended that clients also receive psychological counseling (Knudsen, Ducharme, Roman, & Link, 2005; Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality, 2013).

Suboxone was introduced to the addictions field several decades after the introduction of Methadone, and hence has had the benefit of not receiving the automatic negativity Methadone did upon its introduction to the field (Schwartz, et al., 2008). This has in itself been both positive and negative. One of the negative effects of this lack of knowledge is that there is limited education among addiction professionals, counselors, and medical doctors regarding the use of Suboxone. A study by Knudsen, Ducharme, Roman, & Link (2005) found that more than two-thirds of counselors surveyed “don’t know” how to respond when asked to rate their perceptions of Suboxone’s effectiveness. In another study, 20% of counselors did not know about the effectiveness of Suboxone despite extensive literature supporting its effectiveness (Aletraris, Edmond, Paino, Fields, & Roman, 2016). Rieckmann, Kovas, McFarland, & Abraham (2011) also found a neutral or slightly negative view of Suboxone among counselors and clients. Additionally, the clients in their study seemed to be less informed or had had less experience.
with Suboxone. This finding indicates that limited knowledge of Suboxone may affect perceptions. A positive effect of this lack of knowledge is that, among opioid dependent individuals, Suboxone has found a more positive perception and level of acceptance than that associated with Methadone (Schwartz, et al., 2008; Rieckmann, Daley, Fuller, Thomas, & McCarty, 2007). Studies have also demonstrated that counselors who work in a program offering Suboxone as a form of treatment appear to be more knowledgeable and supportive of Suboxone than counselors who do not work in these programs (Rieckmann, Kovas, McFarland, & Abraham, 2011; Aletraris, Edmond, Paino, Fields, & Roman, 2016). The lack of experience and knowledge regarding Suboxone could negatively affect the perception and stigma of Suboxone as a treatment option. Despite not having the challenges of introduction into the treatment field that Methadone did, Suboxone presents with its own challenges. Since it is relatively newer, the literature indicates that there is a problem with acceptance and understanding due to a lack of familiarity with Suboxone among counselors and providers in general.

**Medication Assisted Treatment and CACREP Standards**

The acceptance of medication utilization in the substance abuse treatment field has been attributed to counselors’ levels of formal education (Forman, Bovasso, & Woody, 2001; Rieckmann, Kovas, McFarland, & Abraham, 2011; Fitzgerald & McCarty, 2009; Humphreys, Noke, & Moos, 1996). While the level of their education is an important factor, the content of their education is also a potential variable. When counselors are exposed to and encouraged to adopt evidence based practices, such as harm reduction, during their academic training, it may increase the possibility of acceptance of harm reduction practices. It has been found that formal training related to medication assisted treatment and employment in a program where medication
assisted treatment was used are the strongest predictors of counselors’ knowledge of medication assisted therapy (Bride, Abraham, Kintzle, & Roman, 2013). However, due to the length of time that Methadone has been approved by the FDA, many counselors have awareness of Methadone that comes from their experiences and knowledge outside of formal training.

The lack of familiarity with medication assisted treatment may be attributed in part to the lack of education in counseling programs in regard to the use of harm reduction theories. Education about the use of medication assisted treatment is not a standard in counseling programs. A 2008 study found that only 33 of 136 participants, or 24%, were taught about Methadone in their counseling programs. The study also found that only 7 out of 133, or 5%, were educated on the use of Suboxone as a treatment option (Madison, Bethea, Daniel, & Necaise, 2008). Education about the use of Methadone and Suboxone is taught in a relatively low percentage of substance use classes. This number is even lower when one recognizes that substance use courses are not mandated or taught in all CACREP programs.

Over the years, several studies have examined the inclusion of substance abuse courses in CACREP programs. When asked by researchers, 52% of faculty believed that substance abuse training was “very necessary” and 27% believed it was “moderately necessary.” However, of these programs, only 30% of the programs required courses in substance abuse/dependency issues. Of this 30%, only one course was required by 19% of the programs, two courses were required by one program, and three courses were required by another program. (Morgan, Toloczko, & Comly, 1997) This study was later replicated and published in 2004, and found few changes to the incorporation of substance abuse training into CACREP curriculums. There was a slight increase, from 81% to 82%, in the number of programs that offer substance abuse classes to graduate students, but of these programs, the percentage of programs that required one or more
courses in substance abuse training remained the same at 30%. However, there was a decline in the number of programs that offered one or more electives, from 77% in 1997 to 50% in 2004 (Whittinghill, Carroll, & Morgan, 2004). This indicates a disconnect in the perception that substance abuse training is necessary versus the actual substance abuse education offered to students.

The 2016 CACREP standards in Section 5: Entry-Level Specialty Areas – Addiction Counseling state in Foundations letter b that “theories and models of addiction related to substance use as well as behavioral and process addictions” are to be taught as part of the foundations of addictions counseling.” However, other standards within the CACREP standards briefly mention addiction related teaching, but do not mention harm reduction as a particular theory to be taught. In Section 5: Entry-Level Specialty Area – Clinical Mental Health Counseling, the text states in the Foundations section letter d that “neurobiological and medical foundation and etiology of addiction and co-occurring disorders” are to be taught. In Section 5: Entry-Level Specialty Areas – School Counseling, it is listed not in the Foundations section but in the Contextual Dimensions letter i which states that “signs and symptoms of substance abuse in children and adolescents as well as the signs and symptoms of living in a home where substance use occurs” are to be taught. In Section 5: Entry-Level Specialty Areas – Marriage, Couple, and Family Counseling, addictions in general are not mentioned as an area to be covered in regard to requirements. (Council for Accrediation of Counseling and Related Educational Programs, 2015)

While the requirements around teaching addiction treatment are not a primary focus in the CACREP standards, nor a component of many CACREP programs’ coursework, addictions are a large component of students’ practicum work. Practicum is frequently cited as the one
course that includes content on substance abuse. One study found that 71% of respondents stated that between 11-50% of clients seen in by their students in practicum presented with substance abuse issues. Additionally, 18% responded that half of the clients seen presented with substance abuse issues, and 64% reported that between 11-50% of their internship students worked in substance abuse facilities. (Salyers, Ritchie, Cochrane, & Roseman, 2006) Another study found that 87% of programs assigned students to field experiences in substance abuse counseling (Morgan, Toloczko, & Comly, 1997). Despite the large number of programs that incorporate substance abuse counseling into their field placement experiences, a small percentage provide adequate training prior to these experiences.

Oftentimes, field placement is one of the first encounters students have with substance abuse education. When individuals feel unprepared to treat clients for substance use disorders, however, they may hesitant to address the co-morbidity of mental health and substance abuse or they avoid working with substance-abuse clients altogether (Cellucci & Vik, 2001). This presents a problem because students who feel ill-prepared may begin to develop stigmas and myths based on their lack of understanding for the individuals they treat.

The limited mention of harm reduction education, and in particular general addictions counseling education, in CACREP programs is concerning when one considers the widespread use of illicit drugs and addictions in this country. It is also concerning when one considers the growing popularity of opioids in the medical community, and also the increased illicit use of heroin and opioids. It is well documented that addictions affect not only an individual, but their family, their employer, their community, and nearly all aspects of an addict’s life. By having had limited education in addictions, the counseling student may be ill-prepared to enter the field and, as a result, possibly develop stigma and negative attitudes towards working with opioid
dependent individuals, and in particular individuals who use Methadone and/or Suboxone treatment.

**Thematic Analysis**

In order to study the attitudes and beliefs of individuals, it is important to understand their lived experiences, as well as the patterns and themes represented by these experiences. One way to gain understanding of the common patterns and themes is through the use of thematic analysis. Thematic analysis is the process by which the researcher identifies, analyzes, and reports patterns and themes within data. Thematic analysis is “a way of seeing, a way of making sense out of seemingly unrelated material, a way of analyzing qualitative information, a way of systematically observing a person, an interaction, a group, a situation, an organization, or a culture, a way of converting qualitative information into quantitative data” (Boyatzis, 1998). Thematic analysis uses various themes to describe the data, and it is also a process of encoding data. A theme is a pattern found in the information that describes and organizes possible observations and which has the ability to potentially interpret different aspects of a phenomenon (Braun & Clark, 2006; Boyatzis, 1998).

Thematic analysis is a six phase process that is used by the researcher to identify the patterns and themes in data (Braun & Clark, 2006). In Phase 1, the researcher becomes familiar with the data. The researcher accomplishes this by immersing themselves in the data and becoming familiar with the depth of the content. The researcher reads the complete data set prior to beginning to code, and then takes notes and starts creating ideas for coding.
In Phase 2, the researcher creates initial codes regarding what is contained in the data and how it interests the researcher. The researcher begins to look for repeating data patterns and themes in the data. In this phase, as many codes as possible are developed.

In Phase 3, the researcher analyzes the codes, sorts them into different themes, and begins looking for patterns. This process is often accomplished through the use of tables, mind-maps, or a listing of the codes on a separate piece of paper.

In Phase 4, the researcher analyzes the themes again and determines if there is enough data to support each particular theme. The researcher reviews and refines the themes by either combining several themes together or possibly separating a larger theme into two separate themes. At the completion of this phase, the researcher should be able to tell how their themes work together and what the overall story of the data is.

In Phase 5, the researcher refines the themes that will be presented in the analysis and begins to analyze the data within each theme. The researcher then conducts and writes a detailed analysis of each theme in relation to the research question.

In Phase 6, the researcher writes the report which describes the themes and patterns across the data set. The researcher describes their findings and uses data to validate their themes.

Even though there are six phases to thematic analysis, the phases are not necessarily followed in order and it is a recursive process. The researcher will move between the phases throughout the analysis of the data. By using thematic analysis, the researcher allows the data to determine the themes and patterns between the subjects.
Thematic analysis has advantages and disadvantages. The advantage to the use of thematic analysis is that it allows for the use of a wide variety of data types to understand and interpret observations about people, events, situations, and organizations. Thematic analysis allows for the communication of the research to a broader audience. It acts as a bridge between various domains and varying orientations and fields (Boyatzis, 1998). Thematic analysis allows the data to determine the themes instead of a researcher trying to force their codes and data into preexisting themes and interpretations. Thematic analysis instead allows the data to guide the themes that are present (Braun & Clark, 2006).

Thematic analysis also has disadvantages and challenges. Thematic analysis allows for the researcher to have flexibility, and this can make it challenging to determine and concentrate on what component of the data to focus on. Researcher projection is another challenge of thematic analysis. In projection, a researcher “reads into” or “attributes” their own emotion, values, characteristics, or attitudes onto the data. The sample of the data also presents a challenge. If the sample has external variables effecting it, which the researcher is not aware of, such variables have the potential of affecting the interpretation of the data. The researcher’s mood and style of interpretation may also affect interpretation of the data (Braun & Clark, 2006; Boyatzis, 1998).

Summary

This study examined the beliefs and attitudes of counseling students in regard to the use of medication assisted treatment as a treatment option for opioid dependent individuals. This study also explored whether education or a lack of education affected the beliefs and attitudes of counseling students in regard to medication assisted treatment. Additionally, this study explored
how counseling students’ perceptions of clients who use medication assisted treatment or the treatment modality are affected by education or external experiences. Lastly, this study explored how these attitudes and beliefs affect the treatment provided to clients and counseling students’ professional career choices.
CHAPTER 3: METHODS

Introduction

This study is a qualitative study designed to explore the beliefs and attitudes that counseling students have regarding the use of medicated assisted treatments as a treatment option for opioid addiction and the effects they have on the counselors’ treatment of clients and decisions regarding their own careers. A qualitative study is appropriate because it focuses on the meaning of people’s experiences as related to their perception of the use of medication assisted treatment as a treatment option. A qualitative study provides an opportunity to illuminate and explore our understanding of the common and shared experiences of the participants, and also provides an opportunity to examine how these experiences affect counseling students’ perceptions of various treatment options.

Research Design

Participants were recruited from counselors in training enrolled in a master’s program within a CACREP accredited counselor education program. The counselors in training were recruited from Duquesne University. Duquesne University is a private, Catholic college located in Pittsburgh, Pennsylvania. This school was selected for multiple reasons, including its convenient location in Western Pennsylvania, because it has a CACREP accredited counselor education program, and because it provided a sample of convenience that can be assessed with available resources.

The program director was contacted at Duquesne University, and I asked them to send out an email invitation to students who were currently registered in their fieldwork
experiences and had completed at least one semester of fieldwork (Appendix A). The email included the informed consent form (Appendix B) for the individual interview and a demographic survey with questions to elicit data to describe the sample (Appendix C), all for the students to review prior to their participation in the study. I also asked the director to provide me information regarding the approximate number of students that the email was sent to. Unfortunately, the approximate number of students that the email was sent to could not be determined, as it was sent several times over the course of several semesters, and so the approximate number of students it was sent to overall was not made available to me.

The participants were offered $10 Starbucks gift cards for their participation in the research interviews. Interested participants responded to the email and indicated their interest in volunteering to be included in the study. Additionally, I went into the Internship I and II classes to personally recruit participants for the individual interviews. Interested participants were asked to email me their name, email address, and telephone number so that I could contact them. I maintained a list of interested participants from which I invited individuals to participate in individual interviews. Volunteers for the individual interviews were scheduled for an in-person or phone interview.

Sample

Interested participants were asked to participate in individual interviews. There were 6 participants interviewed for this study. Four interviews were conducted in person and two interviews were conducted via telephone.

The in-person individual interviews were conducted at a mutually agreed upon time and were conducted in a private study room of Duquesne University’s Gumberg Library, which was mutually convenient for both the researcher and the participants. If the student was unable to
meet in person, the interviews were conducted via telephone at a mutually convenient time. The interviews were structured by an interview protocol.

**Purposeful Sampling**

In qualitative research, it is important that information is obtained from a sample that is able to provide the researcher with rich and thick descriptions of their experiences regarding the issues of central importance to the study (Patton, 1990). The individuals used in the study are informants because they are experts in their own experiences. The sample size of a phenomenological study may typically vary from 4 to 15 individuals experiencing the same phenomena (Creswell, 2013). In addition to having participants experiencing the same phenomena, Maximum Variation Sampling allows for the researcher to interview participants who have experienced the same phenomena but with program variation (Patton, 1990). In this study, six participants were interviewed who had experienced the same phenomena in regard to their educational experiences but done so while in three different tracks of the counseling education program. The final sample size was determined when the data being collected became saturated.

**Key Informant Interviews**

Individuals who expressed interest in participating in the study were asked to meet at a mutually convenient time and place to explore their experiences with clients who use medicated assisted treatment as a treatment option. The in-person interviews were conducted in a private study room at Duquesne University’s Gumberg Library. If participants were unable to meet in person, the interviews were conducted via telephone at a mutually agreed upon time. These interviews took approximately 30-60 minutes to complete.
At the beginning of each interview, the consent form was reviewed, this portion of the process including a review of information regarding who I am as the researcher, the purpose of the study, study procedures, the expected duration of the interview, risks and benefits, compensation, confidentiality, the right to withdraw, the summary of results, and voluntary consent. Participants also turned in the study’s demographic questionnaire (Appendix C). A semi-structured research protocol was used for each of these interviews. The questions for the individual interviews were pre-determined and followed a semi-structured format (Appendix D). Each interview was audiotaped and transcribed following the conclusion of the interview.

Analysis

The informant interviews were audiotaped. As the primary investigator, I also took field notes which included, but were not limited to, observations, responses to additional questions, and other information I felt added to or clarified the data presented. As the researcher, I then transcribed the individual interviews. Once the interviews were transcribed, I began to analyze the collected data from these interviews and my field notes.

In thematic analysis, the researcher identifies, analyzes, and reports patterns and themes within the data (Braun & Clarke, 2006). These themes were explored and analyzed in relation to the students’ attitudes and beliefs towards counseling individuals on medication assisted treatment. I analyzed the transcripts and the responses by using the six phases of thematic analysis. Even though there are six phases of thematic analysis, this method is a recursive process, and so I moved between the phases as I analyzed the data.

In Phase 1 of the thematic analysis, I read the transcripts of the data obtained from the audiotapes. In order to immerse myself in the data, the complete transcripts were read at least twice in order that I become familiar with the content of the data. I took notes on the data and
any notable observations, including body language and voice tones of the participants during the interviews, as I reviewed the tapes and transcripts. As I took notes, I began formulating ideas for coding.

In Phase 2, I created initial codes based on how the data naturally clustered and was related to my research questions. The intent was to create as many codes as needed in order to fully represent the data and begin to group it into themes.

In Phase 3, I analyzed the codes that I had created in Phase 2 and began sorting the codes into different themes and looking for patterns in the codes. I accomplished this task by using a combination of tables and separate pieces of papers to sort the codes into different themes. I also used a color-coded system to identify the participants.

In Phase 4, I reviewed the themes that I had created and refined them to either combine similar themes or separate larger themes into smaller themes. I reviewed the themes and analyzed how they worked together to offer an understanding of how the participants’ attitudes and beliefs surrounding medication assisted treatment as a treatment option were developed.

In Phase 5, I continued to review the themes that had been identified in the initial analysis and analyzed the data in each theme, also writing an analysis of each theme’s data in relation to the research questions. Even while the analysis was being written, I continued to evaluate the themes, and to combine and adjust them as needed.

In Phase 6, I wrote my analysis of the data, which described the themes and patterns found in the data. I used specific examples to validate the themes that were identified. I then used these themes and the subsequent data to answer my research questions in regard to how
counselors’ personal and educational experiences affect their attitudes and beliefs towards the use of medication assisted treatment as a treatment option.

I continued to collect and analyze data until the data was saturated and the themes were exhausted. I accomplished this by beginning to code data statements and organize them into thematic groups at the end of each interview. By the fourth interview, some statements appeared to be new and novel, but they did not generate any new thematic categories. The sixth interview also did not present data that supported the addition of any new themes. At this point, I decided that the data appeared saturated.

The process of analyzing the themes was a recursive process. Even while writing the report, I continued to evaluate the themes and adjust them as needed in order to provide additional evidence for the themes. By analyzing the data organized into common themes, I was able to address the research questions.

**Instrumentation**

It is the role of the researcher to be an instrument in their work. As a key instrument in their work, researchers are responsible for collecting data, observing behavior, and interviewing participants using a tool of open-ended questions that they developed themselves (Creswell, 2013). According to Glense (2006), the researcher is to be a researcher and learner but, while writing their analysis, the researcher also must be an artist, translator/interpreter, and a transformer. The researcher has many roles in the research study, which contributes to the final analysis and understanding the data presented. In order to have these roles in the research study, it is important that the researcher be qualified to perform the research study itself. As the primary instrument of data collection and analysis in the research study, it is also important that the credibility of the researcher be established (Patton, 1990). In order to increase credibility, I
have provided a description of my professional career experience, as well as my interest in this subject, in the following paragraphs.

**Researcher as an Instrument**

I have been working in the mental health field since the completion of my Master’s degree in 2006. My first experience in the field came when I completed my fieldwork experience at a local facility for inmates with co-occurring disorders. My interest in the counseling student’s perception of substance abuse started while I was working in this field placement when I began to question how I had developed my own beliefs and attitudes.

Following graduation, I accepted a position as a drug and alcohol counselor conducting groups for clients with substance abuse disorders. A few months later, I took a position as a counselor working with clients who used Methadone as a treatment option. In my capacity as a counselor, I conducted individual assessments, and group and individual therapy with adults suffering from opioid dependence. Eventually, I began co-leading an Intensive Outpatient Program (IOP) for clients who needed a higher level of care to assist them in developing abstinence from opioids. During my approximately three years at the agency, I became interested in understanding the stigma that my clients faced. I found myself interested in how the attitudes of my peers effected the care they provided to our clients. Additionally, I became interested in why the agency had a high turnover rate. I questioned if it was a result of the agency itself or due to counselors’ attitudes and beliefs about our clients. While employed at this agency, I received my Pennsylvania State Professional Counselor License (LPC).

After obtaining my license, I took a position at another agency treating clients who were diagnosed with chronic mental illness in an inpatient setting. Here, I discovered that several of the clients also had a history of substance abuse. Due a chance for professional advancement, I
took a position as outpatient counselor for another agency. At this agency, I provided individual, group, and family therapy to children and adults, and subsequently became interested in the number of children whose parents dealt with substance abuse and how this affected them. What I discovered was that many of the children and adults faced stigma due to their substance abuse history. I worked at this agency for approximately one year.

I was given the opportunity for professional advancement and took a position at my current employer’s drug free program. In my role as a drug and alcohol counselor, I was now responsible for providing abstinence-based drug and alcohol counseling to clients. Despite having a primarily abstinence-based program, we also provided medication assisted treatment in the form of Vivitrol. I provided both individual and group counseling. During this time, I also conducted a Partial Hospitalization program and an Intensive Outpatient Program (IOP). I became interested in the counselors’ perceptions of clients who chose the abstinence-based program versus the medication assisted program. I discovered that the counselors appeared to have a more negative attitude towards the clients who used medication assisted treatment versus abstinence-based treatment. Additionally, I noticed that clients in the group also tended to have stigma and negative attitudes and beliefs towards other clients who were currently in medication assisted treatment or had previously used it. At the same time, the medication assisted treatment modality Suboxone was gaining popularity, and clients did not seem to have such a strong reaction to this medication in comparison to other medication assisted treatment options, to the extent that I began to question why this might be the case.

After approximately three years working in this department, I was offered the opportunity for professional advancement by taking a position in my current department, which is a Methadone and Suboxone clinic. I have been working in this department for approximately the
past six years – with three years in the role of counselor, one year as a senior clinician, and approximately the last two years in my current role of supervisor. During this time of transition, I also returned to school to begin working on my Ph.D. in Counseling Education and Supervision. I wanted to expand my education and work to train future counselors.

While in my role as counselor, I provided individual and group therapy, and also conducted assessments for clients seeking medication assisted treatment. I also assisted in the development and implementation of the new Suboxone program that the agency was starting. I was responsible for understanding the new medication and assisting in the formation and implementation of the clinical aspect of the Suboxone program. While trying to integrate the new modality into the culture of the program, I became fascinated by the resistance of the existing Methadone clients, as well as the staff. I observed that Methadone and Suboxone clients both saw themselves as superior to the other group, and had their own stigmas regarding the use of medications. Despite both modalities being medication assisted treatments, clients in each modality brought their own attitudes and beliefs regarding the other. Additionally, I observed that staff also had their own attitudes and beliefs regarding the modalities. I observed that new staff often had preconceived ideas about medication assisted treatment in general while more experienced staff had attitudes and beliefs about Suboxone, in part due to their lack of experience with the modality.

After approximately three years as a counselor, I was promoted into a senior clinician role, and then one year later promoted to a clinical supervisor position which I have served in for approximately the past two years. This transition into leadership provided me the opportunity to observe the attitudes and beliefs of new hires. My interest in how new counselors had developed their attitudes and beliefs regarding medication assisted treatment began to grow. I began to
question how they had developed these beliefs, how it affected the care they provided to clients, and how it may have affected their career choices. I felt that it was important for me, both as a supervisor and a future educator, to understand how these attitudes and beliefs developed and if anything could be done to change them. On a larger scale, I feel this is important because, with the expanding opioid epidemic, the likelihood that clients will choose medication assisted treatment is also increasing.

My experience working in the field, in particular with medication assisted treatment, has given me some insight into the stigmas, attitudes, and beliefs that clients and counselors have regarding the use of medication assisted treatment. I believe that my personal experiences in several different aspects of the treatment modality – counselor, co-worker, and supervisor – provide me additional insight into these stigmas. This insight has helped me to analyze and interpret the data for this study, as well as to connect with the participants in order to better understand their attitudes and beliefs.

I recognize that my experiences and personal assumptions regarding others’ attitudes and beliefs have the potential to introduce bias into the study and, ultimately, the findings. In order to decrease bias, I have consulted with my dissertation chair and my committee to gain insight into how to minimize this potential issue in my study. I also reflected on my interview experiences through a personal journal in order to try to minimize the effect of this potential bias.

**Trustworthiness of the Data**

In qualitative research, validity and reliability are more challenging to demonstrate than in quantitative research. In qualitative research, data is obtained from the thoughts and feelings of individuals, and they alone know the trustworthiness of the information they are providing. It
is difficult to prove that the information they are providing is honest and accurate. Despite these challenges, it is possible to demonstrate that the data is trustworthy.

Guba & Lincoln (1982) describe four major traditional criteria that researchers have an obligation to attend to: truth value, applicability, consistency, and neutrality. Truth value is how confidence in the “truth” of the findings was carried out. Applicability is how the findings can be made applicable in other contexts or with other respondents. Consistency is found in whether or not the findings would be consistently repeated if the same or a similar study was replicated. Neutrality is determined by insuring that the findings are based off the responses of the subjects and not the biases, motivations, interests, and perspectives of the researcher. In order to meet the traditional criteria, the researcher needs to have credibility (internal validity), transferability (external validity), dependability (reliability), and confirmability (objectivity).

Credibility is similar to internal validity in that it insures that the phenomena generated are closely related to what the subject intended. In order to obtain credibility in this study, I used minimal prompts in the individual interviews so that I could allow the participants to discuss their thoughts and feelings with minimal guidance from myself.

In order to maintain neutrality and increase credibility, I engaged in the qualitative process of bracketing. According to Creswell and Miller (2000), “it is important for a researcher to acknowledge and describe their beliefs early in the research process to allow readers to understand their position and then bracket or suspend those researcher biases as the study proceeds.” In order to do this, I kept a journal and took field notes throughout the research process. This allowed me to remain aware of my own thoughts, biases, and reactions to the participants and the data obtained throughout the study. By keeping a journal, I was able to
increase the likelihood that my findings are based on the information provided by the participants and not influenced by my own biases, motivation, or interests.

Transferability is how the data collected can be generalized beyond a present study. In order for the data to be transferable, the descriptive data must fit into more than one context or area of study. For a study’s findings to be transferable, enough information about the context of the study, the study design, and the data collected must be available. In order to obtain this element, I provided detailed descriptions of the demographics of the participants and the context of their current study. The individual interviews were transcribed, and this allowed for examination of the descriptive data provided by the participants.

Transferability is also obtained by exploring a study’s implications and exploring any rival explanations (Yin, 2016). In this case, if this study were to be duplicated in another counseling program with similar characteristics to the one used in this study, it is possible that the results would be similar. Additionally, transferability was also increased through the use of multiple informants, providing detailed descriptions of their demographics and their experiences while maintaining confidentiality of the informants, and providing a detailed description of the research setting so that replication can occur.

Dependability means insuring the reliability of the data to allow for replication of the study under similar circumstances in another place in time. In order to increase dependability, a detailed description of the analysis process and methodology used is necessary. I provided a detailed description of each step of thematic analysis and how the themes were developed. This will allow a future researcher to follow the same process and replicate this study.
Confirmability requires insuring that the researcher maintains objectivity during the research. This can often be a difficult task because a researcher generally engages in qualitative data collection because they have a keen interest in a subject or phenomena they want to study. This very interest can cause a researcher to become biased and unconsciously attempt to influence their results. For this study, this element will be important to monitor, as I have worked in medication assisted treatment for approximately eight years and have worked in substance abuse treatment for over twelve years. It is important, however, that this study accurately reflect the experiences of the participants and not my own experiences. In order to increase confirmability of the results, I continuously monitored my thoughts and feelings through the use of journals and field notes.

In order to increase the validity of my research, triangulation was used. According to Guion (2002), triangulation is used “to check and establish validity in their studies.” Guion identified five types of triangulation: data triangulation, investigator triangulation, theory triangulation, methodological triangulation, and environmental triangulation. For the purposes of this study, I predominately used data triangulation, theory triangulation, and methodological triangulation. Data Triangulation involves the use of different sources and data collection. In order to accomplish this triangulation, I checked the data multiple times for phrases and key words from all of the participants to insure the accuracy of the themes presented. In methodological triangulation, I used existing literature to find articles and studies that provided validation for the themes I was presenting. In theory triangulation, you use other professional perspectives to validate the theories. I accomplished this level of triangulation by consulting with a colleague in the drug and alcohol field in order to process my thoughts and ideas regarding the themes so that I could ensure I was correctly conveying what the participants
intended to say during their interviews. By engaging in triangulation, I increased the confidence of my themes.

Several methods were used to increase the credibility, transferability, dependability, and confirmability of the research. It should also be noted that, even though these steps were carried out, complete trustworthiness of the data cannot be insured. However, when these steps are followed, they greatly increase the likelihood that a reader will be persuaded to the meaningfulness of the research conducted (Guba & Lincoln, 1982).

**Ethical Considerations**

At the completion of the dissertation proposal defense, the dissertation proposal was submitted to Duquesne University’s Institutional Review Board (IRB) for approval. After receiving approval from the IRB, the recruitment of subjects and data collection began. The ethical considerations were reviewed and discussed with the dissertation chair and committee during the dissertation proposal and throughout the data collection process. Additionally, ethical considerations were taken into account throughout the entirety of the study.

**Informed Consent**

Informed consent was obtained from each participant prior to the start of the interviews. The informed consent form contained the following information:

1. The purpose of the study, procedures, and the expected time of participation
2. Risks and benefits
3. Compensation
4. Confidentiality
5. Right to withdraw
6. Summary of results

7. Voluntary consent

At the beginning of each individual interview, the informed consent form was reviewed. Participants were reminded that they were not required to participate in the study. They were informed that they had the right to withdraw from the study at any time, and that if they decided to withdraw their consent to participate, there would not be any consequences for doing so. Additionally, if they chose to withdraw their consent to participate, any data collected from them would not be used.

Confidentiality

At the beginning of each individual interview, the researcher reviewed the rules of confidentiality and advised participants that it is impossible to guarantee complete confidentiality. The in-person interviews were also conducted in a private study area in Duquesne University’s Library. This area provided a distraction-free environment, but also provided participants a safe and confidential space in which to discuss their attitudes and beliefs.

Data Collection and Storage

Participants were advised that interviews would be audiotaped and transcribed. At the completion of the transcription, the recordings would be deleted. In order to protect the participants’ confidentiality, all written notes, questionnaires, and transcriptions had all names and other identifying information redacted and replaced with a participant code number. The audiotapes, field notes, transcripts, participant codes, and all data back-up files were kept in a safe in the researcher’s home which only the researcher had access to. The researcher will keep
the field notes and transcripts in this safe for no less than three years from the study’s completion.

**Reports of the Findings**

Prior to the start of the interviews and data collection, participants were informed that their identities would be protected in the research findings of the dissertation. During the data analysis and final report, the researcher quoted participants in the report; however, each participant’s confidentiality is maintained by avoiding the provision of any identifying information for the participant and by referring to them by their participant code number. The final report and analysis of the data was made available to the participants upon request and at no charge to any participant.

**Participant Risk**

It is likely that the topics discussed in the individual interviews are topics that also discussed in the participants’ counseling profession and educational community. As a result, there was minimal risk to each participant for participating in the study. The researcher conducted individual interviews to minimize the risk to participants. The researcher is a Licensed Professional Counselor in Pennsylvania with extensive experience in medication assisted treatment counseling.

**Delimitations**

The delimitations of this qualitative study included the sample selected for this study, my research approach, and my chosen methodology. As a researcher, I chose to study counseling students’ perceptions, and because I found limited research related to understanding their perceptions regarding medication assisted treatment, I chose to undertake an exploratory qualitative study.
The selection of participants for this study created potential limitations. I chose this sample because they volunteered and agreed to participate in the study. This sample of convenience was used because my limited resources made it difficult to recruit more diverse participants. Additionally, the parameters of the sample were chosen because I felt that participants engaged in their fieldwork experience were more likely to have knowledge of medication assisted treatment or to have worked with opioid dependent individuals than students who had not yet participated in fieldwork experience.

The qualitative research design was chosen in order to allow for exploration of the phenomena of the participants’ attitudes and beliefs. To minimize the effects of structure, a semi-structured interview process was utilized to allow the participants and ultimately the researcher to explore their attitudes and beliefs with minimal prompting or guidance.

Thematic analysis was chosen as a systematic procedure to ensure that the data was used to determine the themes. Thematic analysis allowed for very precise steps to be taken in analyzing and constructing meaning from the data. It is possible that, if another form of analysis were used, different results might occur, which presents this as a potential delimitation.

I found that my own bias regarding the use of medication assisted treatment had the potential to contaminate my analysis and the construction of meaning from the data provided in this study. In an attempt to minimize this influence, I maintained a journal of my thoughts and feelings toward medicated assisted treatment as they arose in response to my experiences in this study. Additionally, I used thematic analysis and its very precise steps to analyze and construct meaning from the data and keep it separate from myself.
Contribution to the Field

I believe this qualitative study provides an important contribution to the field. As the opioid epidemic in the United States continues to increase and the use of medication assisted treatments to treat opioid dependence also increases in turn, it is important to understand how the next generation of counseling students perceive the use of medication assisted treatment as a treatment option. This knowledge is important to understanding how their perception of clients, the modality, and their education all affect their perceptions, career choices, and ultimately the care they provide. As a counselor educator, it is important to explore how the education we provide can influence these perceptions. It is also important to analyze these perceptions in order to determine if adjustments need to be made to the education we provide.
CHAPTER IV: RESEARCH FINDINGS

Introduction

The findings of this study come from examining the attitudes and beliefs of counseling students’ perceptions of mediation assisted treatment as a treatment option for opioid dependence. Using semi-structured interviews with counselor education students near the end of their professional training, I was able to allow these narratives to reveal the themes and guide a thematic analysis of the data. The interviews provide a detailed perspective of the participants’ attitudes and beliefs, and how various factors affect their perceptions of MAT.

This chapter provides a case by case analysis of the data derived from these interviews. These data include the information gleaned from the interviews and my case notes as collected during the interviews and analysis. Each interview corresponds to a table identifying the supporting statements related to each theme. This chapter also includes a table showing the cross-analysis of each theme and which participant indicated the theme as a way of demonstrating which theme is more common across multiple participants. This case by case analysis allowed for an introductory analysis and understanding of the data set, which facilitated the development of the themes and the connections between the research questions. The analysis found that students’ perceptions of medication assisted treatment was affected by their educational experiences, which is explained in more detail in the subsequent chapter.

Participant Information

There were six participants who volunteered and were selected to participate in a semi-structured, individual interview for this study. To protect confidentiality, the participants were each assigned a participant identification number, and they are identified by this number.
throughout the report of research findings. The age range of the participants was 24-47 years old (the average age being 28.8 years). All of the participants were enrolled in CACREP accredited, master’s degree counselor education programs at Duquesne University at the time of their interviews. Four of the participants were enrolled in the Clinical Mental Health program, one was enrolled in the School Counseling program, and one was enrolled in the Marriage, Family, and Couples program. Three participants had been in the program for less than two years and three had been in the program less than three years. Five of the students were currently enrolled in the Internship 2 class at the time of their interviews, meaning that they had completed more than 300 hours of supervised fieldwork, out of a required 600 hours, and one was currently enrolled in the Internship 1 class, indicating that this participant was within the first 300 hours of their supervised clinical experience. The total number of addictions courses they had taken ranged from 0 to 5, with the average number being 1.7 classes. Three of the participants had experience working with opioid dependent individuals and three did not have any related experience. Two participants had experience working with individuals in medication assisted treatment and four participants did not have any experience with MAT. Table 1 provides a comparison of relevant participant characteristics.
Table 1:

**Participant Demographic Information**

<table>
<thead>
<tr>
<th>Participant ID</th>
<th>Age</th>
<th>Program</th>
<th>Number of Years in Their Program</th>
<th>Currently Enrolled In</th>
<th>Total Number of Addictions Courses</th>
<th>Exp. Working with Opioid Dependent Individuals</th>
<th>Exp. Working with Patients in MAT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>47</td>
<td>Clinical Mental Health</td>
<td>≤ 3 years</td>
<td>Internship 1</td>
<td>5</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>2</td>
<td>25</td>
<td>Clinical Mental Health</td>
<td>≤ 3 years</td>
<td>Internship 2</td>
<td>1</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>3</td>
<td>25</td>
<td>Clinical Mental Health</td>
<td>≤ 3 years</td>
<td>Internship 1</td>
<td>1</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>4</td>
<td>25</td>
<td>School Counseling</td>
<td>≤ 2 years</td>
<td>Internship 2</td>
<td>0</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>5</td>
<td>27</td>
<td>Marriage, Couple, and Family</td>
<td>≤ 2 years</td>
<td>Internship 2</td>
<td>1</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>6</td>
<td>24</td>
<td>Clinical Mental Health</td>
<td>≤ 2 years</td>
<td>Internship 2</td>
<td>2</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

**Individual Interviews**

Four of the interviews were conducted as in-person interviews in a private study room at Duquesne University’s Gumberg Library. Two of the interviews were conducted via telephone at a mutually agreed upon time. The interviews were conducted between April 10, 2017 and August 7, 2017. Each interview took approximately 30-60 minutes to complete.

All of the interviews followed a semi-structured interview format (Appendix D). Each of the interviews was transcribed to obtain accurate, verbatim data. I also took field notes and made notes of observations while completing the interview.
Analysis of Individual Interviews

After the completion of the interviews, all of the interviews were transcribed verbatim. I chose to note pauses in speech or other fillers such as “ah” or “uh” as a method of obtaining an accurate description of what the participant was saying. I decided to transcribe the data myself as a way of becoming familiar with the data. This also allowed me to become more familiar with patterns and recurring statements that began the ongoing analysis of the data. In order to increase my familiarity, I listened to the tapes several times and read the transcriptions multiple times. As I was reading the transcriptions, I took notes on the data in the margins and began to explore and note how the themes were connected.

Once the transcription process was completed, I used thematic analysis to begin the analysis process. In Phase 1 of the thematic analysis, I read the transcripts of the data that had been obtained from the audiotapes. In order to immerse myself in the data, the complete transcripts were read at least twice in order that I become familiar with the content of the data obtained. I took notes on the data and any outside observations, including body language and voice tones of the participants. As I was taking notes, I began formulating ideas for coding.

In Phase 2, I created initial codes based off the data and how the data relates to my research questions. I looked for data that repeated and any themes that emerged. The intent was to create as many codes as possible.

In Phase 3, I analyzed the codes that I had created in Phase 2 and began sorting the codes into different themes and looking for patterns in the codes. I accomplished this task by using a combination of tables and separate pieces of paper to sort the codes into different themes. I also used a color-coded system to identify the participants.
In Phase 4, I reviewed the themes that I had created and refined the themes to either combine similar themes or separate larger themes into smaller themes. I reviewed the themes and analyzed how they worked together to offer an understanding of how the attitudes and beliefs of medication assisted treatment as a treatment option are developed.

In Phase 5, I continued to review the themes that had been identified in the initial analysis and analyzed the data in each theme, also writing an analysis of each theme’s data in relation to the research questions. Even while the analysis was being written, I continued to evaluate the themes, and to combine and adjust them as needed.

In Phase 6, I wrote my analysis of the data, which described the themes and patterns found in the data. I used specific examples to validate the themes that were identified. I used these themes and the subsequent data to answer my research questions in regard to how counselors’ personal and educational experiences affect their attitudes and beliefs towards the use of medication assisted treatment as a treatment option.

**Theme Development**

The codes for the research were developed by bracketing similar words or phrases used by the participants. Once the codes were developed, these codes were analyzed to look for patterns. These patterns were then used for the basis of each theme. I analyzed the themes several times and combined or separated them in order to gain a clearer understanding of the data in relation to the research question. The names of themes were derived from similar words or phrases used by the participants.
Case by Case Analysis

This section provides a detailed description and analysis of each of the participants’ interviews. The initial analysis was conducted in the same order that the interviews originally occurred. Each narrative provides an analysis of the themes identified.

Individual interview #1. This interview was conducted with a 47-year-old female who had been enrolled full-time in the Clinical Mental Health Counseling Program for more than three years at the time of the interview. She was currently enrolled in the Internship 1 class. She reported that, during the course of her education, she took five courses which included information on addictions counseling. She reported that she had experience working with opioid–addicted individuals, but did not have experience working with individuals in medication assisted treatment.

The interview was conducted in a private study room in the university’s library. The room provided a private, quiet area with minimal distractions where she could openly discuss her thoughts and experiences without the presence of others. Prior to the interview, she had been emailed the demographic questionnaire and consent form for her review. Prior to starting the meeting, I met her in the library’s downstairs lobby and introduced myself, and then escorted her to the private study room. I reviewed the consent form and voluntary participation with her. She was advised that her participation was voluntary and that she could leave at any time. I also reviewed the consent form, which included information regarding who I am as the researcher, the purpose of the study, study procedures, the expected duration of the interview, risks and benefits, compensation, confidentiality, the right to withdraw, a summary of results, and voluntary consent. I informed the participant of my intent to audiotape the interview and received her
consent to do so. I advised her that I would be transcribing the interview and that, once it was transcribed, the tape would be erased. At this time, she confirmed her willingness to participate in the study. Her signature was obtained on the consent form, she completed the demographic questionnaire, and I began the interview. The interview lasted approximately 27 minutes, with the entire process including review of consents and procedures taking approximately 40 minutes.

Participant #1 appeared to be eager to participate in the study. Prior to the start of the tape, she was asking questions about the study and noting that she found the material to be interesting. She expressed a slight amount of anxiety regarding taping. As I was preparing to begin the interview, I noticed that I was personally experiencing a combination of excitement and anxiety about my first interview. I found myself getting ahead of myself in regard to the questions and wanting to make sure that I got every question on the form answered. I was able to remind myself that this was a semi-structured interview and, once I began the interview, I found that my anxiety had decreased.

I asked Participant #1 to describe what she knew about medication assisted treatment. She started by stating: “Um, I don’t know. I am not as comfortable with the subject.” She talked about her coursework: “Ahhh, we covered it a little bit in, um, ethics and addictions, ummm, coursework.” Of her fieldwork experiences, she noted, “The facility that I worked in for practicum and internship, they were, ummm, a no substance.” She clarified that the facility was abstinence-based with the answer: “Yeah, right.”

She proceeded to provide more information regarding her knowledge of medication assisted treatment:
Um, so I mean, what do I know about it? Ummm, I know it as Methadone clinics. I know there is a difference. Ummm, I know there is Suboxone and, ummmm, other different medications used but, umm... It’s just a, ummm, I guess it would be kind of the opposite of what [an] abstinence-based program [is] where it is more like, ummmm, maintaining, ummm, life choices, I guess? Ummmmm, you are not actually, you are just learning skills to handle the addiction in a healthier way.

I asked her to then reflect on her comment, “They are just learning skills in a healthier way,” to which she replied, “skills and not in medical and just, ummm, not sharing needles and things like that. Just kind of managing the addiction rather than abstaining from use.” I then transitioned into asking about what she had learned about medication assisted treatment in school. After reviewing the transcription, I later realized that I should have had her elaborate on her comment more before moving on from the topic.

I asked her what she had learned about it in school. She stated “Ummm, just of kind of like snippets, not like a whole, I wouldn’t say we dedicated a whole lot of time, um, to it. From what I recall, most of it was like the ethics surrounding it. Ummm, the, ummm, guidelines, state guidelines, ummm, federal guidelines, ummm, and just some of the theories that support it.” I asked her to clarify the types of guidelines she was referring to, and she answered: “Umm, diagnosis and treatment guidelines, ummm, HIPPA, ummm, other ethics.”

In order to clarify whether medication assisted treatment was discussed specifically, I asked her about if it was regarding the actual medications. She replied, “I recall in Diagnosis and Treatment that we did have a psychiatrist come in and kinda talk a little bit about the neurotransmitters and things like that, but other than that, I don’t recall actual, ummm, you
know, like treatment plans on [the] use of… just recommendations. As a counselor, I would just recommend; I wouldn’t be diagnosing.” I further clarified that she had not learned about the diagnosing and only the treatment, “what to look for, what kind of things might work for a client.”

In order to understand her thoughts regarding medication assisted therapy, I asked her what she thought about it. She responded:

I am apprehensive about it. I am so used to the, umm, the abstinence side of it. Umm, and I just, while I understand that it is probably a safer, umm, safer for the community to have it somewhat managed, ummm, I don’t know if it ever actually treats the addiction part or if it kind of prolongs it. I don’t know, I’m kind of in the middle there. I am on the fence, for sure.”

I attempted to clarify what she was on the fence regarding, and she answered: “Whether it is effective? Whether it’s, ummm, I’m not 100% sure it’s ethical, you know, so…” She then clarified: “I don’t know that the doctor should be prescribing things that are actually hurting someone’s body.”

Participant #1 proceeded to talk about her fear related to the medications, as well as how this related to her concerns about ethics:

We know that medications for, you know, just treating a headache or something like that can affect your liver, and you know any long-term use medication effects organs, so I just kinda wonder what that’s all about, but I do understand the decriminalization part of it and, you know, the relief of stress and that aspect, but at the same time I just don’t know if it is really 100% ethical.
During this part of the interview, Participant #1’s anxiety and lack of decisiveness appeared to be increasing. In order to clarify what might be affecting this, I asked where her apprehension might be coming from, at which point she responded: “Umm, probably socialization about it. Ahh, you know, I am 47, so you, I think maybe, that plays into it. Umm, for most of my life, that it has been ‘say no’ [giggling], so ‘just say no to drugs.’ So, not really learning to manage addiction, but rather try to eradicate it all together.” With a follow-up question, she was able to clarify that she comes from the abstinence-based mindset, which was related to her personal experience: “Anyone I know personally who has gone through, like, AA or NA, and that’s, you know, just the mindset I have had for recovery.”

Since Participant #1 stated she had a mindset favoring abstinence-based treatment, I wanted to understand her perception of medication assisted treatment. I asked her what came to her mind when she heard the term “medication assisted treatment.” She answered: Honestly [giggling], what comes to mind is something out of, like, One Flew Over the Cuckoo’s Nest, where they are all like lining up at the window for their meds and just kinda getting in line and just kind of like, just, of being in a fog and just knowing they want their meds, but really not working their program, so to speak.” I asked her to reflect upon this description and tell me if she visualized or heard anything additional when she thought of it. She answered: “I think of all the outside stuff. I think about the… you know what happens in the parking lot. Like, are we sharing drugs? Are we sharing information? Are we just going there to get by, you know, to the next? I don’t know. Just all that kind of stuff.”

She explained that these thoughts were related to experience. When asked to elaborate, she stated, “Personal experience with family members and knowing that a lot of, umm, I don’t know if the word ‘nefarious’ is the correct [one], but like the, you know, not really using the
facility the right way.” She explained further that, based on her experience, they “use it as a meeting place and, you know, kind of doctor-shopped and that kind of stuff.”

I proceeded to ask her if she had any experience with clients in medication assisted treatment, and she answered, “I actually don’t think I have seen any clients that have been through an assisted.” She explained, “I think they were all abstinence-based.” She also acknowledged that, while she does not believe any of them were in medication assisted treatment, she could not be certain: “I’m not quite sure. I’m not 100%.”

I wanted to find out how her personal and professional experience had affected her perception of individuals who chose medication assisted treatment. She commented:

I mean, I know a few people that it’s worked wonders for. I just know a lot more where they kind of just prolonged the addiction. You know, or mixed it, haven’t worked the whole recovery program, so to speak, so I mean I just think that there may be two people I personally know where they actually used the program, kind of the 18-month kind of use, and then I know somebody who was on it for 10 years. Was on Methadone and then, umm, decided to just abstain, but he kinda worked it, you know. He was safe. He was able to work, and so I mean, I can see the benefits of that. He was able to maintain his family and wasn’t being separated from his family for long periods of time and not being separated from a job. So, but I just don’t know if it has been 100% effective. I don’t know. That is just my perspective, I guess. It could be changed.

We talked about her perception of how long individuals tend to stay on medication assisted treatment, and she suggested: “I think I read 5, 5 years.” She discussed how the individuals she had previously been referring to “were pretty successful with it” and noted that
the ones who were not successful, in her perception, were: “the ones who weren’t, weren’t 100% into it.” She stated that she was uncertain of their motivation for the treatment, “whether they were there because of part court-mandated type thing, or I don’t really know.”

She talked about her perception of the individuals she was aware of who had participated in treatment: “I think is a great, I think it a good concept. I just think we’re maybe a little far off being perfect or as effective as it can be, and I just think that comes down to regulations. Like whose regulating the facilities. Honestly, the directors of the facilities are probably the biggest factors in how some things are run, are successful in some way.” She proceeded to discuss a local facility that was: “being run pretty poorly, and I do believe it was recently closed, ummm, for tax reasons, fraud, that kind of thing.” She stated that: “So, I just think it really does come down to who’s really in it for, you know, the client, and who is in it for business.”

She also discussed how her personal experience with the individual affected her perception: “…because I know the individual and I know that her background was… you know, she was [a] recovering addict and, umm, and it just kind of like soured me on it. Like, you know what people are going through and you took advantage of a pretty vulnerable population, and you were part of that population, so I don’t know how you could that?” Participant #1 also connected her experience and perception with her concerns regarding ethics: “Yeah, yeah, yeah, ethics. So, I don’t know. I don’t know how you regulate ethics really other than check up on and make sure people are following procedure, but still that’s kind of, that’s kind of a daunting task.”

I transitioned the conversation into her gaining an understanding of her attitudes toward the use of Methadone and Suboxone, and she answered: “While I think, like, any kind of medication, pharmaceutical, whatever, you know, whether it is fighting cancer or addiction, I
think you know it’s just… if it is used in the right way, it can be highly effective. Ummm.

Again, I worry about anything being abused, and being part of helping someone abuse it, that’s where I struggle.” I asked her to clarify what she knew about the actual drug, and she answered: “Don’t they just mimic the dopamine in the body, in the brain? That is all I really know about the actual drug.”

As I was asking her about her perception, I internally reflected on her earlier statements regarding the Methadone clinic she had mentioned and asked her to describe how she perceived a clinic working.

I believe, I am not a 100% on this, but, ummm, it is by appointment. Well, the one I know of in the South Hills, it is by appointment, and I think it’s only open actually till mid-day. Maybe there is a doctor that’s affiliated with it, but I don’t think that he’s on all the time. I think he just comes in and out and meets with clients once in a while, but, umm, it is dispensed. I believe you have to wait a certain amount of time before leaving the facility.

She clarified her comment by adding: “Methadone. I don’t know anything about a Suboxone clinic, though, so.”

While reviewing the transcripts, I realized I had missed an opportunity to explore her concerns about the potential for abuse in more depth. Instead, I had transitioned to her understanding of the counseling component of the Methadone clinic. It is possible that my own personal concerns and experience in the field may have influenced the direction of the interview, as I was still subconsciously focused on her referring to the clinic as being like One Flew Over the Cuckoo’s Nest. As result, I attempted to gage her understanding of the operations of the clinic and asked
her about the counseling component. She commented: “I am sure it would be kind of like when somebody is in, like, a court-mandated type situation where you have to meet with a counselor at least once a week, you have to meet with a group at least once a week, attend a meeting. I’m assuming it would be the same; I don’t know actually for sure. I wouldn’t feel comfortable saying I know that 100%.”

After discussing her knowledge regarding the operations of a medication assisted treatment facility, I attempted to shift the focus to her feelings about counseling a person in medication assisted treatment. When asked about her feelings, she stated: “I would be fine with it, I’m positive. I would be positive about that. I think a lot of it is behavioral, I’m thinking so.”

I asked her if she saw any difference in counseling a client who uses medication assisted treatment versus a client who is not. She answered: “Because I haven’t had that experience, I don’t. I couldn’t say that I have seen the difference.” She proceeded to clarify, “On one hand, you might be dealing with a lot of the anxiety and, you know, depression that kind of consumes somebody that [is] be a substance abuser but, ummm, at the same time, you might also be dealing with someone who doesn’t, isn’t completely 100% into therapy.” She also expressed concern about possible resistance and lack of commitment to treatment: “Some resistance, ummmm, you know some, definitely, some resistance for somebody who isn’t, who doesn’t have that, you know, ‘I want to completely quit, I just want to manage life [feeling].’ I think.”

Since she expressed that she saw no difference between individuals in medication assisted treatment and individuals not in MAT, I transitioned the questioning forward to her thoughts about taking a position as a counselor in a medication assisted treatment program. She commented:
That would be, kind of like, kind of like what I am doing right now. Just jump in and see how this goes. I’m apprehensive about it. Ummmm, I am curious about it so, ummm, it would be more of [a] curious[ity to] see how this actually works because it is not something that [is] in my experience, in my mindset. Like I said before, would it be like 100% ethical, so I would like to see the other side of it and just see, you know, are there a lot more? I don’t know what the statistics are, so it would be interesting to see that, too.

I asked her to clarify her apprehension, and she answered, “Yeah, I think without experience, you really can’t feel 100% comfortable either way.” Without prompting, she stated how her internship had led her to question the effectiveness of abstinence-based treatment:

Ummmm, you know, I always wonder, you know, I’ve only been in internship for a couple months, so I mean I do wonder if the complete abstinence, isn’t kind of a little tough for some people. You know, to handle everything else. Like, you know, changing your mindset, changing everything else, changing cognition, changing behavior. That is kind of hard for someone who may have anxiety or, you know. It’s just a lot to handle.

By Participant #1’s questioning of the challenges involved in abstinence-based treatment, she appeared to increase her curiosity regarding medication assisted treatment, and commented: “So I think it would be interesting to see both sides.” She stated that she would be open to taking a job in a medication assisted treatment facility: “I would.”

I proceeded to ask her how her educational experience may have prepared her for a possible job in this area, and she responded:

Honestly, I think addictions could be a complete degree in itself. Just, you know, I really think it’s so, first of all, it is so, ummm, substance abuse in general is so widespread.
Addictions, just, there are too many things that fall under the addictions umbrella, so I just, honestly, I think we have really just touched on it in the masters level. I am sure it is different in the doctoral level, but in the masters level, I don’t think I have enough, but I am also somebody who wants to be 100% confident in things I do. So, it is not going to happen until you get experience.”

I realized that I had not been specific enough regarding my questioning whether or not her educational experience had prepared her for a job in medication assisted treatment, and so I asked for clarification. She stated, “I don’t think I am completely prepared for addictions. I think I am for medically assisted therapy, if that’s what you mean?” Based on her previous statements, I was surprised by her answer, so I asked for additional clarification, to which she replied: “Oh no. I didn’t understand what you were saying to me.” She stated, “Addictions in general. I am not comfortable with one class and group dealing with addictions group. You know we had so many other things, and talking about ethics is completely different than actually talking about, umm, treatment and, you know, setting goals and objectives with a client. I just, I, you know, I definitely think there can be some, umm, additions to that part.”

In order to clarify further, I asked if she felt prepared to do counseling but not necessarily addictions or medication assisted treatment, to which she replied, “Uh huh.” She explained that she felt addictions was “a specialized thing, addictions. I don’t really think that it is a general topical area.”

She explained that she had not had exposure to clients on medication assisted treatments in her fieldwork: “No. No.” Without prompting, she proceeded to state, “And that could be
something that would enhance the program, you know, between internship one and two. Maybe if you are going to do addictions, try both. Don’t just have an abstinence-based program only.”

She proceeded to state, “I don’t feel I am completely trained in addictions, to go out and get a job in addictions. Working with someone, you are impacting their life, you know what I mean? I just don’t feel...” When asked to clarify if she felt her education had prepared her to go into addictions, she stated: “No.”

As I was reviewing the transcript later on, I realized that I could have asked her what may have helped prepare her more, but instead I began to finish the interview with the question regarding anything else I could have asked her which I had not, but which would help me better understand her perception. She replied, “You know, I think a lot of my attitudes are based in, you know, family and the way I was socialized growing up. So, I mean, a lot of that, ummm, I don’t know if you want to add something about family, but that would be completely different then.”

At this point, I encouraged her to say more, in that if she thought these experiences had affected her perception of medication assisted treatment, she was welcome to share with me. She proceeded to share:

“Ummm, yeah, just because I have a unique family. I probably have, I don’t know if I have a unique family, I mean, I probably do. My father is a police officer and he was in Narcotics for a long time, so I have that kind of experience, and then I also have a brother that was a heroin addict, and you know he passed away recently from complications of his addiction, not from overdose but, umm, from his health, and it was more an addiction lifestyle.”
She acknowledged that, based on her family’s experience, she was able to see both sides: “Oh yeah.” She reflected on how her internship may have affected her perception, “I have seen people get so frustrated that they leave a program. You know, so if they are leaving a program, it’s not really helping. So, maybe they do need that extra.”

At the conclusion of the interview, I walked the participant to the library lobby and thanked her for her participation. Upon parting, I returned to the library interview room and collected my thoughts. At this time, I took down some field notes reflecting on my experiences. I was especially concerned about this interview, as it was the first interview, and I found myself very focused on the interview questions. Despite my initial nerves, I was pleased that I had been able to remain engaged and interested throughout the interview.

The narrative above provides a review of Participant #1’s description of the themes being studied. If information was not relevant to the phenomena, it was excluded from the analysis. The following chart provides Participant #1’s supporting statements for phenomena being studied.

Table 2:

<table>
<thead>
<tr>
<th>Analytical Categories from Research Questions</th>
<th>Themes</th>
<th>Supporting Statements</th>
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<tbody>
<tr>
<td>1. Attitudes and Beliefs Towards Clients</td>
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<td></td>
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<tr>
<td>1. Lack of Commitment</td>
<td>1. Lack of Commitment</td>
<td><em>they want their meds but not working their program; haven’t worked the whole recovery program, so to speak the ones who weren’t, weren’t 100% into it</em></td>
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<tr>
<td>2. Attitudes and Beliefs Affect Perception</td>
<td>isn’t completely 100% into therapy</td>
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<td></td>
<td>not really using the facility the right way</td>
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<td></td>
<td>use it as a meeting place and, you know, kind of doctor shopped</td>
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<td></td>
<td>are we sharing information?</td>
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<tr>
<td>2. Lack of Motivation</td>
<td>are we just going there to get by, you know, to the next?</td>
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<td></td>
<td>whether they were there because of a part court-mandated type thing</td>
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<td></td>
<td>some resistance for somebody who isn’t, who doesn’t have that, you know, I want to completely quit, I just want to manage life</td>
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<tr>
<td>3. Mistrust</td>
<td>I think of all the outside stuff. I think about the, you know what happens in the parking lot. Like, are we sharing drugs?</td>
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<tr>
<td>4. Detachment from Reality</td>
<td>being in a fog</td>
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<tr>
<td>5. Untreated Mental Illness</td>
<td>you might be dealing with a lot of the anxiety and, you know, depression, that kind of consumes somebody that [is] be a substance abuser</td>
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<tr>
<td>2. “I don’t know”</td>
<td>I don’t know, I am not as comfortable with the subject</td>
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<td>I guess it would be kind of the opposite of, what, abstinence-based program</td>
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<td>don’t they just mimic the dopamine in the body, in the brain? That is all I really know about the actual drug.</td>
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<tr>
<td>I don’t know anything about a Suboxone clinic</td>
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<tr>
<td>I wouldn’t feel comfortable saying I know that 100%</td>
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<tr>
<td>8. Mixed Feelings</td>
<td>I’m kind of in the middle there. I am on the fence, for sure</td>
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<tr>
<td>9. “It is a good thing.”</td>
<td>I mean, I know a few people that’s its worked wonders for</td>
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<tr>
<td>I mean, I can see the benefits</td>
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<tr>
<td>I think it’s a great, I think it’s a good concept</td>
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<tr>
<td>if it is used in the right way, it can be highly effective</td>
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<tr>
<td>10. Harming Someone’s Body</td>
<td>the doctor should be prescribing things that are actually hurting someone’s body</td>
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<tr>
<td>any long-term use medication affect organs</td>
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<td></td>
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<tr>
<td>I worry about anything being abused</td>
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<td></td>
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<tr>
<td>11. Uncertainty of Effectiveness</td>
<td>you are just learning skills to handle the addiction in a healthier way</td>
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</table>
kind of managing the addiction rather than abstaining from use

I don’t know if it ever actually treats the addiction part or if it kind of prolongs it

whether it is effective?

I just know a lot more where they kind of just prolonged the addiction

I just don’t know if it has been 100% effective

I just think we’re maybe a little far off being perfect or as effective as it can be

I think, you know, it’s just if it is used in the right way it can be highly effective

I don’t know what the statistics [are]

<table>
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<tr>
<th>12. Lack of Monitoring</th>
<th>One Flew Over the Cuckoo’s Nest</th>
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<tbody>
<tr>
<td></td>
<td>where they are all like lining up at the window for their meds</td>
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<td></td>
<td>I just think that comes down to regulations. Like, who’s regulating the facilities?</td>
</tr>
<tr>
<td></td>
<td>I just think it really does come down to who’s really in it for, you know, the client and who is in it for business</td>
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<tr>
<td></td>
<td>I think he just comes in and out and meets with clients once in a while</td>
</tr>
</tbody>
</table>
3. Educational Experiences

|   | 13. Limited Exposure | just of kind of like snippets, not like a whole, I wouldn’t say we dedicated a whole lot of time, umm, to it
|   |                  | I think we have really just touched on it in the masters level |
|   | 14. Limited Fieldwork Experience | I actually don’t think I have seen any clients that have been through an assisted
|   |                  | I’m not quite sure, I’m not 100%
|   |                  | I am also somebody who wants to be 100% confident in things I do. So it is not going to happen until you get experience
|   |                  | that could be something that would enhance the program, you know, between internship one and two. Maybe if you are going to do addictions, try both. Don’t just have an abstinence-based program only |
|   | 15. Lack of Coursework | I think addictions could be a complete degree in itself
|   |                  | there are too many things that fall under the addictions umbrella
|   |                  | I think is a specialized thing, addictions
<p>|   |                  | I don’t really think that it is a general topical area |
| 4. Other Experiences | 16. Family and/or Friends in Addiction | anyone I know personally who has gone through like AA or NA, and that’s, you know, just the mindset I have had for recovery personal experience with family members and knowing that a lot of, umm, I don’t know if the word ‘nefarious’ is the correct [term], but, like, the, you know, not really using the facility the right way because I know the individual and I know what her background was. You know, she was [a] recovering addict and, umm, and it just kind of like soured me on it. Like, you know what people are going through and you took advantage of a pretty vulnerable population, and you were part of that population, so I don’t know how you could do that? I also have a brother that was a heroin addict and, you know, he passed away recently from complications of his addiction, not from overdose but, umm, from his health, and it was more an addiction lifestyle |
| 17. Culture | I am 47, so you, I think maybe, that plays into it. Umm, for most of my life, that it has been ‘say no’ [giggling] so ‘just say no to drugs’ You know, I think a lot of my attitudes are based in, you |</p>
<table>
<thead>
<tr>
<th>18. Others People’s Stories/Perceptions</th>
<th>My father is a police officer and he was in Narcotics for a long time so I have that kind of experience</th>
</tr>
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<tr>
<th>5. Perceptions Affect Client Care</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>19. Increased Curiosity</td>
<td><em>I am curious about it so it would be more of [a] curiosity to see how this actually works because it is not something that is in my experience, in my mindset</em></td>
</tr>
<tr>
<td>20. No Difference</td>
<td><em>I couldn’t say that I have seen the difference</em></td>
</tr>
<tr>
<td>21. Increased Counselor Anxiety</td>
<td><em>I worry about anything being abused and being part of helping someone abuse it, that’s where I struggle</em></td>
</tr>
</tbody>
</table>

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<tr>
<th>6. Professional Career Choices</th>
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<tbody>
<tr>
<td>23. Not Enough Knowledge/Unpreparedness</td>
<td><em>I don’t feel I am completely trained in addictions, to go out and get a job in addictions</em></td>
</tr>
<tr>
<td>25. Fear</td>
<td><em>I think without experience you really can’t feel 100% comfortable</em></td>
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<tr>
<td></td>
<td><em>I’m apprehensive about it</em></td>
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**Individual interview #2.** This interview was conducted with a 25-year-old male who had been enrolled part-time in the Clinical Mental Health Counseling Program for more than
three years at the time of the interview. He was currently enrolled in Internship 2. He reported that, during the course of his education, he had taken one course which included information on addictions counseling. He reported that he had experience working with opioid-addicted individuals and had experience working with individuals in medication assisted treatment.

Participant #2’s interview was conducted in person using the same interview process used with Participant #1. This interview was conducted immediately following the completion of my first interview. The interview lasted approximately 41 minutes, with the entire process including the review of consents and procedures taking approximately one hour.

Participant #2 appeared to be eager to participate in the study. Prior to the start of the interview, he was asking questions about the study and expressing his eagerness to share experiences that he had previously had. As I was preparing to begin the interview, I noticed that I was calmer and more confident in my ability to interview than I had been in my first interview.

I asked Participant #2 to describe what he knew about medication assisted treatment. He started by stating: “I don’t know that much, actually.” He then stated that what he did know was from class and his clients:

…I mean, we might have gone over it in class, but from what my clients have told me, mainly my one client, ummm, and basically that’s, ummm, you know, they have these Suboxone and Methadone and other sorts of clinics basically for people who, ummm, treat, to titrate – that is the word, right? … Umm, yeah, I knew I was close. I know the word. Sooo, ummm, they basically, you know, titrate up to a certain amount like they do. I think Methadone, it is like 80mg. or whatever, and, uhhh, and then with the expectation that it is going to kinda like give you what you need to get through your day, and then
you go again. They have counselors there but then you can also like, and they have therapists or workers there that you can talk to about the addiction, but must be because of the coding or something, you can still go to a mental health facility and still get services there. I am not really sure how that works. I think it is a good thing. But anyway, that is as about as much as I know.

I attempted to clarify that his understanding came from what his clients had told him, and he responded: “Ummm huh.” I asked him what he had learned about it in school, and he said, “Not much.” He explained that: “We didn’t focus on that because there is so much, like, abstinence model, you know, and they focus on, you know, and 12 steps, and our teacher wasn’t hell bent on it, but was also realistic.” He explained that: “We talked a little bit, like I said.” He stated that: “The teacher actually brought one of his friends in, clean 6 or 7 years off heroin, and uh, yeah, I mean that was, that was educational.” He proceed to state, “What I learned from that was basically [laughing] if you don’t have something really significant, and from my client, if you don’t have something significant, uh, to get you away from it, you’re not going to get away from it. Uhhh, so I guess I learned that in school, albeit it not in a PowerPoint situation.”

I asked him to clarify the term “significant” and he described the circumstances of one of his clients: “My other person at the clinic was just like: “[in a funny voice] ‘Yeah, my, uh, someone I worked for in the summer realized that heroin addicts, that they work really well and this is like, I don’t know, and then she brought me to the clinic, and hey, I’ll try something new. I knew, two months later, and there it is.’ You know, ‘try something new,’ that’s not going to get you away from your favorite thing in the world.”
I attempted to clarify further where he had learned about medication assisted treatment, from individuals and, per his words, “not a PowerPoint.” He stated:

Yeah, that’s where I learned, really. I guess what I learned from the PowerPoint perspective is, we learned there must have been slides about it, but we just really focused on AA, abstinence, non-abstinence models, and how they may be applicable, but you know, that’s not gonna [giggling], you know, fit in any jobs that we are likely gonna get, so you know we focused on that a lot and I wish I could answer this better, but I genuinely don’t remember talking that much about medically assisted heroin.

While reviewing the transcripts later, I realized I had missed an opportunity to explore what he meant by the term “medication assisted heroin.” In thematic analysis, it is more difficult to analyze the language being used; however, it should be noted that this may be related to an underlying attitude.

When asked if basically everything he had been taught was primarily focused on abstinence based or AA, NA, he answered, “Yeah.” For additional clarification, I asked if the education had been limited in regards to medication assisted treatment, and he stated, “Yes.”

I next transitioned into asking him about his thoughts regarding the use of medication assisted treatment as a treatment option. He replied, “I mean, I think it is good and helpful. Umm, I wish I didn’t have to say to that, but, umm, some people just don’t have the willpower or, let’s be real, sad but true, honest, the reason to kick it, so this is better than being strung out and being a complete tool on the economy, family, society, [giggling] umm…” I sought additional clarification in regard to how he viewed the treatment, to which he replied, he saw it as a “liability. Yeah, I see it as positive. It is simultaneously a crutch, obviously, in its own way,
a strain on resources and all that, but I mean if it, we, are looking at the whole picture, the whole picture, considering our society and the way they treat substance abuse, and [giggling] how cheap heroin is, it is a good alternative.”

I wanted to clarify his thoughts regarding the term “crutch”, so I asked for additional clarification. He referred back to history, and stated,

Well, I mean, we’ve all seen the video by now. I mean, the people came home from ‘Nam, you know, and they were all, a lot of them were using opium and whatever, and then you know, 95% of them had no withdrawal symptoms because they had a good life, good family, and all this to return to, so their body didn’t, you know, their body was processing all the chemicals probably in a different way from the euphoria of being back in the homeland and, you know, not fighting some, like, weird, unnecessary [giggling] terrible, legal, whatever, war anymore. So, ummm, you know, uhh, they didn’t need it. They had enough of a reason, they had enough of a desire. They, you know, didn’t have any need to go out and find it or stay addicted and go through a terrible withdrawal. This is like, ideally, all these medications for psychotherapy were originally intended to be, like, “well, do this and then you are going to see the therapist and we will take you off of them,” and all intended to be, and that is how they started, but we know that there are some people who need them. Probably 50% of people I know in psychiatric treatment from my internship don’t. If they really took the reins on their life, they wouldn’t need them; 50% definitely need them. [laughing] So, I am generalizing to that now, but this is included I think, you know, I think it is a crutch or, it’s a crutch, it is a stepping stone, it’s one or the other.
I attempted to ask for additional clarification by asking if he felt that mediation assisted treatment in itself is a crutch or that some people use it is a crutch, but that other people may also use it as a stepping stone. He clarified by stating, “Yeah, yeah, it’s hard. I don’t have a very, I have a very a liquid mind.” He clarified further by stating, “It’s like, I don’t black and white things, I don’t do it.” When asked if he saw if he could “see it both ways,” he stated, “Yeah, exactly.”

I wanted to gain additional information regarding his perception of “medication assisted treatment,” so I asked him what came to his mind when he heard this phrase. He answered, “Well, I would get curious, you know. How long were they addicted? What kind of family do they have? Ummm, you know, I think medication assisted treatment, oh, what’s their back stories? Is this really applicable? It could be applicable? It also could not be. It could be like, wow.”

I attempted to assess where his curiosity came from. “The curiosity just comes from, I think, wonder. I wonder if, of all the ways to deal with addiction, why this one for this specific person?” I transitioned into asking what his experience had been with clients who use medication assisted treatment. He discussed two clients who he had worked with in his internship:

“Well, like I said, I’ve, before this tape was rolling, I’ve seen, I’ve seen two dope addicts – one in recovery who quit cold turkey out of being pregnant and not wanting their child not to be messed up, and one who just, who did enter medication assisted and was like [giggling], yeah, I’ll just resay it here so you have it on tape, [in a funny voice], ‘yeah, you know my old boss brought me to the clinic up on the northside and, um, you know,
they made a Facebook post and, you know, like, all these things, and they are really like, you know, like, rooting for me and we are going to do this and she is going to open this center and she is going to get this funding and she is going to use people like me qualitatively to demonstrate that it is effective, and all this stuff and, you know, I was like, I’ll try something new.’ And in the back of my mind, I was like [giggling] ‘You are 30, you have been addicted to heroin for 15 years; it is going to take more than this, it is going to take more than, you know, some Methadone and wanting to ‘try something new’ to get you away from this stuff.

Since he was discussing having experience with a client on medication assisted treatment and a client not on medication assisted treatment, I wanted to know what his perception was of the difference between the two treatments. In order express this, he seemed to need to clarify what medication assisted treatment was: “Methadone or, that is medication assisted, right? Yeah, that is medication assisted. Sorry, I told you I don’t know much.”

He proceeded to talk about a client who was pregnant and “quit cold turkey”:

She tried everything, not only tried, but she didn’t follow everything, and was in active addiction and several things, but yeah, she was pregnant, she was having a child, her motherly instincts kicked in, and she was just like [in a funny voice:] ‘I’m not gonna have, ahhh’ … what do you call a baby who is addicted to heroin? I was gonna say a crack baby, but that is not applicable here, a baby like that, and ‘I’m not gonna have a baby that’s born with addictions’ – and she just quit. And she said she went through the sweats and the chills and the this and that for, you know, a whole month, but she stuck it out because she knows what happens if you keep using that.
In comparison, he described his other client:

who got involved and was completely enabled by his family. You know, died multiple
times, brought back to life 4 or 5 times from what I understand. Family enabling kept
him alive through a lot of it, but did all of these things. I think his favorite, oh, what’s his
thing? Is it Xanax and Benzos? I think it is. I think it is like, super lethal, but like, super
awesome; he was like, ‘there’s nothing better, but you are there, but you are super
relaxed’ – and to be fair, he, that might be what he returned to instead of heroin after he
left the Methadone.

He next stated: “We had to close him because he was a liability.” He clarified that the
patient was a liability “because he was doing things like ‘ashing’ while laying in his bed”
but not because he was on Methadone; “On methadone it was fine,” he noted.

While talking about the client not being a liability while on Methadone, Participant #2
began talking about his perception of seeing his client on Methadone. “Yeah, I kept seeing him
when he was on Methadone. He was like [in a funny voice:] ‘Uh, I’m good,’ but there is a
certain lifelessness in these people who, um, you know, who for them, heroin, that is in their
mind. I mean you are a zombie.” Without prompting, he next began talking about another client
and how the client refused to give money to homeless addicts, and how “They will actually call
the people out because they know that look because they have had it in their eyes and are like,
we will never forget you.” He proceeded to state, “There is a certain lifelessness.”

When I attempted to clarify what he meant by “lifelessness,” he stated this was related to
people “who are addictively addicted to heroin,” but then immediately began to refer to his client
on Methadone and stated: “There wasn’t enough. He wasn’t lifeless, but where was the desire
for something better in life? It wasn’t, you know, it wasn’t there, wasn’t.” He stated that, for the client, at times, “It was like, ‘oh, I’m gonna be clean. Oh, good job. I’m a good boy.’”

I transitioned into asking him what his perception of individuals who chose medication assisted treatment as a treatment option was, and he answered: “I just, I really don’t have a set, ahhh, again, it’s hard.” He proceeded to ask questions that come to his mind when clients enter medication assisted treatment:

“I’m very, like, a human is a human, and, ummm, so I would be more, you know; it’s more, what end are they using it towards? Are they going up on Methadone and then going, you know, going to OVR and reconnecting with good people and cutting off connections with their old dealers and friends and, umm, you know, are they doing that? Or are they just like, going on Methadone, making no other lifestyle changes? That’s basically, yeah, okay, so if you want two concretes, if they are doing Methadone and making other lifestyle changes, that’s phenomenal, perfect, they are going to more likely in my mind, ummmm, go on [to] succeed, stay clean, and, uhhh, ‘clean’ in quotation marks and all that. If they are just going Methadone to just, this is the difference between the stepping stone and the crutch; this is helping me codify in my mind; this is helpful for me. The stepping stone is if they are making other lifestyle changes, if they are just like, leaning on the crutch, you know to get around, and not make any other lifestyle changes, I’m like, ‘we’ll see how long this lasts.’

I wanted to know his attitudes towards Methadone and Suboxone, specifically. He stated, “I honestly don’t know much about them.” He added that: “There is something that apparently you use for a very short term, and a day to a week, some sort of natural thing and, uhhh, you do it for,
like, that period of time and you are good. I forget what it is called.” He then began to talk about the lack of research related to treatment: “Our glorious paid-off scientists in society obviously don’t pay attention or, you know, don’t research, blind eye, and unfortunately prey on these people to keep these treatments going so, ummm, they are acceptable for now.” He stated, “I think if there are better options out there, that it is horrendous that they’re the only options.”

After reviewing the transcripts, I realized I could have asked for additional clarification in regard to his perception of the effectiveness of treatment. I recognize that part of the challenge I faced was keeping the participant on topic and away from political beliefs, which may have made me apprehensive about following up on this particular question.

I proceeded to ask him about his feelings regarding counseling a client on medication assisted treatment, and he answered: “That’s fine. I wish there was better coordinated. I wish I knew what those counselors were talking about.” He proceeded to express concern about his client: “Like my client, I mean, how are they going to do that?” He then discussed how he felt that “agencies are so, ummm, we’re so in our bubbles and we’re overworked, so we don’t have time to step outside of the bubble.”

I redirected him back to his feelings about counseling his client who was on medication assisted treatment, and how he felt about that experience. He answered:

I mean, I just, I was, whenever they offered something from the clinic, I was like, ‘Yes, thank you for telling me, and I could work this.’ I would let them know, ‘Thank you, anything you feel comfortable with, there is no need at all, there is no pressure, but when you do, it helps me. It lets me understand what you are going through out there more,’
and just like, ethically like, as possibly I could, ‘Please feel free to offer me any of this; it was helpful when they were sharing.’

He clarified further, “I’m not going to pressure you. You can keep, you can very serious about confidentiality, you can keep all that there and I’m not going to try to pull a power play on you, you know, and do unethical things, but when you do share that, I know what is going on and I can help you better.’ That is, basically, I waited for those moments.”

I wanted to explore his concerns about ethics, and he clarified, “I’m very serious about people being able to share certain parts of themselves with certain people, very serious about that. Ummm, and if this person didn’t feel like sharing what went on over there, this person did tell me anything, they would tell anyone anything.” He added, “We have a right to confide in the people that we want to confide in and, when you are dealing with a power differential, I try to, not in just this case, but many cases as I can, as a counselor in training, I try to really respect people, do as little pressuring as necessary and possible, and really let them have control of their storyline.”

I attempted to clarify if he saw medication assisted treatment and mental health treatment as two separate treatments, and he responded: “Well, here is the thing: on paper, they are. Well, in someone’s mind, they might be, but life is only one thing.” He clarified further that: “I have to honor that billing, funding, society does it that way and so I did.” He acknowledged that this was his agency’s perspective, but not necessarily his perspective, with the comment, “No, of course not.”

He described a situation in Internship class where his challenges with keeping them separate had caused him frustration:
I was thinking about how, how some of my classmates [who] are in group supervision are like, ‘Yeah, well, I’m in this drug and alcohol facility and my supervisor was there and the person was trying to talk about how, like, they use drugs to kind of, and alcohol to kind of, like, cover up things from their past with their family, and this and that, [and] the supervisor was like ‘we really can’t go there,’ and I was like, ‘we really need to go there.’ I was like, I’m just, like, mentally ripping my hair out because I’m just, like, you are going to. This managed care is basically to keep some people with yachts, with boats in southern states happy, you know, sipping high quality margaritas off the coast of Florida, you know. These managed care people, who really don’t know what is going on, are making treatment be restricted to this because, if they go outside of this, they can’t get reimbursed for the treatment, and I’m just like, ‘oh my God, you are keeping this person a wreck.’

I was able to get him to clarify that this separation of care was what he perceived as unethical, to “keep them apart, keep them apart as long as you want to, and the client wants to, but it almost gets unethical to be like [in a funny voice:] ‘well, we can’t talk about that, we can’t talk about your real problems, because you are here for these other problems.” He proceeded to talk about how he felt the need to refocus the addictions treatment back to mental health due to billing and how he felt this was ethical, “I had to because that is how billing works. That is technically ethical, considering, because that is what they signed onto for treatment, and if they want to bring some of it into it, as long as I can spin it back to mental health, that’s tot’s fine.”

I wanted to explore his thoughts regarding taking a position on counseling and treating clients who use medication assisted treatment. He stated that “it is community mental health, so whoever walks in the door walks in the door.” He stated that: “My feelings towards it are, here
is another person, and I didn’t really think too much about the medication assisted treatment besides, I hope I am not contradicting what the other therapist or other facility is saying.” He explained that his personal experiences affect his perceptions of individuals. He stated, “From my life being a yogi, you know, a person is a person. We all have, you know, we all have our karmas and experiences that bring us to a certain situation, and I am called in to help them with their mind at this particular part in their journey.”

In order to clarify his thoughts regarding working as a counselor, I asked specifically about his thoughts on taking a position as a counselor in a medication assisted treatment facility. He answered, “I mean, I’d do it because it was a job, and I’d probably get, I’d probably help people out, you know.” He expressed concern about its effectiveness and noted that he might be misleading people,

but at the same time, I would feel kinda like, you know, I had one client who was a restaurant manager for a long time and, after a while, they were like, ‘I can’t.’ They were good at it, but after this many years of it, they were like ‘I can’t keep telling high school kids to get, like, real jazzed up to work minimum wage and, you know, to make mediocre food, like, I can’t keep lying like that.’ I think, eventually, I’d be like, I can’t keep offering treatment that’s only like 3% effective. Statistically. Like, I just, I just can’t.

He then expanded on his concerns regarding the effectiveness of treatment and how it affects his perception, stating, “I feel it is stretching it. Isn’t that the statistic, that only 3% of people who enter rehabilitation programs actually, you know, stay clean, and the average amount of times that it takes to enter a treatment program is about 13 for someone to actually stay clean?” I attempted to clarify his concerns about the effectiveness and how it relates to his
challenges with keeping treatment separated. He stated, “I would feel restricted.” He proceeded to express concern about the lack of research related to medication assisted treatment and how he focuses on evidence based practices, saying: “I still use evidence based practices for the vast, for the most part, but I mean, it’s strictly mental health and it is so broad what you can do that is evidenced based, so that’s nice.” I attempted to clarify his perception of medication assisted treatment in regard to being evidenced based, and he responded, “It is evidence based, just, oh my gosh, it’s just, it’s, the numbers are just so, just so low, there has to be something wrong.” He also talked about experiences in Portugal and how that has affected his perception, noting, “I wouldn’t 100% believe in it from the start, but it’s effective for those people who buy into it and for those, whom, it is their pattern of desire.”

Additionally, in response to the information regarding his personal research, I wanted to understand how his education might have prepared him for a possible job in medication assisted treatment. He stated, “I have a cursory… ‘cursory’ is not the word, ‘modest’ is not the word… I have a functional understanding of how drug and alcohol counseling works.” He proceeded to state that his internship had also helped him: “After about a year working there, I feel I have more than a functional understanding, but people learn by experience, so I feel like my education did a job, uhhh, functioning, getting me functional.”

I wanted to clarify whether he felt he was “functional” with addictions in general or medication assisted treatment. He clarified, “With addictions, but with medication assisted treatment. Addictions. With medication assisted treatment, I’d say my understanding was modest.” He stated that, regarding taking his first job, “Modest works for that, and I would want to do more research myself before taking a job. Even if I got the job, I would still feel, like, unethically prepared unless I did legwork on my first day there.”
When asked if his education had prepared him, he stated that his education had prepared him more for “addictions in general, 100%,” than medication assisted treatment. He stated that he had been given limited preparation for medication assisted treatment, saying, “We went over it in a very cursory way. Maybe it was like one or two days of the fourteen weeks that we were in the class, ummm, and it was, you know. I really don’t remember many specifics, but I do remember it being talked about, and so, you know, there was other things to focus on.” He stated that he and his classmates got “the general overview.”

Without any prompting, he next began to talk about his concerns regarding the CACREP requirements and how it would be helpful to learn more about medication assisted treatment “because we are in western Pennsylvania, you know, I’d be, I think, you know, if there is still a way to meet CACREP requirements if you put a little bit more on that, it would be helpful for us.”

When asked specifically if he thought learning more about medication assisted treatment specifically would be helpful, he stated: “I think it would be helpful. I mean, it is more [that] I think it would be fruitful to stay specific to this area because most people don’t leave.” He talked about the easy accessibility of medication assisted treatment:

Oh my gosh, why not if you are living in western PA., where, you know, Washington County is right down the road, you know, why wouldn’t you put a couple extra days into medication assisted? Because, you know, even driving, I drive all over the city for work every week; I put, I put, it’s not much, but about 300-400 miles on my car a week all over, north, west, south, and the only place I don’t go too often is east. And, ahh, you
know, you see signs everywhere, ‘Methadone phone number,’ ‘Suboxone, this phone number,’ and it is just everywhere.

Participant #2 then discussed his desire to be able to assist people in his personal life with addiction and the prevalence of addiction, stating, “Someone I do care for, their brother is addicted to heroin, and addiction is everything. And you know, I’m just like, I wish I could talk to the family, but it is not my place – so it’s everywhere.” He transitioned back to how he believed more information about medication assisted treatment could be helpful, adding, “Why not, if you are in [a] western PA. counseling program, specialize in that just a little bit more, get people a little bit more prepared? Wouldn’t that be a selling point?”

I wanted to gain more clarity regarding his fieldwork experience, so I inquired if he had any other experience with clients on medication assisted treatment. He answered, “I’m sure there have been.” He discussed the challenges of obtaining that information, saying, “But it is community, so people come in and out, and the amount of people who stay for a long period of time, umm, is, it is about 50/50.”

In order to attempt to gain insight into whether his coursework had helped him in his fieldwork, I asked him about whether or not his education had helped, and he said, “Yeah, yeah. There is a reason this is required coursework beforehand.” He explained, “I took Addictions during my start of Internship 2 and it helps me.” He expressed that, if he had taken it earlier, it may have benefitted him more: “I wish I had taken [it] before, you know, maybe when I was Practicum or Internship 1,” and that part of the reason he had not was because “it wasn’t required before as a pre-req.”
I wanted to understand whether he thought it would be helpful for it to be a pre-req, and he answered, “I honestly think it would be because, you know, at the clinic, everyone talks about it. In mental health, I think we all know it, just no one is saying anything yet, but this is the direction it is going.” He explained that he believes this is in part due to: “Drugs are much more widespread and, ummm, mental health dual diagnosis is, I mean, where we are going? I don’t think, 50 maybe even 25 years from now, they don’t have to be separated or so far apart.” He explained that not only does he believe it would have helped him in the future, but it would also have helped him gain a better understanding in his coursework: “It would have helped me a lot. It helped me a lot when I was in that class and I was like, ‘oh, when my person was telling me that in Internship 1, that’s what they meant.’”

When I asked him at the end of the interview if there was anything else he would like to share with me, he began talking about CACREP, noting, “I would say the requirements should be, like, umm, change them up a little bit. My gosh, allow for specialization for the area.” He continued to explain that, “I am grateful that CACREP did its job in broadening it and making sure all the bases were covered, but you know some of it just, it could have used more personalization.” He discussed how he feels that he: “learned better from my roommate about Native Americans because they don’t have the gene to process ethanol, so they get much more into the alcohol.”

At the conclusion of the interview, I walked the participant to the library lobby and thanked him for his participation. Upon parting, I returned to the library interview room and collected my thoughts. I was concerned about this interview, as I felt I had faced challenges getting the information I needed, as Participant #2 had tended to go in unexpected directions, and I had felt challenged in continually redirecting him to the topic at hand. I had to remind myself
that part of being a researcher is allowing the research participant to take you where they feel the story is; it is their story rather than the researcher’s. At this time, I took field notes on any thoughts I had. I was concerned about the potential results of this interview, as I had not heard the participant discuss how his thoughts affected client care or his possible career choices, but he had instead focused on the education component. I had to remind myself not to expect any results and that the interviews would be conducted until the themes were saturated. Additionally, one interview would not exclude a research question from being answered.

I was also concerned because I found myself focused on the language he had chosen to describe the clients. I felt that I had been able to hear stigmatizing words; however, thematic analysis does not allow for interpretation of language. I was pleased that I had been able to remain engaged and interested throughout the interview. I was able to be mindful of my initial internal reactions to the words he had chosen and not allow myself to react to them, thereby possibly affecting the results of the interview.

The narrative above provides a review of Participant #2’s description of the phenomena being studied. If information was not relevant to the phenomena, it was excluded from the analysis. The following chart provides Participant #2’s supporting statements for phenomena being studied.

Table 3:  

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<th>Analytical Categories from Research Questions</th>
<th>Themes</th>
<th>Supporting Statements</th>
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<tr>
<td>1. Attitudes and Beliefs Towards Clients</td>
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</tr>
<tr>
<td></td>
<td>1. Lack of Commitment</td>
<td>What end are they using it towards?</td>
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| 2. Lack of Motivation | If you don’t have something significant to get you away from it, you’re not going to get away from it
where was the desire for something better in life?
You know, ‘try something new,’ that’s not going to get you away from your favorite thing in the world
some people just don’t have the willpower, or let’s be real, sad but true, honest, the reason, to kick it |

| 4. Detachment from Reality | there is a certain lifelessness in these people
I mean, you are a zombie |

| 2. Attitudes and Beliefs Affect Perception | 7. “I don’t know” | I don’t know that much actually
I genuinely don’t remember talking that much about medically assisted heroin |
|   |   | Methadone or, that is medication assisted, right? Yeah, that is medication assisted. Sorry, I told you I don’t know much
|   |   | I honestly don’t know much about them
| 8. Mixed Feelings | I think, if there are better options out there, that it is horrendous that they’re the only options
|   |   | When asked if he saw if he could “see it both ways” he stated, yeah, exactly
| 9. “It is a good thing.” | I think it is a good thing
|   |   | I mean I think it is good and helpful
|   |   | I mean, if it we are looking at the whole picture, the whole picture, considering our society and the way they treat substance abuse and how cheap heroin is, it is a good alternative
| 11. Uncertainty of Effectiveness | stay clean, and, uhhh, ‘clean’ in quotation marks and all that
|   |   | scientists in society obviously don’t pay attention or, you know, don’t research, blind eye, and unfortunately prey on these people to keep these treatments going so, ummm, they are acceptable for now
|   |   | I think eventually I’d be, like, I can’t keep offering treatment
that’s only like 3% effective. Statistically. Like, I just, I just can’t

I feel it is stretching it. Isn’t that the statistic, that only 3% of people who enter rehabilitation programs actually, you know, stay clean, and the average amount of times that it takes to enter a treatment program is about 13 for someone to actually stay clean?

It is evidence based, just, oh my gosh, it’s just, it’s, the numbers are just so, just so low there has to be something wrong

3. Educational Experiences

13. Limited Exposure

I asked him what he learned about it in school, and he stated: not much

we talked a little bit

I genuinely don’t remember talking that much about medically assisted heroin

I honestly don’t know much about them

With medication assisted treatment, I’d say my understanding was modest

we went over it in a very cursory way

the general overview
| 14. Limited Fieldwork Experience | I inquired if he had any other experience with clients on medication assisted treatment, and he answered: 
   *I’m sure there have been*
   *I kept seeing him when he was on Methadone*

| 15. Lack of Coursework | In reference to his Addictions course, he stated: *I wish I had taken [it] before, you know, maybe when I was [in] Practicum or Internship 1*
   *it wasn’t required before as a pre-req*

   In reference to Addictions as a pre-req, he stated: *It would have helped me a lot*

   *I would say the (CACREP) requirements should be like, umm, change them up a little bit. My gosh, allow for specialization for the area*

   *if you are in a western PA counseling program, specialize in that just a little bit more*

| 4. Other Experiences | 16. Family and/or Friends in Addiction | Someone *I do care for, their brother is addicted to heroin, and addiction is everything. And you know, I’m just like, I wish I could talk to the family*

| 5. Perceptions Affect Client Care | 19. Increased Curiosity | *I would get curious*
<table>
<thead>
<tr>
<th>20. No Difference</th>
<th>I think medication assisted treatment, oh, what’s their back stories? wonder if, of all the ways to deal with addiction, why this one for this specific person?</th>
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<tr>
<td>My feeling towards it are, here is another person and I didn’t really think too much about the medication assisted treatment a human is a human</td>
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<th>6. Professional Career Choices</th>
<th>23. Not Enough Knowledge/Unpreparedness</th>
<th>Even if I got the job, I would still feel like, unethically prepared unless I did legwork on my first day there</th>
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<td>24. Lack of Interest</td>
<td>I mean, I’d do it because it was a job</td>
<td>I would feel restricted I wouldn’t 100% believe in it from the start, but it’s effective for those people who buy into it and for those, whom, it is their pattern of desire</td>
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**Individual interview #3.** This interview was conducted with a 25-year-old female who had been enrolled full-time in the Clinical Mental Health Counseling Program for more than three years at the time of the interview. She was currently enrolled in Internship 2. She reported that, during the course of her education, she had taken one course which included information on
addictions counseling. She reported that she did not have experience working with opioid dependent individuals or individuals in medication assisted treatment.

Participant #3’s interview was conducted in person using the interview process used with Participant #1 and Participant #2. The interview lasted approximately 32 minutes with the entire process including the review of consents and procedures taking approximately 45 minutes.

Participant #3 appeared to be nervous about participating in the study. As I was preparing to begin the interview, I noticed I felt excitement about another interview. I found myself experiencing an intense curiosity about her thoughts. I was concerned initially because she had appeared to give short answers during our first few interactions, and I was concerned about my ability to get her to open up and express her thoughts freely.

I began the interview by asking her what she knew about medication assisted treatment, and she answered, “Not much, I guess. Medication assisted treatment, I am going to assume, is what it sounds like and like, you, ummm, get for treatment, for treatment you get medicine. I don’t know.” I asked her what came to her mind when she heard the term “medication assisted treatment,” and she responded: “I think of psychiatrists. I think, specifically, that is what I think. People who are getting, using medicines that help with their, ummmm, I guess, symptoms or whatever.”

I became concerned at this point that my question was not clear, so I attempted to clarify what she though in relation to opioid dependent individuals. She explained that it was a “crazy topic” that she had talked about that day in class, and that from her understanding it concerned “how you can use different drugs as a medicine instead of, you know, a recreational drug.” She further clarified that, “You want to be careful with what you give them, ummmm, especially
them.” Reviewing the transcripts later, I realized I had missed an opportunity to explore her concerns further regarding why she had stated you need to be careful.

Since she was talking about discussing medication assisted treatment in school, I asked her for additional information regarding what she had learned. She answered, “Like, I don’t think, I don’t remember it specifically, any one using that term, which is why I am a little bit confused. What, I guess, which is why I am confused by what it means.” At this point, I debated whether or not I should clarify what “medication assisted treatment” meant, but I became concerned that I would influence the results of the study, so I decided to give minimal prompts and allow the participant to provide insight to her own understanding without influence.

She proceeded to recall classes where medication assisted treatment may have been discussed, saying: “Now I think of it, umm, in all the classes, but you, ummm, when you learn about different diagnoses, you learn about medication that they are given, ummm, but then there is also the whole, you know, other than [the] pharmacological side point of view, there is a whole treatment point of view that is not really depending on drugs.” She explained that it tended focus on abstinence-based treatment: “When I think of maybe, like alcoholism, like the alcoholic, the AA, that model.” She stated that there was also talk of medication assisted treatment, saying, “For instance, you know, I don’t know the name of the drug for whatever they use, but like, it helps with them staying away from alcohol and be, like, but it helps them get away from [it],” but stated, “I can’t remember but it helps them stay away from it.” In order to make sure that I was understanding her correctly, I questioned if she was referring to Vivitrol, and she nodded her head “Yes” and chuckled, commenting, “I am really bad with names of drugs.”
Since she had introduced the topic of Vivitrol, I determined this was an opportunity to redirect her to the concept of medication assisted treatment which I was interested in exploring. In order to accomplish this, I asked her if she was aware of other medication assisted treatment options such as Methadone, Suboxone, and Vivitrol, and what came to mind when she heard those names. She replied, “Honestly, I think I need to get my phone out and look at them because, yeah, I can’t remember.”

I attempted to clarify that she had heard of them but was not really familiar with them, to which she replied, “Yeah.” I asked her if she knew what they were used for, and she answered, “No, like even my own medications, I wouldn’t know that. I know the medication. I know the name of it, but the whole scientific name, I would google that.”

She explained that her interest in this area was limited, commenting, “I lean more towards, like, the behavioral aspect anyways. I never really wanted to get into the whole, ahhhh, you know, drugs and psychiatry and all that. Whatever it is, I’ve always like, I don’t know, if I’m just scared of that? Like, so, yeah, I never really focused much on drugs.”

Her mention of the behavioral aspect made me curious about what she thought of when she thought of the treatment of addictions. I asked her how she perceived opioid addiction being treated. She requested clarification of the question, so I asked her, when she thought of counseling an individual who was using heroin or maybe mis-using opiates, what did she think would be a good treatment option? “I honestly don’t, don’t know because, I don’t, I haven’t much experience in that department. I would have to do a lot more research.” She referred back to her discussion in class that day and her concerns regarding the use of medication assisted treatment, saying, “how, like, people who need different kinds of addictions, how is giving them
more drugs helping them?” She expressed indecisiveness in her stance on medication assisted treatment, saying, “I’m not sure where I stand on that exactly,” and noted how she can acknowledge the concern, commenting, “I guess I see that point of view.”

I wanted to explore her concerns about the medication helping with treatment, so I clarified if she was curious whether it would help or not, and she responded: “They’re already mis-using the opiates.” Without any prompting, she brought up concerns about trust: “How are they gonna trust them? How can you trust them not to mis-use anything else?” Recognizing that trust appeared to be a concern for her, I decided to explore this more deeply, as this was becoming a reoccurring theme in my interviews.

She explained that trust was a factor for her “especially if they are adults. I mean, now you are going to start monitoring them, monitoring them but, then it is like, but you don’t want to baby them, but you can’t trust them.” She explained that this causes confusion for her, in part because: “I would need a lot more research, to do a lot more research, and get a lot more experience in that department.”

Since it appeared I was able to get her to associate medication assisted treatment with opioid dependence, I attempted to clarify this connection. When asked if psychiatry comes to her mind when she hears that term, she answered, “Yeah,” but I also asked for clarification, to make sure she was not referencing Methadone or Suboxone or things like that, and she again responded, “Yeah.”

At this point, I became concerned that her answers were going to be based off of her perception of medication assisted treatment being related to psychiatry. As a result, I attempted to redirect her by asking if she had had any experience with clients on medication assisted
treatments like Methadone, Suboxone, or Vivitrol. She answered, “I know some of my clients have mentioned it, but it is something they have used in the past.” She explained that, at her internship, “they already, I’m not gonna say they are cured, they are still in recovery, but they already, ummm, [have] gone through the whole, they have already gone through the, like, if they have substance abuse, they[’ve] already gone through the whole withdrawal. They have been through treatment center.” She explained that, at her site, “we don’t deal with that part,” and as a result, “that is not something, I ever had direct experience, dealing with somebody.” She stated that, while they did talk about their clients’ pasts, she did not have any experience working with opioid dependent individuals.

Due to her lack of experience, I attempted to use a hypothetical situation in order to understand her feelings. I asked her how she would feel if a client told her they were choosing medication assisted treatment as an option. She answered, “I would probably keep a closer eye on them.” She explained that her caseload comes in “3 days a week, and some days we do check-ins and see how they are doing. I would be more focused on that, those individuals rather than everyone else. I would watch those individuals more than the individuals on my caseload.” I asked for clarification in regard to what she meant by keeping a closer eye on them, and she responded, “See how they are doing, like, behavior-wise sometimes you can tell; sometimes you can tell if they are on something or if they are not, but I’d probably.” She explained that her internship “is a really relaxed environment,” but if she had someone on medication assisted treatment: “Me, I guess I wouldn’t be as relaxed around that.”

She explained, “the whole addiction factor” would make it difficult for her to relax and lead her to question, “what if they, what if they’re mis-using?” She explained that she would be concerned they would mis-use “the medication assisted” treatment because: “I wouldn’t assume
they would have, ahhh, the substance that they are relapsing from.” She expressed concern that they would mis-use the medication assisted treatment because: “a lot of the, my clients, are suicidal, and more than once some of them have mentioned using, popping pills as a way out so, like, that is – that is what makes me a little tense.”

I decided to explore her fear that medication assisted treatment would cause more harm. She explained that this fear was related to the “whole addictions factor” and her concern that “if they are hooked on something once, I mean, yeah, you should have the option to, ummm, get better, but that fear is in the back of your mind that something might go wrong.” She expressed further concern, saying, “When any kind of drugs or medications [come in], I think there is a fear of overdosing, whether it is knowingly or unknowingly,” and that: “I have fear in the back of my head.”

In order to explore her perception of clients who have chosen this option, I asked about how she perceived them. She responded, “I think I would perceive them to be, ummm, like courageous, that they know that can happen, yet they are still doing it.” Despite seeing them as courageous, she expressed concern about their motivation: “I would hope, ummm, because it would be that they want to get better and they are sick of the relapse or whatever.” She explained she would “still have that fear,” which I wanted to explore in terms of whether it was related to her previous concerns of trust, which she stated was the case, “Yeah.” She perceived these individuals as “taking a big step, a really big risk to trust themselves.” She explained that, “I have seen, like, in my caseload, you know, but it once a small accident, they are prescribed pain killers and then they spiral down. They, like, this person was perfectly fine and doing really good in their recovery.” These experiences “automatically create a fear or doubt” which affects her trust.
I transitioned into attempting to gain an understanding of her knowledge of Methadone or Suboxone, specifically. She asked: “Are those drugs that make you kind of sick or are they different?” I explained they are used to treat opioid dependence and asked if they sound familiar, and she answered, “It does. It sounds familiar, but I can’t think of what it is.” I attempted to clarify further if she was familiar with them, but she answered, “Nah, I just remember reading about it somewhere.”

I wanted to understand if she had learned about these drugs in her coursework. She stated: “I think. Ummm, I think in Delmonico for Addictions. I think I heard him say it once or twice.” I asked for additional clarification, as to whether she had been taught about them specifically. She explained that, “I was out a lot, so I am not even sure,” which could even affect whether or not she knows whether they were discussed. She stated, “I remember reading it in the book and I remember him talking about it, but I don’t, I can’t think of what it was on.”

I transitioned back to discussing her feelings regarding counseling a client who used medication assisted treatment. I wanted to see if I could get additional information regarding her thoughts. She reiterated similar information as before, “I would be a little bit more careful. Make sure how they are doing, how they are feeling? Make sure you know they have supports in place and appointments, stuff like that.”

Due to her ongoing concerns about monitoring, I wanted to see her perceptions regarding taking a position as a counselor who treats clients on medication assisted treatment. She answered, “I would have to think, like, I mean if it is a good job, but I think of a job, but it, guess it depends on where I am at the moment. Could I handle that stress, that job?” I wanted her to reflect on what she perceived as stressful about the job. She perceived this aspect as: “knowing
that, ummm, my whole caseload is like that” as stressful. She expressed concern in saying, “I don’t know if, like, especially if at this point, I don’t think I would be able to go home and sleep peacefully at night with all of that.” She stated that, in order to do the job, she felt: “I would need a lot of more experience in handling that type of caseload.”

Other than her fear, I wanted to see if anything about medication assisted treatment specifically made her feel hesitant about taking a job, and she responded, “I think it’s the whole, I don’t know if it is a misconception of addictions or the whole idea behind it, that there is anything that at this point would make me a little hesitant.” I wanted additional clarification regarding the term “misconception,” and she clarified that she was not sure if “misconception” was the right word, but her concern was related to the potential harm of the treatment: “Like, someone is addicted to something and now you’re, especially with the whole opiates, like, are you taking more medication? What are you doing? I think that would be my concern.” She explained that her fear would also cause her a conflict because “it would be really courageous. I think someone would have to be courageous to take that step, especially if they want to get better. So, yeah, it would be really, so, yeah, but my thought at the end, that would be my thought process, but then again, I also understand there are only so many options that you have.”

In order to understand her fear and anxiety, I wanted to see how her education had prepared her for a possible job, and she answered: “Not fully.” I asked her what may have been lacking or what may have been needed to make her feel more prepared. She stated, “I don’t have the full understanding.” In order to feel more prepared, she added “there should have been a little bit more, more, I guess, classes, or at least more focus on the drugs part of counseling.” She explained, “We got a lot of information about what drugs, about the drugs and the behavioral-wise or, like, we got a lot of information on the, they classified what’s what, but I
don’t think we actually get a lot of information on how to deal with somebody who is taking a specific drug.”

Due to her perception that her education had been limited, I wanted to understand if she saw any difference in the treatment of clients who were and who were not on medication assisted treatment. She explained that treatment would be “not very much different,” but explained that she would: “be wary with medical assisted, knowing they have drugs at hand.” However, she expressed concern about commitment, “whereas others who are trying to work on get[ting] treatment for their addiction or something, most likely they probably don’t have much, or that is something.” She elaborated upon this view by saying that clients on medication assisted treatment “have it at hand,” which would make her “a little bit more waary.” I referenced back to her earlier statements about her being concerned for them and “having difficulty sleeping at night,” and if this would affect her with clients who used medication assisted treatment, to which she replied, “Yeah.”

I wanted to confirm whether she had experience with clients on medication assisted treatment in her fieldwork, given her reports of increased anxiety. She stated, “They are not on it during it.” I asked, since she was aware clients were on it, if they ever talked about it, and she answered, “Not really. I mean, they talk about using drugs, but not really the treatment they have gone through, ummm, to be clean.”

The final question of the interview was if there was anything I had not asked that I should have asked which would help me understand her beliefs regarding the use of medication assisted treatment. She explained, “I was never really interested in the whole drugs and alcohol concept.” She explained that her culture affected this, as “I wasn’t really exposed to much information like,
real information, until I went to university, so not even ten years.” As a result of this limited exposure, she explained that she was “still learning about the different drugs and the treatment for it.” She went on to further explain that, “growing up, especially, it was always, why would someone even start? Like, I never really was exposed to all of that, now.” Due to her limited exposure, she added, “it never really interested, in all of that.” She proceeded to explain that she continues to have no interest in the subject, “So even now, like, um, not going to go home and start doing research. It’s not happening. Like, if I come across an article or a website, I’ll look into it, but it is not something I actively pursue.” She explained that she feels she is in a “protective bubble” and that, as she is “coming out of that today, I am learning a lot more and I understand that it’s important to be educated about it and to understand,” but “I won’t go home and do research, but eventually I will look into it, so we can get exposed to it.” She acknowledged the: “need to be updated. I need to see what kinds of medications there are, what types of programs there are, and what’s in the program.” She said that, for her, this process is: “baby steps, but I’ll get there.”

At the conclusion of the interview, I walked Participant #3 to the library lobby and thanked her for her participation. Upon parting, I returned to the library interview room and collected my thoughts. I was pleased that some themes appeared to have begun repeating; however, this interview also illustrated missing themes. I became concerned about the risk that the data would not become saturated. At this time, I took field notes on any further thoughts I had.

The narrative above provides a review of Participant #3’s description of the phenomena being studied. If information was not relevant to the phenomena, it was excluded from the
analysis. This chart provides Participant #3’s supporting statements for the phenomena being studied.

Table 4:

*Participant #3’s Supporting Statements*

<table>
<thead>
<tr>
<th>Analytical Categories from Research Questions</th>
<th>Themes</th>
<th>Supporting Statements</th>
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<tbody>
<tr>
<td>1. Attitudes and Beliefs Towards Clients</td>
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<tr>
<td>1. Lack of Commitment</td>
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<td><em>whereas others who are trying to work on get[ting] treatment for their addiction or something, most likely, they probably don’t have much, or that is something</em></td>
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<td>2. Lack of Motivation</td>
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<td><em>I would hope, ummm, because it would be that they want to get better and they are sick of the relapse or whatever</em></td>
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</table>
| 3. Mistrust                                  |        | *How are they gonna trust them?*  
*How can you trust them not to mis-use anything else?*  
you can’t trust them |
| 6. “trying to better themselves”             |        | *I think I would perceive them to be, ummm, like, courageous*  
*they want to get better*  
taking a big step, a really big risk to trust themselves* |
<p>| 2. Attitudes and Beliefs Affect Perception    |        |                       |</p>
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| 7. “I don’t know” | Not much, I guess
People who are getting, using medicines that help with their, ummmm, I guess, symptoms or whatever
how you can use different drugs as a medicine instead of, you know, a recreational drug?
Like, I don’t think, I don’t remember it specifically, anyone using that term, which is why I am a little bit confused. What, I guess, which is why I am confused by what it means
I can’t remember, but it helps them stay away from it
I think I need to get my phone out and look at them because, yeah, I can’t remember
It sounds familiar, but I can’t think of what it is |
| 8. Mixed Feelings | Yeah, but I’m not sure where I stand on that exactly |
| 9. “It is a good thing.” | you should have the option to, ummm, get better |
| 10. Harming Someone’s Body | they’re already misusing the opiates |
When asked if psychiatry comes to her mind when she hears that term, she answered, yeah, but not in relation to Methadone or Suboxone or things like that, again she answered: yeah |
fear is in the back of your mind that something might go wrong

I think there is a fear of overdosing, whether it is knowingly or unknowingly

Like, someone is addicted to something and now you’re, especially with the whole opiates, like, are you taking more medication? What are you doing?

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<tr>
<th>11. Uncertainty of Effectiveness</th>
<th>How, like, people who need different kinds of addictions, how is giving them more drugs helping them?</th>
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3. Educational Experiences

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<tr>
<th>13. Limited Exposure</th>
<th>I don’t think we actually get a lot of information on how to deal with somebody who is taking a specific drug</th>
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<tr>
<th>14. Limited Fieldwork Experience</th>
<th>I don’t, I haven’t much experience in that department [addictions]. I would have to do a lot more research</th>
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<tbody>
<tr>
<td></td>
<td>that is not something I ever had direct experience dealing with [with] somebody</td>
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<tr>
<td>15. Lack of Coursework</td>
<td>I would need a lot of more experience in handling that type of caseload</td>
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<td>there should have been a little bit more, more, I guess, classes, or at least more focus on the drugs part of counseling</td>
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<th>4. Other Experiences</th>
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<tr>
<td>17. Culture</td>
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<td>I wasn’t really exposed to much information like, real information, until I went to university, so not even ten years</td>
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<tr>
<td>growing up, especially, it was always, why would someone even start? Like, I never really was exposed to all of that, now</td>
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<tr>
<td>She explained that she feels she is in a protective bubble</td>
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<th>5. Perceptions Affect Client Care</th>
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<tr>
<td>19. Increased Curiosity</td>
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<td>someone is addicted to something and now you’re, especially with the whole opiates, like, are you taking more medication? What are you doing?</td>
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<th>20. No Difference</th>
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<tr>
<td>She explained that treatment would be not very much different</td>
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<th>21. Increased Counselor Anxiety</th>
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<tr>
<td>you want to be careful with what you give them, ummm, especially them</td>
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<tr>
<td>Me, I guess I wouldn’t be as relaxed</td>
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<tr>
<td>22. Increased Monitoring</td>
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I would be a little bit more careful. Make sure how they are doing, how they are feeling?

what if they, what if they’re mis-using

I have fear in the back of my head

automatically create a fear or doubt

still have that fear, be wary with medical assisted, knowing they have drugs at hand

She elaborated that clients on medication assisted treatment have it at hand, which would make her a little bit more weary
I would probably keep a closer eye on them

now you are going to start monitoring them, monitoring them, but then it is like, but you don’t want to baby them, but you can’t trust them

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<td>I would need a lot of more experience in handling that type of caseload</td>
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Individual interview #4. This interview was conducted with a 25-year-old male who had been enrolled full-time in the Masters in School Counseling Program for more than two years at the time of the interview. He was currently enrolled in Internship 2. He reported that, during the course of his education, none of the classes had included information on addictions counseling. He also reported that he did not have experience working with opioid dependent individuals or individuals in medication assisted treatment.

The interview was conducted via telephone. Due to time constraints, the interview had to be rescheduled once. Prior to the interview, Participant #4 had been emailed the demographic questionnaire and consent form for his review. The consent form and demographic form were mailed to him via U.S. Mail in order to obtain original copies since he was unable to email them to me. He sent them back to me via pre-paid postage.

I contacted Participant #4 via telephone at our pre-arranged meeting time. I conducted the interview in a private area in my home where the answers would not be heard by others. Prior to the start of the interview, I reviewed the consent form and voluntary participation form sent via U.S. Mail. He was advised that his participation was voluntary and that he could end the interview at any time. I reviewed the previously signed consent form, which included
information regarding who I am as the researcher, the purpose of the study, study procedures, the expected duration of the interview, risks and benefits, compensation, confidentiality, the right to withdraw, a summary of results, and voluntary consent. I asked him if he had any questions before we began. I informed the participant of my intent to audiotape the interview and received his consent to do so. I advised him that I would be transcribing the interview and that, once it was transcribed, the tape would be erased. He stated his agreement. At this time, he agreed to continue his participation in the study. The interview lasted approximately 31 minutes with the entire process, including review of consents and procedures, taking approximately 40 minutes.

Participant #4 sounded anxious to participate in the study. As I was preparing to begin the interview, I noticed I had anxiety about completing the interview. I recognized that I was concerned because it was the first interview I would be conducting via phone. I recognized that doing the interview via phone might present a challenge for me, as I would be unable to analyze body language or facial expressions that could affect my line of questioning or give me additional information. At this point, I made a conscious decision to be more mindful of the words or phrases he might use as a way of trying to understand any implied meaning and to guide my line of questioning.

Since this interview was being conducted via telephone, I made the decision to ask the participant on tape if I had his permission to audiotape this call, despite his previous consent for me to do so, to which he replied, “Yes.” Once his permission was granted again, I began the interview.

In order to gage his basic knowledge of medication assisted treatment, I asked him what he knew about medication assisted treatment. He responded,
What I would know is that, you know, if you have an aliment, you can speak with a doctor and a doctor can use their best knowledge of the situation and prescribe you, prescribe you medication that can help you with that. Then use a pharmacy and use medication to help you, you know. You know, whether it be antibiotics or some sort of other type of medicine to help you, you know, treat whatever your aliment is.

I recognized that my question may not have been clear, so I attempted to clarify what he knew about medication assisted treatment in regards to opioid dependence. He stated:

“I guess I would be a little less knowledgeable about that, but I, what I do know is that, ummm, with opioids and medications, they can oftentimes those be linked together and correlated. You know, oftentimes there are people that are, ummmm, addicted to, whether it be, umm, heroin or other types of drugs like that, fentanyl. They can oftentimes use drugs like OxyContin, other types of, or Xanax, whatever sort of prescription drugs they can get their hands on. Ummm, oftentimes can be related to one another like they have similar chemical build-ups.

I attempted clarify what he meant by noting “the similar chemicals,” to which he replied, “I know that those are very similar.” Without prompting, he began to discuss his knowledge level, “I guess I don’t have too much firsthand knowledge.” He stated,

I don’t know many people that abuse, ummm, heroin or hard drugs, but I do know people that have had difficulties with, ummm, certain prescription drugs. I know that both can be pretty addicting and they both need to be, ummm, monitored, you know, especially prescription drugs that be, being prescribed; that there are certain ways you are supposed to take them and, ummm, you have to be very careful and cautious when you use them.
In order to try to understand where his understanding of the term “medication assisted treatment” came from, I inquired about what he had learned about medication assisted treatment in school. He responded, “Being in counseling, I actually haven’t learned too much. This is from, ummm, school counseling perspective, so I didn’t take Addictions counseling, so I guess I wasn’t taught too much, and you are taught in counseling you will run into people with drug problems, things like that.” He explained, “Most of my understanding of drug addiction came from kinda more my own readings and more of my own, ummm, personal interests; you know, documentaries I have watched, et cetera.”

At this point in the interview, I became concerned that there was a misunderstanding regarding the term medication assisted treatment. Internally, I debated about whether or not to clarify and/or educate Participant #4 regarding the term. Instead, I attempted to redirect by asking if any of his documentaries had mentioned commonly used medications, such as Methadone, Suboxone, or Vivitrol. He answered, “I think I know a little bit about some of those like, ahhh... Is Vivitrol used to help, ummm, curb people’s addictions to drugs? I think like Antabuse is for alcohol and things like that? Just a few.” I answered his question with a simple “Yeah” with the intent to reassure him that this was what I was referring to.

Without prompting, he stated: “Most of my knowledge of that did not come from graduate school work. It came from, uhhh, my own, my own research or just like my own, yeah, no, just like, you know, reading similar novels regarding counseling books. Things like that will come up, but as far as actual coursework for school counseling, I didn’t come across anything like that.” I asked him specifically if he had been taught about medication assisted treatment in terms of Methadone, Suboxone, and Vivitrol in school, and he answered, “No, not really.” He proceeded to explain, “I guess I am not sure if that is like a hindrance on like what I was taught,
or not taught in grad school [but…] I think it would have been cool to learn a little bit about substances from someone who has firsthand knowledge of how this works.”

I transitioned the conversation to his thoughts regarding the use of medication assisted treatment as a treatment for opioid dependence. He commented, “I have mixed thoughts.” He explained that he thought “everyone should have, like, the right to choose their treatment.” He stated that “if treatments have, you know, double blind studies and third-party studies and they are proven to work, I think it is a wonderful thing and that’s something worth pursuing.” Despite seeing the benefits, however, he questioned the effectiveness: “A few people that are addicted to opioids, and you ask them about getting a certain type of, you ask them to take a certain type of treatment which may or may not work for them; that might be like asking a drunk person whether or not they are good to drive, you know? Just because they are having difficulties.” He explained that his other concern was “the addictive qualities of a lot of prescription drugs.”

Without prompting, he next began talking about his personal experience and his concerns:

I just, I mean, I come from a pretty, like, educated background, like most of my friends have similar educational backgrounds, whether it be young professionals or people in graduate school, things like that. I know a good amount of people, whether it be from high school sports, college, college sports, ummm, different walks of life, but mostly similar to mine that have had issues dealing with prescription drug abuse, so I think it’s, I think it’s interesting that people want to get off opioid addiction by using prescription drugs. Just because I feel, like, so many people are addicted to prescription drugs
themselves, so I think it’s something needs a lot research and needs a lot of, like, being monitored heavily.

I asked him what his additional thoughts were regarding the use of medication assisted treatment, and he responded: “I guess I am just not knowledgeable enough on the subject.”

I attempted to get additional information in regard to his perception, and he began talking about how people’s educations or experiences may effect the way they treat clients. He noted:

I mean, when people are super-educated on this subject, they might just think drugs are bad and, you know, treat every drug the same and... Or, like, people might just use their own personal opinions or, like, and their experiences, but that person’s might not be everyone’s experience or if, you can’t cite like literature and studies like that, you are basically just speaking from your own experience, which may not be a good thing, and it may not be beneficial to your client.

I attempted to understand what thoughts came to his mind when he heard the term “medication assisted treatment.” He responded:

When I hear medication assisted treatment, what comes to my mind? I think of someone that’s obviously addicted to some sort of drug. And, ummm, I would think mostly in my mind, I think mostly addicted to street drugs going to, ummm, a doctor, you know, their physician and, you know, talking about how they are addicted. I am thinking in more of a clinical sense, umm, a doctor talking about how they can use medicine to help that and I think it is something that a lot of people that may be addicted to, you know, whatever drug they’re on… They may have mixed emotions towards [it] because they, you know, is this gonna be something else I am going to become addicted to?
He further clarified: “I guess in my limited understanding, I might think of it as a Band-Aid.” He also clarified that his limited knowledge might be affecting his perception, saying, “I’m not as knowledgeable on the subject as I would like to be.” I attempted to explore if he had come across any students in his fieldwork who had used medication assisted treatment, and he answered, “I haven’t come across any case studies or even in my own limited experience in the field; nothing really, ummm, I’ve come across.”

Due to his limited fieldwork experience, I attempted to understand his perception of individuals who may choose this treatment option based off of his own research.

I guess it is a good thing because they are trying to get help. I think oftentimes maybe they might have looked into, like, the research a little bit, you know, if there is positive research out there for medication assisted treatment for, ahhh, you know, whatever their ailment is or whatever their addiction is. Uhhh, I think, I think it’s almost like a futuristic type thing, it is… probably hasn’t been around forever. Like, uhhh, you know, one of those ‘talk to your doctor about this’ – it might be like one of those, trying to make themselves better.

I wanted to explore his perception of such patients bettering themselves. He answered,

Maybe that they have tried a lot of other things. Maybe that they have tried a lot of the social, umm, you know, maybe they have tried a lot of support groups and got their families involved in their lives and things like that; it just hasn’t worked and I guess they’re just, more, I wouldn’t say like a last straw, but they really are trying to take care of the biological component to their addiction the best they can.
I redirected back to his perception of individuals who chose this treatment option. He answered, “I see it as someone being pretty nervous about the whole thing. They are probably, if they chose that option. They are probably really, ummm… guilt, they feel guilty about, you know, their addiction, and they are doing something.” He stated, “I see them as someone trying to better themselves, I guess.”

I asked him about his perception of Methadone and Suboxone. He responded, “I guess I am not too knowledgeable about everything, uhhh, related to this.” He explained his concerns regarding the possible research: “I mean, if these are drugs that are used, like, if doctors are prescribing these drugs, you’d think, you’d think they would do some sort of research to prove they work.” He expressed concern about the negative side effects “with a lot of prescription drugs out there, it’s a laundry list of negative side effects but, ummmm, you know, everyone reacts to medicine a little bit differently.” Despite his concerns regarding the side effects, he expressed, “I think it could be a good thing for some people and, if it wasn’t a good thing for some people, then it probably wouldn’t exist.”

Participant #4 mentioned the positives of medication assisted treatment. I attempted to see if this translated to his feelings about counseling a client who uses medication assisted treatment. He responded:

I think it would be interesting to talk about. I think it would be really interesting to listen to their attitudes about it because, as I was just feeling out words to describe, there is probably a lot of emotions going on there. Umm, their experiences with it are probably pretty tumultuous, you know. They are starting a new prescription and, with starting a new prescription, you will notice a lot of changes, ummm, in your body and your mind.
and, ummm…. As I was saying earlier, if you are doing your best to take care of the biological aspect of addiction, you can really focus a lot more on the social aspect. So, I think it could be pretty interesting. Ummmm, I guess I haven’t been super well trained, admittedly, in dealing with that population, but at the same time, I think it could be a pretty positive experience because it is also showing that clients are at least taking some steps towards, you know, work on some of their issues.

Despite his being in school for counseling, I wanted to understand how his attitudes might affect his professional career choices, so I asked him how he would feel about taking a job as a counselor, maybe in a school where students chose medication assisted treatment. He commented:

I think it would be a pretty interesting position and, um, you know, I wouldn’t feel wrong about it. I think with any sort of job, you kinda looking into the company you work for, its, ummm, its mission, mission statement, things like that, and you know, as a counselor, you are a helper, you want to help people get better, and I think you know if you are counseling people with that, like that, as I was saying earlier, it’s people trying to get better, then it could be a good population to work with. Ummmm, I think it is important that the staff are well trained, you know. If you hired me and told me tomorrow that I would be working with this population, and the only training I had was an HR thing and, where, you know, I walked into my cubicle and just gave, ummm, a voided check for my deposit and then I had to meet, you know, a dozen new clients the next day, I would be kind of worried about taking that job. Just because I feel like I need, ah, to be knowledgeable about, you know, these medication assisted treatments so that I can think, just, I think, just keeping everyone knowledgeable about drugs and how they work is
pretty much, ummm, key, umm, for keeping a place like that, ummm, functioning highly, highly functioning.

Since he had stated that he would be comfortable taking a job as a counselor working with mediation assisted treatment, with proper preparation, I wanted to see how he would feel towards individuals and their choice to use medication assisted treatment, or if it would affect the type of care he was providing. He answered:

I guess I wouldn’t feel any negative attitudes towards them. You aren’t like my personal accounts and my preferences. I try not to, you know, put too many labels or judge or place my own values on people. I think, like I have been saying the past couple questions, if people [are] trying to improve themselves, I think it is good. At the same time, maybe keep them researching and, you know, maybe there is like blogs on the internet of, you know, people who are using treatment that monitor them and, you know, maybe have a little community there. I think it is... I think it’s a positive thing. It is not necessarily, I don’t think, anything terribly negative about them.”

I asked for clarification regarding what he had said about monitoring them. He explained, “I would like to do self-checks, see, how you are feeling? It is important to be cognizant of how you are feeling at the moment and bring patients back down to that sort of here-and-now perspective.” I transitioned back to his thoughts regarding taking a position as a counselor treating clients who use medication assisted treatment. I wanted to understand how his education may have prepared him for taking such a job. He commented:

Ummm. Honestly, I was, I liked Duquesne’s program a lot, but at the same time, that’s, ahhh, a lot of the addictions related… really didn’t, ummm, addictions related counseling,
I felt like was kinda slighted, you know. I know a lot of my friends in the cohort were required to take addictions counseling, but I as a school counselor wasn’t. I think I just had to take, like, a special education course in its place or something like that. So, I guess I would be qualified technically, like I have a… I’m a National Certified Counselor and, um, something that would be my own personal responsibility, you know. Whether that be to take a course or whether it be to do my own research, ummm, you know, study up a little bit more on that. I guess, I would feel a little, ummm, anxious; I would feel a little underprepared. I feel like the Duquesne counseling program could have prepared me more for that population because, as a school counselor, I mean, a lot of my friends in mental health are like, ‘We can’t be school counselors,’ but school counselors can be any type of counselor because they have, allow National Certified Counselors that have a school counseling certificate. And I was thinking about that and I thought it was cool, but at the same time, there are a few courses that you guys took that I really wish I took. I mean, I got on my CPCE and my NCE, I got really, really high marks and I finished them, ummm, super quickly, and I felt really prepared. And since we are having a psychologically undergrad, background in psychology undergrad, I have read like a million books by different psychologists and I really feel like I understand a lot of terms in psychology and counseling, but at the same time, I feel there are certain things, you know… you can read a million books or you can listen to a bunch of podcasts or, um, you know, you read Counseling Today magazine, things like that. But at the same time, you, there is still so much you missed by not immersing yourself in things that may not have been super interesting to you at first. I feel like addictions like that might not be my favorite, ummm, branch of counseling, but it is something that I think taking a course in
would have been really beneficial for me, to kinda learn something new and become a better counselor.

Since he felt his education had not prepared him, I inquired about his experience in his fieldwork. He denied that he had had any exposure to medication assisted treatment in his fieldwork, saying: “No, I, ahhh, my fieldwork was at a six-twelve magnet school.”

Due to him lacking experience and feeling unprepared, I attempted to ascertain what would have made him feel more prepared, and he commented, “I just feel taking, ummm, the addiction class would have helped.” He also stated, “I feel like taking more exams would have been really beneficial.” He proceeded to explain that his lack of exams had not been very beneficial to him, saying, “I didn’t really take that many exams in graduate school.” He explained that he also felt it would have been more helpful “to require the students to report on things they might not have been as knowledgeable about.”

At the end of the interview, I asked him if there was anything that I should have asked him that I had not, which would help me better understand his position. Initially, he stated, “No, not in particular.” Then he went on to further state, “You know, if you don’t know too much, then you aren’t going to have too much of an opinion. I guess I, maybe you know, I connected my lack of opinion with my lack of knowledge, so I think that is basically where I stand.”

Once the interview was ended, I stopped the tape and thanked Participant #4 for completing the interview, and the call was ended. Once the call ended, I took an opportunity to reflect on the call. I recognized that doing the interview via phone had presented challenges due to my not being able to review body language, and this made it more difficult to gage the participant’s responses. I became concerned because he had seemed to be guarded and I had had a difficult
time understanding his attitudes and beliefs towards clients. I was struck by one of his final statements regarding his lack of knowledge affecting his lack of opinion. At this time, I took the opportunity to make additional field notes.

The narrative above provides a review of the participant’s description of the phenomena being studied. If information was not relevant to the phenomena, it was excluded from the analysis. This chart provides Participant #4’s supporting statements for the phenomena being studied.

Table 5:

**Participant 4’s Supporting Statements**

<table>
<thead>
<tr>
<th>Analytical Categories from Research Questions</th>
<th>Themes</th>
<th>Supporting Statements</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Attitudes and Beliefs Towards Clients</td>
<td>1. Lack of Commitment</td>
<td><em>is this gonna be something else I am going to become addicted to?</em></td>
</tr>
<tr>
<td></td>
<td>6. “trying to better themselves”</td>
<td><em>one of those trying to make themselves better someone trying to better themselves</em></td>
</tr>
<tr>
<td>2. Attitudes and Beliefs Affect Perception</td>
<td>7. “I don’t know”</td>
<td><em>I would be a little less knowledgeable about that I guess I don’t have too much first hand knowledge I guess I am just not knowledgeable enough on the subject</em></td>
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</tbody>
</table>
|   | I'm not as knowledgeable on the subject as I would like to be  
|   | I guess I am not too knowledgeable about everything, uhhh, related to this  
| 8. Mixed Feelings | I guess I have mixed thoughts  
| 9. “It is a good thing.” | if treatments have, you know, double blind studies and third party studies, and they are proven to work, I think it is a wonderful thing and that’s something worth pursuing  
|   | I think it is, I think it’s a positive thing  
|   | I guess it is a good thing  
|   | I think it could be a good thing for some people  
|   | if people [are] trying to improve themselves… I think it is good  
| 10. Harming Someone’s Body | He explained that his other concern is: the addictive qualities of a lot of prescription drugs  
|   | with a lot of prescription drugs out, there is a laundry list of negative side effects  
| 11. Uncertainty of Effectiveness | a few people that are addicted to opioids, and you ask them about getting a certain type of, you ask them to take a certain type of treatment which may or may not work for them, that might be like asking a drunk person whether or not they are good to drive, you know? Just  
|   |
|   |   | because they are having difficulties.  
|   |   | I think it’s something needs a lot research  
|   |   | I guess in my limited understanding I might think of it as a Band-Aid  
| 12. Lack of Monitoring |   | needs a lot of, like, being monitored heavily  

|   |   | 3. Educational Experiences  
|   | 13. Limited Exposure | Being in counseling, I actually haven’t learned too much  
|   |   | I guess I wasn’t taught too much  
|   |   | most of my knowledge of that did not come from graduate school work  
|   |   | as far as actual coursework for school counseling, I didn’t come across anything like that  
|   |   | I asked him specifically if he had been taught about medication assisted treatment in terms of Methadone, Suboxone, and Vivitrol in school, and he responded: No, not really  
|   |   | I haven’t come across any case studies  
|   |   | addictions related counseling, I felt like was kinda slighted  
|   | 14. Limited Fieldwork Experience | even in my own limited experience in the field, nothing really, ummm, I’ve come across   


Denying that he had exposure to medication assisted treatment in his fieldwork, he said, No, I, ahhh, my fieldwork was at a six-twelve magnet school.

15. Lack of Coursework

I know a lot of my friends in the cohort were required to take addictions counseling, but I as a school counselor wasn’t. I think it would have been cool to learn a little bit about substances from someone who has first hand knowledge of how this works. It is something that I think taking a course in would have been really beneficial for me, to kinda learn something new and become a better counselor. I didn’t take Addictions counseling. I just feel taking, ummm, the addiction class would have helped.

4. Other Experiences

16. Family and/or Friends in Addiction

I know a good amount of people, whether it be from high school sports, college, college sports, ummm, different walks of life, but mostly similar to mine, that have had issues dealing with prescription drug abuse.

18. Others People’s Stories/Perceptions

Most of my understanding of drug addiction came from kinda more my own readings.
and more of my own, ummm, personal interests, you know, documentaries I have watched, et cetera.

most of my knowledge of that did not come from graduate school work. It came from, uhhh, my own, my own research

<table>
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<tr>
<th>5. Perceptions Affect Client Care</th>
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<tbody>
<tr>
<td>19. Increased Curiosity</td>
</tr>
<tr>
<td>I think it would be interesting to talk about. I think it would be really interesting to listen to their attitudes about it because, as I was just feeling out words to describe, there is probably a lot of emotions going on there</td>
</tr>
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| 22. Increased Monitoring          |
| I would like to do self-checks, see how you are feeling? It is important to be cognizant of how you are feeling at the moment and bring patients back down to that sort of here-and-now perspective |

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<tr>
<th>6. Professional Career Choices</th>
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<tr>
<td>23. Not Enough Knowledge/Unpreparedness</td>
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<tr>
<td>I guess I haven’t been super well trained, admittedly, in dealing with that population</td>
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<tr>
<td>Just because I feel like I need to be knowledgeable about, you know, these medication assisted treatments</td>
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<td>that would be my own personal responsibility, you know. Whether that be to take a course or whether it be to do my own research, ummm, you know, study up a little bit more on that</td>
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<tr>
<td>24. Lack of Interest</td>
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<td>25. Fear</td>
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**Individual interview #5.** This interview was conducted with a 27-year-old female who had been enrolled full-time in the Masters in Marriage, Couple, and Family Counseling Program for more than two years at the time of the interview. She was currently enrolled in Internship 2. She reported that, during the course of her education, one class had specifically discussed addictions, but “most throw the notion of the possibility of working with an addict.” She reported that she had had experience working with opioid dependent individuals and individuals in medication assisted treatment.

The interview was conducted via telephone. Prior to the interview, she had been emailed the demographic questionnaire and consent form for her review. The consent form had been
received from her during in-person recruiting trip in her internship class. She was emailed a second copy of the demographic form, which she completed and emailed back to me.

I contacted Participant #5 via telephone at our pre-arranged meeting time. I conducted the interview in a private area in my home where the answers would not be heard by others. Prior to the start of the interview, I reviewed the consent form and voluntary participation. She was advised that her participation was voluntary and that she could end the interview at any time. I reviewed the previously signed consent form, which included information regarding who I am as the researcher, the purpose of the study, study procedures, the expected duration of the interview, risks and benefits, compensation, confidentiality, the right to withdraw, a summary of results, and voluntary consent. I asked her if she had any questions before we began. I informed the participant of my intent to audiotape the interview and received her consent to do so. I advised her that I would be transcribing the interview and that, once it was transcribed, the tape would be erased. She stated that she agreed. At this time, she agreed to continue her participation in the study. The interview lasted approximately 28 minutes with the entire process, including review of consents and procedures, taking approximately 35 minutes.

Participant #5 sounded excited about participating in the study. As I was preparing to begin the interview, I noticed I was more confident about my ability to complete the interview via phone, as this was the second phone interview. Based on my previous experience with a phone interview, I made a conscious decision to be more mindful of possible language clues.

Since this interview was being conducted via telephone, I made the decision to ask Participant #5 on tape if I had her permission to audiotape the call, despite her previously having
consented to my doing so, to which she replied, “Yeah, that’s fine.” Once her permission was granted again, I began the interview.

I started the interview by attempting to assess her knowledge of medication assisted treatment, and she answered, “I mean, we briefly talked about it in our addictions class.” She began to describe her practicum experience, where “a lot of the women there use, like, Methadone kinda as their maintenance drug.” She also described experience with another client outside of her practicum: “I know one of my clients that I was previously working with also used it as her maintenance drug.” For confidentiality concerns, the name of the agencies she referenced have been removed. She explained: “I do know that you can still get a high off of it if the dose is too high, or sometimes people will take like, Xanax or something, then will use crack or cocaine. Ummm, so if you do use heroin, it really doesn’t give you that high because it blocks that.” She explained that, in class, they also discussed: “different things, from using, like, LSD in a safe environment to treat Posttraumatic Stress Disorder or using, ummmm, certain types of drugs to treat different types of disorders versus, like, maintenance kind of drugs in that kind of aspect.”

She explained that most of her knowledge came from her internship experience, “mostly from there because the women lived there 24/7. I was completely in their environment.” Without prompting, she described what she witnessed with her clients. “I mean, seeing them when they came back from the clinic, some of them were fine. Some of them were like asleep, some of them, you know, because their doses were too high maybe or they needed changed.” She explained that, “I was kinda just thrown in that environment and saw it first hand in that aspect versus reading it in a textbook.”
I inquired to see what she had learned about medication assisted treatment in school, and she responded:

We briefly, we touched about, in Addictions. It was more, that class was more geared towards, like, if you are working with addicts. What are different ways you can, like, do counseling with them that isn’t just, sit here and talk kinda, of, like multimedia things we can bring into the sessions. Ummm, I guess, like, the medications were kinda, everyone had their pros and cons. Should we allow them to do this? Should we still have Methadone clinics? Ummmm, there was another one they were talking about. I can’t remember off the top of my head. Some type of, like, clinic for something, but I can’t remember what it was. It was just, should we keep doing those? Should we not do those? Whether it is like Suboxone or Narcan, is that okay? At the time, people who overdose are like, ‘Whoa, I can just go and get this Narcan injection or, ummm, the inhalant, and I will be fine, so I can just go out and use; doesn’t really matter.’ So, like, it kinda, it has pros/cons. If you are using responsibly, most clients that I have worked with have good experiences with it, but then again, some may sell it, some may abuse it. I know some people have to go [to] the clinic to get their doses while other people, once they prove that they are responsible enough, they can get, like, take-home prescriptions with them. Ahhh, which I didn’t get that, until a couple weeks ago actually with that. So, that’s kind of where we were at in Addictions class, talking about that. It was more of just, like, what were our opinions versus should we keep doing these, should we not, and that kinda stuff.”

Her explanation of her classroom’s discussion and many of the questions they were debating prompted me to ask her about her thoughts regarding the use of medication assisted
treatment as a treatment option. She answered, “For me personally, if it’s working for them and they are using it responsibly, I don’t see what the issue is with that.” Despite not seeing the issue with it, she talked about her mixed feelings regarding the use: “I’m sure it helps something, but it probably damages something else in the long-run and it probably needs to be… more studies done with that.” She discussed a client and noted that she “gets take-home medications like Methadone. She keeps it in, like, a lock box; she keeps the keys on her because there are kids in the house.” She stated that her client “just had a baby last month; CYF was involved in that because, obviously, the baby was born with, like, withdrawal.” She talked about how that was “upsetting.” She also talked to the client about if the “doctors talked about any long-term effects that your son might have because of that, and she said no.” She proceeded to state, “Now, whether that is true or not, I don’t know.” She explained that “things like that can be researched more to see, you know, if we are handing out these medications. Like, what are the repercussions with women who are pregnant or women who’ve just given birth and have gone through withdrawal, like, what’s that kid’s life outlook going to be for them? Are there going to be struggles?”

I wanted to clarify that a majority of her concerns were related to the long-term effects, and she said, “Yeah.” She proceeded to state, “I think, like, obviously if they are not abusing it, I am fine with that.” She described her experience at her fieldwork, adding, “You know, there were girls getting Benzos and, ummm, other different pills from the Methadone clinic when they are going out of the house.” She stated they were “smuggling them in through various body parts” or “put stuff in the kids’ diapers.” She stated that they “would take other prescription medications to get some type of high because it was blocking other certain receptors with the Suboxone and, like, Methadone and stuff.”
I inquired if this experience caused her trust issues, and she answered,

Not so much trust issues with me because the girl…. I mean, obviously, I was upset. Like, here, really? There are kids in the house. They did it really in the hallways where everyone walks. The one girl was pregnant and she was the one bringing them in her various body parts, and I’m thinking, like, ‘Come on.’ Ummm, and the standards, and I guess my standards are just different. Ummm, I mean I wasn’t working with those clients individually. I was working with them in groups, and I guess that kind of trust was kind of broken. I mean, I was maybe more annoyed with them, you know, like, we are here trying to help you guys. People in addiction or just people, I don’t know, in psychiatric treatment, and they say, ‘oh, you don’t care about me and stuff.’ It’s like, ‘no, we do or we wouldn’t be coming back every day. I mean, and deal with this kind of environment.’ So I think that, kinda, I’m coming here and so are these people who are paid therapists; we are trying to help you guys out and this is, kinda like, what you do in return? So, it was kinda frustrating.

At this point, I sensed frustration in her voice, which I asked her to reflect on. She discussed her frustration with them “breaking rules within the faculty.” She discussed how their behavior caused her challenges with their treatment, saying:

You think you are going through a session, they are making a breakthrough, but at the same time, you’ve been in this situation before. Like, this could be their fifth time they were in treatment, so they know how it works and they are kinda just telling you what you want to hear and, like, manipulating you to the point that you really have to question things in your own mind, which is kind of confusing at times.
I asked if she thought they were manipulating her, and she responded, “Yeah.” After reviewing the transcript, I later recognized that I should have asked her to reflect more on her perception of manipulation.

I attempted to assess if she had any knowledge of any other medication assisted treatments, asking if she “had any experience working with patients on any other type of medication assisted treatment besides Methadone.” She responded, “I think that they use Suboxone for certain treatments, but I’m not sure; you can correct me if I’m wrong on that.” She explained, “I’ve really only just dealt with women who were using Methadone as their, like, treatment or maintenance drug.” I attempted to see if she had any other experience with clients who use medication assisted treatment, and she answered, “I mean, like, for psychiatric disorders, yes, if that’s kind of what you are looking for.”

Without prompting, she began to discuss connections between mental illness and substance abuse, saying:

In addiction, I mean, I have to guess they go hand in hand. I mean, the dual diagnosis thing, sometimes you need to fix or work on one problem that hopefully can correct the other problem in the long run. Which, sometimes those work hand in hand, but, umm, I’ve worked with individuals who were like bi-polar and were on medication for that, but at the same time, they are also within the Methadone clinic, so it was kinda like a toss-up as to which came first. Which should be looked at more closely, cause I think sometimes that can be missed, and when they are just, like, ‘Oh, you are using heroin or you are doing this, so we will just put you on this type of maintenance drug,’ when at the same time, like, they really just need to work on whatever psychiatric disorder they have, you
know, because they don’t know how to cope with something, so that is what they use as their method.

At this point, I recognized that a new idea might be emerging – the connection between mental illness and substance abuse. I inquired about her perception of them and how they are interplayed. She explained that she believed: “Sometimes today, ummm, not all doctors are trained. I mean, they are all trained in the medical model, which is the bio-psycho-social aspect and the well-being type model.” As a result, she felt that some questions were left unanswered, such as: “What is the underlying cause versus let’s just give you something that is covering this up, but yet we are not really working on what the underlying issue is that could be causing issue for you at the moment.”

I transitioned the interview toward her perception of individuals who choose any of the medication assisted treatment options. She responded, “I mean, if it is working for them and they are not abusing it, not selling it, and not taking, you know, like Xanax and then smoking crack so they are still getting high from it, then I think that’s fine. So, if it is working for them and they are staying out of trouble and they are clean from the aspect that they are not using street drugs, I think that’s fine.”

I wanted to assess what her thoughts were regarding clients who may not be using it the correct way, and to assess if she had different perceptions. She responded,

I would maybe question why they are doing that? Like, why? What is their underlying motive that you know they, maybe they feel if they give it to a friend who is using, then they’ll stop or something? Kinda just trying to figure out, like, what, do you just need resources and no one is giving you those resources? Or trying to, and you need money to
pay for a gas bill versus like, going to get on LIHEAP or something, like, trying to figure out what the underlying cause is.

Her thoughts appeared to focus more on curiosity for their motives more than their personal behaviors.

Since her focus appeared to be based on her experience with clients on Methadone, I decided to see if I could gain an understanding of her perceptions regarding those treatment options as a way to gage her overall attitudes. She expressed concerns about the side effects of the medications, saying,

I mean, I don’t know much about the other ones and, like, how the side effects affect those individuals. I just know that working with the women who were on Methadone, ummm, some of them, I think, are prescribed too much. But, I mean, the high’s kinda the same basically, ummm, between Methadone and heroin. Like, obviously, because certain groups that we ran, when women would come back from the clinic, they would completely be asleep or, like, their eyes would be in the back of their head. Like, you could tell they were feeling some type of way because they clearly weren’t paying attention because you could tell just by their body language, and most of the time it was because, like, their doses were too high.

She stated that her concerns about the side effects drove her concerns about the lack of regulations for the clinics, going on to say: “So, I think that needs to be regulated more now, whether or not you know the ones administering it, giving out Methadone. There is an abundance of people there, that they push you through the system and just get you in and out. I
really don’t know how the clinics work, so I don’t know if they need more staff, you know, to help regulate that, or what they kinda need to do.”

I transitioned to her thoughts regarding counseling a client who uses medication assisted treatment. In response, she reflected on her experience with her client who was on Methadone: “I mean, [I] think that, like, the client I was just working with who had a baby, she is completely, ummm, like physically present. She knows who she is. She is very time oriented, place oriented, and obviously we did good work together.” She further reflected that this client was contradictory to some of the other clients who were on Methadone and who she worked with in group:

But some of the other women who were in the residential setting, clearly, when you are running groups, I mean, when you are in group, not paying attention and are in and out, ummm, but when you are doing an individual session, I don’t think it is any different then a client coming in high or drunk. That’s not ethical; you can’t do, psychologically, like, you are not present, so you can’t really do work because they are not going to, maybe remember things, maybe not process stuff, especially, like, if you are doing psych kind of stuff.

She proceeded to describe clients who are misusing methadone as: “Just, like, out of it, not really there.”

I wanted to further assess her thoughts and feelings about working with clients on medication assisted treatment. I asked her to reflect on this. She expressed that she would feel more curiosity. “I would probably ask them, kinda like, more background information. How
long have they been using it? What is, kind of, their background history? Do they even have
that type of information?"

I attempted to assess if she saw the treatment of clients on medication assisted treatment
differently than that for clients who were not, and she answered, “Umm, no.” She explained,
“I’m just very non-judgmental. It’s a safe place; like, I don’t want them to feel I am treating
them differently whether they are on it or not, or if they bring it up and talk about it. And I don’t
really know unless someone pre-warns me or they bring it up and talk about it.” She again
referred back to her curiosity and how this would impact her session, saying, “just, normally, I
just ask, how long have you been using? That is what, your, like, maintenance?” She stated that
she also tended to “empathize with them, that I may not be an addict, but experienced addictions
within my family, and that it’s not easy with that. If that’s how you cope, so I am just praising
them because they don’t always hear that.”

Even though she had had experience in her internship, I wanted to understand her
perception about taking a job working as a counselor treating clients using medication assisted
treatment. She said, “I haven’t really thought about it. I mean, I feel like I would probably be a
little apprehensive at first because I have never been in that type of environment, but I’m sure
like, once you are there a couple days and you get kinda used to the routine and how things
work, it would be just like any other agency with clients.”

I wanted her to reflect on her apprehension about this type of job. She responded,
“Sometimes I would catch myself feeling very anxious, sometimes when I was working at the
RTF center.” She reflected that she doesn’t “know if it is maybe because their anxiety is real, lot
higher” or “talking a lot faster or just moving a lot.” She expressed concern about “mirroring their behaviors and, kind of their, like, anxieties.”

I asked her to reflect on her perception of their behaviors. She answered, “I think they are just a little bit more on edge.” She explained this may be in part because “they don’t really want to be there; no one really wants to be there.” She explained: “very few women completed the program while I was there. A lot of the women, ummm, got kicked out because of their behaviors or they just left.” She stated that she believes some of this goes back to their past experiences, saying “they have been in and out of, like, jail.” She reflected that some of this may have been affected by other matters: “I mean, it also goes back to, when did they start using? If they began using at that age because that, it kinda like, I noticed that is how they were acting. If they began using when they were twelve or sixteen and they are 30-some, that is kinda how they are acting.”

I asked her if she noticed a difference between the clients who were on Methadone versus those who were not on Methadone, and she answered, “Oh yeah.” I asked her to reflect on the difference. She responded,

One girl I worked with individually, she, her drug of choice was crack, and she just, so, younger than some of the other girls, but she didn’t seem as, like, out of it all the time, and you could actually have, like, conversations with her. And she didn’t seem as on edge or in the fight or flight mode versus some of the girls who were on Methadone; they kinda just seemed like they were just hyper aware of their, like, surroundings and, like, did they need to react to this or how should they react to this?
I transitioned the discussion to how education had prepared her for a possible job. She stated: “I mean I, whenever I went into practicum, and I really had to look for stuff.” She expressed limited interest in working in addictions, saying, “I just really don’t want to work in [an] addictions kind of environment.” She explained that the experience: “wasn’t terrible. I could clearly work in this type of environment if I had to because I clearly survived.” She stated that she felt she “could work in an addictions facility.” She expressed concerns about some of the treatment options, saying:

I know that some of the agencies around her have really, really long group hours which, I don’t like that, and kind of, don’t think that’s beneficial to them. Like, three or three and a half hour groups, nobody is really paying attention that long. And the groups that they did in the treatment facility was like an hour and a half hours, which is fine because there were sometimes twenty-some women in there, except everyone talked.

She stated that she “would prefer working, kind of, in an outpatient setting,” and that she only “put myself in that situation because I knew some time I was going to run into someone whose boyfriend or brother or, you know, someone in their family has struggled with it.”

I asked her to reflect on her anxiety related to working in addictions at her internship. She responded, “I don’t know if I was just stereotyping them; that it would just be a bad environment, like, I just didn’t know what to expect.” I asked her to reflect on her anxiety further, and she answered, “What is it, the fear of the unknown that you just really don’t know?”

I asked her to reflect on whether any of her educational experiences besides her internship may have helped her feel more prepared for a possible job, and she responded, “I feel like I would be more prepared.” She stated, “I think putting myself in the RTF setting and then
also realizing, in an outpatient setting, like, the majority of the people I worked with, there was addiction somewhere – whether it was them.” I asked her to reflect specifically on her coursework, and she said, “I didn’t take an addictions class until after my practicum, so that didn’t really help because I didn’t have that class.” I asked her if she thought the addictions class would have helped her if she had taken it before practicum, and she answered, “Probably, yeah.” She stated that she also thought, “I think the teachers and professors constantly reminding you, like, ‘you may not want to work with this population, but guess what, it is going to come up sometime, somewhere, you are going to run into [it], so you probably just be prepared to talk about addiction or something.”

At this point, I asked her if there was anything else that I should have asked her which I had not that would better help me understand her attitudes and beliefs. She stated that there was not. I thanked her for participating and I ended the call.

The narrative above provides a review of Participant #5’s description of the phenomena being studied. If information was not relevant to the phenomena, it was excluded from the analysis. This chart provides Participant #5’s supporting statements regarding the phenomena being studied.

Table 6:  

**Participant 5’s Supporting Statements**

<table>
<thead>
<tr>
<th>Analytical Categories from Research Questions</th>
<th>Themes</th>
<th>Supporting Statements</th>
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</thead>
</table>
| 1. Attitudes and Beliefs Towards Clients     | 1. Lack of Commitment | At the time, people who overdose are like ‘whoa, I can just go and get this Narcan injection or, ummm, the inhalant, and I will be fine so I
<p>| | |</p>
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<tbody>
<tr>
<td>1.</td>
<td>can just go out and use; doesn’t really matter</td>
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<tr>
<td></td>
<td>you know there were girls getting Benzos and, ummm, other different pills from the Methadone clinic when they are going out of the house</td>
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<td></td>
<td>some may sell it, some may abuse it</td>
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<tr>
<td>2. Lack of Motivation</td>
<td>they would take other prescription medications to get some type of high</td>
</tr>
<tr>
<td>3. Mistrust</td>
<td>She referred to Benzos, stating that they were smuggling them in through various body parts</td>
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<td></td>
<td>that kind of trust was kind of broken</td>
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<tr>
<td></td>
<td>telling you what you want to hear and, like, manipulating you</td>
</tr>
<tr>
<td></td>
<td>they put stuff in the kids’ diapers</td>
</tr>
<tr>
<td></td>
<td>they know how it works</td>
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<tr>
<td>4. Detachment from Reality</td>
<td>Some of them were, like, asleep</td>
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<td></td>
<td>their eyes would be in the back of their head</td>
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<td></td>
<td>when you are in group not paying attention and are in and out</td>
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<td></td>
<td>Just like out of it, not really there</td>
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<tr>
<td>5. Untreated Mental Illness</td>
<td>sometimes you need to fix or work on one problem that</td>
</tr>
<tr>
<td>2. Attitudes and Beliefs Affect Perception</td>
<td></td>
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<td>-------------------------------------------</td>
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<tr>
<td>7. “I don’t know”</td>
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<tr>
<td>I think that they use Suboxone for certain treatments, but I’m not sure; you can correct me if I’m wrong on that</td>
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<tr>
<td>I don’t know much about the other ones</td>
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<td>I really don’t know how the clinics work</td>
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<tr>
<td>8. Mixed Feelings</td>
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<tr>
<td>it has pros/cons</td>
<td></td>
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<tr>
<td>9. “It is a good thing.”</td>
<td></td>
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<tr>
<td>if it [is] working for them and they are using it responsibly, I don’t see what the issue is with that</td>
<td></td>
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<tr>
<td>I’m sure it helps something</td>
<td></td>
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<tr>
<td>If you are using responsibly, most clients that I have worked with have good experiences</td>
<td></td>
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<tr>
<td>I mean, if it is working for them and they are not abusing it, not selling it, and not taking, you</td>
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<tr>
<td>10. Harming Someone’s Body</td>
<td>what are the repercussions with women who are pregnant or women who’ve just given birth?</td>
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<td></td>
<td>some of them, you know, because their doses were too high maybe or they needed changed</td>
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<td></td>
<td>damages something else in the long run</td>
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<td></td>
<td>She talked to a client about the long-term effects that your son might have because of that</td>
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<td></td>
<td>I think are prescribed too much</td>
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<tr>
<th>12. Lack of Monitoring</th>
<th>needs to be regulated more now, whether or not you know the ones administering it, giving out Methadone</th>
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<tr>
<td></td>
<td>I don’t know if they need more staff, you know, to help regulate that, or what they kinda need to do</td>
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abundance of people there that they push you through the system and just get you in and out

| 3. Educational Experiences | 13. Limited Exposure | I mean, we briefly talked about it in our addictions class
It was more of just, like, what were our opinions versus should we keep doing these, should we not, and that kinda stuff |
| 14. Limited Fieldwork Experience | I’ve really only just dealt with women who were using Methadone as their, like, treatment or maintenance drug |
| 15. Lack of Coursework | I didn’t take an addictions class until after my practicum, so that didn’t really help because I didn’t have that class |

| 4. Other Experiences | 16. Family and/or Friends in Addiction | I may not be an addict, but experienced addictions within my family |

| 5. Perceptions Affect Client Care | 19. Increased Curiosity | I would probably ask them kinda, like, more background information. How long have they been using it? What is, kind of, their background history? Do they even have that type of information? |
When talking to patients on Methadone, she said: *normally I just ask, how long have you been using? That is, what, your, like, maintenance?*

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<th>20. No Difference</th>
<th>I don’t want them to feel I am treating them differently whether they are on it or not</th>
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</table>
| 21. Increased Counselor Anxiety | What is it the fear of the unknown, that you just really don’t know?  
I would catch myself feeling very anxious |
| 22. Increased Monitoring | we did do searches of them |

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<th>6. Professional Career Choices</th>
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<tbody>
<tr>
<td>23. Not Enough Knowledge/Unpreparedness</td>
<td>I feel like I could be more prepared</td>
</tr>
</tbody>
</table>
| 24. Lack of Interest | I just really don’t want to work in addictions  
would prefer working, kind of, in an outpatient setting  
When referring to her fieldwork experience, she said it: wasn’t terrible. I could clearly work in this type of environment if I had to because I clearly survived  
I could work in an addictions facility |
Individual interview #6. This interview was conducted with a 24-year-old male who had been enrolled full-time in the Clinical Mental Health Counseling Program for less than two years at the time of the interview. He was currently enrolled in Internship 2. He reported that, during the course of his education, he had taken courses which included information on addictions counseling. He reported that he had had no experience working with opioid dependent individuals.

Participant #6’s interview was conducted in person using the same procedure as was used for Participants 1-3. The interview lasted approximately 29 minutes with the entire process, including review of consents and procedures, taking approximately 40 minutes.

Participant #6 appeared to be eager to participate in the study. As I was preparing to begin the interview, I noticed I was calmer than I had been prior to my previous interviews. I found that I was more confident in my ability to interview and to get the questions answered.

I began the interview by asking Participant #6 what he knew about medication assisted treatment. He stated that he did: “have adjacent experience working with some addictions, but my work was all integrated dual diagnosis work, so we didn’t use it.” He stated that “it is
popular among some of the treatment centers we have in this area.” He began to discuss his thoughts regarding it, saying:

There’s still a really big debate about if you should give someone with an addiction any additional medication. How much does it work? But, like, especially, like, Vivitrol has become extremely popular because there are advisements on buses now. Ummm, so I think what I know is it can be helpful for some people, but I know it is such a controversial topic that I feel like people are afraid to talk about it, so…

I asked him for particulars regarding what he knew about the medication. He stated:

I know there’s, ummm, medications that can, like, if you are, if you have an addiction to alcoholic substances, that any time you drink that they make you violently ill, or there is, ummm, I don’t remember which one it is, but there is a substance that kinda gives you, ummm, feeling of that high if you are addicted to… is it opioids? I think, and it gives you the feeling of the high without having to, and I think they’re supposed to wean you off of it. And to me, even saying that sounds kinda strange. Ummm, then that one of the dangers with that thing is that, ummmm, I think that is a different one; there is one that, ummm, it blocks your, ah, dopamine receptors and that, the big danger with it is that you can shoot up and it doesn’t matter how much you shoot up; you are not going to feel it but it can still kill you.

He explained that his “roommate did his internship working in addictions, and so he would always constantly talk [to] people who were prescribed that one; I don’t remember which one it is.” He further explained, “I know he would talk a lot about that one because he, we, have people who would OD, but they didn’t really know they were.”
Besides his roommate having provided him information, I attempted to understand what he had learned about medication assisted treatment in school. He responded:

“So, we talked about it in Addictions class and we touched on it in community-based interventions. We also touched, ummm, on cause; the professor had experience with integrated dual diagnosis work, so she touched on it there. Ummm, and kind of didn’t explain a whole lot because that just didn’t, wasn’t her area, but we talked about it a good bit. Ummm, in Addictions class, ummm, just kind of weighing the pros/cons, there was a lot, a lot of group discussion about it, just…. Just what we thought and the consensus was people were, like [in a funny voice] ‘we don’t know,’ so yeah. Ummmm, I don’t [know] if that answers your question.

I asked him if he remembered anything specifically. He responded, “I remember, like, specifically learning about Vivitrol and I remember learning about Suboxone; ummmm, and I think they briefly talked about Antabuse.” He explained that he also:

had to know what, like, what you had, what certain courses of action you were supposed to take, like versus pills versus tabs and, like, is it paired with therapy? Is it paired with groups? Is it paired with individual? And then try to match to what kind of program the client might have been in, whether it be partial, in-patient, stuff like that, so we touched on all of that. God, please don’t ask me for specifics.

I clarified that he did not remember the specifics and, without prompting, he stated: “I remember that because I, because I have no desire to work in addictions. Yeah, so I know that no matter where you work, it’s probably going to touch you, somehow, but, ummm, I’ve never really been in the thick of it, so I just remember the gist.” When I asked him to clarify that it did
not interest him, he stated, “I don’t like the way it sounds; I feel like a bad therapist. Ummmm, you know it wasn’t like, I was not, yeah, not… my jury is still out on how I really think about it, so I don’t know.”

After he stated that “My jury is still out on how I really think about it,” I asked him to reflect on his thoughts regarding the use of medication assisted treatment as a treatment option. He answered:

I definitely think it should be available because, if there is someone that it works for them, I would absolutely advocate for that. Ahhh, to me, it is just, it’s scary to expose someone who is already in active addiction to another substance that can be, ummm, so addictive, as much good as it might do. So, I, I don’t know how you would design a system that, like, is able to say, like, ‘it would be good for this person but not this person.’ Ummmm, I, but I just believe that there are people who, ummmm, either for their own preferences would prefer to be on some kind of medication because that feels like treatment to them, ummm, and maybe those people need to have some individual work done, to do some re-programming. But that, if that’s important to them and that’s what works for them, then I think it should be an available option, but I just don’t think it is for everybody and I don’t think it is something that should be done in, like, mass groups of people.

I asked him to reflect on the term “re-programming” and if this related to clients on medicated assisted treatment, and he answered:

No, that would be like, I’ve had clients – you know, not in addictions work – who are very perseverant on being on their medications. They feel their medications are really
what helps them, [so] it’s important to them and, if that’s what works for you, that is good. But if that’s, can also be an addictive substance, you know, I feel like there might be some education given there. And, yeah, if the person wants to do it, you know they are going to do it and, if it’s the best option for them, it makes the most sense. But, ummm, that’s what I mean by re-programming; education is probably a better word.

I asked him to reflect on his fear related to the use of medication assisted treatment, and he answered: “It’s just the pure thought of, and especially if someone is far along in recovery and, you know, not that relapse is out of the question, but just kind of mirror the exposure effect. Here is a substance that can be really addictive, but as much as it is going to help you.” He explained that his fear leads to mixed feelings regarding the use of the medication, saying: “I think you can do a lot of harm in that sense, but it can also be good, but it is very much a double-edged sword.” He further explained, “If that’s what works for the person, then it does more good than it does harm, then why not?”

I asked him what comes to his mind when he hears the term “medication assisted treatment,” and he answered:

I always have vivid imagines of, like, Vivitrol even has commercials now. Like [giggling], ummm, so that’s always the big one that comes to mind. And I just have this, ummm, because I have never been in, like, an addictions treatment center, I have this vision of, I think, and – I think this is even perpetuated by some of the questions on the NCE, because they ask, you know, would you do the tabs versus the pills or this versus that, paired with this, would a doctor have to do this themselves, and so it almost, I have this image of,, like a dispensary with, ummmm, like, you just go in, you get it, you go to
your groups and you leave. So, if it sounds kind of silly when you say it, but immediate thought, yeah.

Based on this description, I asked him how he envisioned the people who chose that treatment option. He responded, “If that’s what works for them, then that’s great.” When I asked him if he visualized them going in and getting their pill, he said, “Yeah.” I questioned how he perceived their interaction with therapy, and he answered:

If they are open to therapy, so that vision of them isn’t about the person, I think it is more about the system. So, like, that vision for me is like, if that is the way it is set up, then what the hell are we doing as clinicians to just kind of like cycle people through? So, ummm, but that’s what it sounds like, and maybe I don’t know enough cause, like I said, I have never been in a treatment center, but that’s maybe worst case scenario but, ummm, yeah.

I asked him to reflect on his image of a dispensary, and he answered:

I don’t know, probably sheer lack of, like, experience. ‘Cause like, I said I have never been in an addiction treatment center and what it looks like is framed by my experience in class and what my roommate tells me, what his is like. And, ummmm, he’s there and some of the folks he had depending on what track in the program they were in were on. Ummmm, at least Suboxone, I know that, ummm, and he didn’t make it sound like that, but that’s just kind of the image I have in my head. And to me that’s not like, ‘Oh, the person is here to get their pill.’ It is a system, a system failure if that is really how it is and we would just like shove medication on people and hope it works, and then be, like, ‘Oh, yeah, you should go to group, too.’
Reflecting on this comment, I asked if he thought counseling was an afterthought, and he answered, “If medication assisted treatment was, like, the way to go, and they were like, ‘you should probably go to therapy, too, but make sure you take your pills’.”

I transitioned the discussion to his experiences with clients who used medication assisted treatment. He stated, “I have not had any who were on, ummm, any at least of any medication that I knew was for substance abuse.” He explained that, at his internship: “I worked for two psychiatrists who were very anti-medication assisted treatment for addiction.” He further explained that the “IDD treatment was very much about motivational interviewing and stages for change and really just focusing on that. And, ummmm, and kind of figuring out which was the bigger issue at the time, the person’s addiction or the person’s mental health?”

I asked him if his attendings’ beliefs affected him at all, and he said:

No, because I think I am still open to it. Ummm, and I don’t want to make a solid opinion about it if I don’t know enough about it, so, and I don’t feel I know enough about it. Ummmm, just because I don’t have any work experience in the area. You know, it is one thing to sit in class and, like I said, I told you how much I remember but, to actually, to actually go and do it if we had more in Vivo, I don’t know, maybe I would be able to make a more concrete opinion.

I asked him what his perception was of individuals who chose medication assisted treatment as a treatment option. He responded:

You know, I think that’s, ahhh, I think that is a difficult call to make because, even in even in our education for addictions, it is made very clear that addicts lie. They do whatever they can, ummm, and I believe that on a case by case basis. Yeah, umm,
because I, and that is very much shaped by my experience that, ummmm, I work with a lot of people who are still very much in the old mindset of mental health. That, like, all our patients are trying to manipulate us, and they just want their meds and they want to be left alone and, kind of. And so here I am, the new young therapist who is like, ‘no, no.’ Like, so I, you know, if they are doing it for the right reasons, then that’s what I think. If the person just wants to be addicted to Vivitrol or Suboxone, but then I’m like, I don’t know. Do they go into [it] being, like, ‘I want another addiction?’ Kind of, ummmm, so if it’s being used for the right reasons, then that’s what my perception of the person is.

I asked him to reflect back on his comment that “addicts lie” and whether he believes that to be truer with clients who use medication assisted treatment. He answered:

I would say it is about the same because I am kind of torn. Like, that, if the person elects to go on treatment like I said, unless they are actively looking for another substance, that’s still a step in the right direction; it’s some kind of treatment. It is something they are trying and maybe they don’t know if [it] will work for them or it’s kinda like that last resort. They’ve tried other things, umm, and you know, maybe they know themselves and this is what works or maybe it is one those people that’s taking a medication… is very important to them, and how they perceive their health and getting better, so I would say it is about the same. Ummm, just because I don’t, I don’t believe that all addicts lie, so, but that’s what everyone tells you, so I don’t know.

He further stated that his experiences had been shaped by what others had told him, saying, “I’ve heard very few good, good recovery stories about [it] from people who have worked in
addictions. So, it’s not to say that, you know, those people are only focusing on the bad ones, but I want to hear more; I want to hear more good about people, so yeah.”

I asked him what he knew about Methadone and Suboxone, specifically. He answered, “Well, a methadone clinic that, that I am not a 100%. I would not be able to describe to someone how a Methadone clinic works. I know that… I know that it is a positive thing, but I couldn’t tell you I know what they do; I’d be afraid, I’d be afraid of misconstruing in it, ummm.”

I asked him to reflect on why he perceived it as a positive, “Because I think it’s, it’s that the whole purpose of methadone clinics is harm reduction.” He stated that “people are going to make their own choices, but if I can get them to be safer about it, that’s great. I think that is great.” He expressed frustration with himself regarding his lack of knowledge regarding a Suboxone clinic, saying, “I wish I could tell you I remember what Suboxone does.”

I asked him to reflect back on his perception of medication assisted treatment as a dispensary and how it may relate to his perception of a Methadone or Suboxone clinic. He responded:

No, it’s just I think that’s, like, a worst case, a worst case scenario. Ummmm, and like I said, that’s a, you know, system failure on our part if that’s the way it is. Ummmm, and you know, I think a methadone clinic does kind of sound like that, but if you are doing it for the right reasons, I don’t really believe I can, you know, that it can be truly harmful. Like I said, it kind of operated from some kind of harm reduction perspective, so even if it’s just a dispensary, maybe it is what those people need and that is all they want, too. So, a dispensary could be good or bad if we’re doing it and not advocating for the other
piece of it, then I think that is what the failure is. Then that’s all the person wants; there is not really much we can do.

I asked him about his feelings about counseling a client who uses medication assisted treatment.

He stated, “I’d see it as a wonderful addition to, ummm, any type of treatment.” He acknowledged that he is “with a lot of people, clinicians, who are like, ‘those are the people who are not capable of therapy,’ and I feel like these folks get [that] to that.” He proceeded to state that:

They just want to come in, get their medication, and they lie and they will do anything to get the next fix. And I’m sure that’s true on the individual level sometimes, but I, I cannot believe that there are not, that there are not people who therapy would not benefit in addition to medication assisted treatment because if, maybe, you know, similar to anti-psychotics. If medication assisted treatment is what gets you, to you, where you can be capable of therapeutic work, then that is wonderful, that is great. Ummmm, if the client doesn’t want to be there, that is another story. That’s another story if, ummm, you know, if they don’t want to be in therapy, that doesn’t mean I am not going to do my job, but you have to want it, so…

Based on his feelings about counseling a client who uses medication assisted treatment, I asked him what his thoughts would be in regards to taking a position as a counselor treating clients who use medication assisted treatment as an option for opioid dependence. He answered:

I would do it if I knew more about it because I, ummm, like I said, I’m considering a job as a dual diagnosis therapist. So, I’m, like I said, most of my experience is with, like, serious mental illness, ummm, but it’s, umm, yeah, I would do it, no problem. I wouldn’t
want to go in blind and I would feel like I’d have to be very open about that, like, ‘This is my first job in addictions, so help me out.’ But yeah, I would do it.

I reflected back on his previous statement about having no desire to work in addictions, and he said: “I don’t have desire to work in addictions, but I would do it.” He explained further, “It’s one of those things that, as you go through your Masters program, they ask, ‘What do you not want to do?’ And I’m like, ‘addictions,’ but I am capable of change. You know, I can’t ask my clients to be if I’m not, so…” I asked him what would make him open to it, and he said, “I am open to it. It’s just not, like, it just not my first choice.” He explained further, “I would never want to put myself in a position where I totally rule something out. And, but, yeah, not my first choice, has never been.”

I wanted him to reflect on why it is not his first choice in order to see if his perception had effected his career choices. He responded:

I think, just because I am just more passionate about, ummmm, about working with other groups of people. But, like I said, my main focus and what I’ve wanted to do forever is to work with LGBT youth and families. Ummm, and you know, kinda dabble in some older adults who are within the community, too, just because of the health care disparities. Ummm, but I know addictions touches all those communities, too. And actually, umm, I was reading something the other day that, especially among gay men my age, that alcoholism is becoming almost as big of a problem as HIV is right now. And so I think, when I get down to it, it’s that straight addictions counseling does not appeal to me, but I am absolutely open to working with... I don’t think I will find myself in a
treatment center, but in a role, you know, working with people in active addiction, absolutely.

At this point, I wanted to see if his educational experiences may have prepared him for a possible job in an addictions center, and he said, “Education, yes; experience, no.” I asked him to elaborate on what may have helped him, and he answered: “I mean, like I said, we, you touch on, you touch on addictions in some courses and then, to have the addictions course, it is a great course. It gives you a great overview. Like I said, it’s not my focus, so I would need a little refresher, but as you know, as an entry level person looking for greater experience, if I had no other options, I would take it.”

Since his answers appeared to be slightly contradictory, I asked him, if he were offered a job in medication assisted treatment, did he feel that his education would have prepared him to know enough about it to be able to do the job, and he answered, “No.” I asked him to elaborate on what may have helped. He replied:

Ummmm, you know, it’s almost one of those… it’s an entire treatment modality. So, I think that we just needed to spend more time on it. Ummm, because like I said, I have basic knowledge of it from class, but you know, ummmm, but I feel like I should remember more and I don’t, like, but I’m like, I don’t know if we got too deep. We talked a lot about what our feelings were around it, and that is important, but as far as, like, who offers it, how you go about getting it… Ummm, like I said, don’t even remember, like, what you actually do at a Methadone clinic. So, it’s almost as if it could be its own course. Umm, yeah, or even if what, during summer, yeah, but that specifically, no.”
I asked him if he had had any experience in his fieldwork with clients being on medication assisted treatment, and he answered: “No, I had a lot of patients ask for anti-anxiety meds, but no, no, no Vivitrol, Suboxone, Methadone; no, I’d be like, ‘Talk to the doctor.’”

I asked him if there was anything I could have asked him that I had not which would better help me understand his attitudes and beliefs. He stated that there was not. At this point, the interview was ended.

The narrative above provides a review of Participant #6’s description of the phenomena being studied. If information was not relevant to the phenomena, it was excluded from the analysis. This chart provides Participant #6’s supporting statements for phenomena being studied.

Table 7:

*Participant #6’s Supporting Statements*

<table>
<thead>
<tr>
<th>Analytical Categories from Research Questions</th>
<th>Themes</th>
<th>Supporting Statements</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Attitudes and Beliefs Towards Clients</td>
<td>1. Lack of Commitment</td>
<td><em>If they are open to therapy</em></td>
</tr>
<tr>
<td></td>
<td></td>
<td><em>just want their meds</em></td>
</tr>
<tr>
<td></td>
<td></td>
<td><em>want to be left alone,</em> <em>want to come in,</em> <em>get their medication</em></td>
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<tr>
<td></td>
<td></td>
<td><em>just wants to be addicted</em></td>
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<tr>
<td></td>
<td></td>
<td><em>even if it just a dispensary,</em> <em>maybe it is what those people need and that is all they want</em></td>
</tr>
<tr>
<td></td>
<td>2. Lack of Motivation</td>
<td><em>if they are doing it for the right reasons</em></td>
</tr>
<tr>
<td>2. Attitudes and Beliefs Affect Perception</td>
<td>7. “I don’t know”</td>
<td>8. Mixed Feelings</td>
</tr>
<tr>
<td>-------------------------------------------</td>
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<td>------------------</td>
</tr>
<tr>
<td>7. “I don’t know”</td>
<td>I don’t feel I know enough about it</td>
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<tr>
<td></td>
<td>I would not be able to describe to someone how a Methadone clinic works</td>
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<tr>
<td></td>
<td>I wish I could tell you I remember what Suboxone does</td>
<td></td>
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<tr>
<td></td>
<td>my jury is still out on how I really think about it</td>
<td></td>
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<tr>
<td></td>
<td>if that’s important to them and that’s what works for them, then I think it should be an available option, but I just don’t think it is for everybody and I don’t think it is something that should be done in, like, mass groups of people</td>
<td></td>
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</tbody>
</table>

| 3. Mistrust | all our patients are trying to manipulate us |
|             | they lie |
|             | they will do anything to get the next fix |
|             | addicts lie |
|             | They do whatever they can |

| 5. Untreated Mental Illness | kind of figuring out which was the bigger issue at the time, the person’s addiction or the person’s mental health? |

<p>| 6. “trying to better themselves” | It is something they are trying |</p>
<table>
<thead>
<tr>
<th>9. “It is a good thing.”</th>
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</thead>
<tbody>
<tr>
<td>It can also be good, but it is very much a double-edged sword</td>
</tr>
<tr>
<td>I am kind of torn</td>
</tr>
<tr>
<td>I definitely think it should be available because, if there is someone that it works for them</td>
</tr>
<tr>
<td>If that’s what works for them then that’s great</td>
</tr>
<tr>
<td>if the person elects to go on treatment, like I said, unless they are actively looking for another substance, that’s still a step in the right direction; it’s some kind of treatment</td>
</tr>
<tr>
<td>I know is, it can be helpful for some people</td>
</tr>
<tr>
<td>I know that it is a positive thing, but I couldn’t tell you I know what they do</td>
</tr>
<tr>
<td>if that’s what works for the person, then it does more good then it does harm, then why not?</td>
</tr>
<tr>
<td>the whole purpose of Methadone clinics is harm reduction</td>
</tr>
<tr>
<td>people are going to make their own choices, but if I can get them to be safer about it, that’s great. I think that is great</td>
</tr>
<tr>
<td>If medication assisted treatment is what gets you to, you where you can be capable of therapeutic work, then that is wonderful</td>
</tr>
<tr>
<td>Section</td>
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<td>-------------------------------</td>
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</tbody>
</table>
| 10. Harming Someone’s Body    | to expose someone who is already in active addiction to another substance that can be so addictive, as much good as it might do

a substance that can be really addictive, as much as it is going to help you, ummm, I think you can do a lot of harm in that sense |
| 11. Uncertainty of Effectiveness | there’s still a really big debate about if you should give someone with an addiction any additional medication

How much does it work? |
| 12. Lack of Monitoring       | I have this image of, like a dispensary with like, you just go in, you get it, you go to your groups, and you leave

I think it is more about the system. So, like that vision for me is like, if that is the way it is set up, then what the hell are we doing as clinicians, to just kind of, like, cycle people through?

When referring to a system failure, he said: I think a Methadone clinic does kind of sound like that

just a dispensary

So a dispensary could be good or bad if we’re doing it and not
advocating for the other piece of it, then I think that is what the failure is

I said that’s a, you know, system failure on our part if that’s the way it is

It is a system, a system failure if that is really how it is and we would just, like, shove medication on people and hope it works, and then be like, ‘Oh yeah, you should go to group, too’

they were like, ‘You should probably go to therapy, too, but make sure you take your pills’

| 3. Educational Experiences | 13. Limited Exposure | we talked about it in Addictions class and we touched on it in community-based interventions

We also touched on cause; the professor had experience with integrated dual diagnosis work, so she touched on it there and kind of didn’t explain a whole lot because that just didn’t, wasn’t her area, but we talked about it a good bit

In Addictions class, just kind of weighing the pros/cons, there was a lot, a lot of group discussion about it, just... Just what we thought, and the consensus was, people were like, [in a funny voice:] ‘We don’t know’
I remember, like, specifically learning about Vivitrol and I remember learning about Suboxone, ummmm, and I think they briefly talked about Antabuse

I mean, like I said, we, you touch on, you touch on addictions in some courses

It gives you a great overview

<table>
<thead>
<tr>
<th>14. Limited Fieldwork Experience</th>
<th>I had a lot of patients ask for anti-anxiety meds, but no, no, no Vivitrol, Suboxone, Methadone</th>
</tr>
</thead>
<tbody>
<tr>
<td>15. Lack of Coursework</td>
<td>you know, it’s almost one of those; it’s an entire treatment modality</td>
</tr>
<tr>
<td></td>
<td>So it’s almost as if it could be its own course</td>
</tr>
</tbody>
</table>

4. Other Experiences

| 18. Others People’s Stories/Perceptions | I worked for two psychiatrists who were very anti-medication assisted treatment for addiction |
|                                        | I’ve heard very few good, good recovery stories about, from people who have worked in addictions |
|                                        | my roommate did his internship working in addictions, and so he would always constantly talk [about] people who were prescribed that one; I don’t remember which one it is |

5. Perceptions Affect Client Care
19. Increased Curiosity

Do they go into [it] being, like ‘I want another addiction?’

21. Increased Counselor Anxiety

It’s scary to expose someone who is already in active addiction to another substance

6. Professional Career Choices

23. Not Enough Knowledge/Unpreparedness

I’d would do it if I knew more about it

I wouldn’t want to go in blind and I would feel like I’d have to be very open about that, like, ‘This is my first job in addictions, so help me out’

24. Lack of Interest

I have no desire to work in addictions

I think, when I get down [to] it, is that straight addictions counseling does not appeal to me

It’s just not, like, it’s just not my first choice

I don’t have desire to work in addictions, but I would do it if I had no other options, I would take it

Cross-Case Analysis

The six participants in the individual interviews frequently shared similar statements or sentiments as they described their perceptions of medication assisted treatment. Despite the commonalities, not all of the analytical categories were represented in each individual interview.
Table 8 provides a cross-case analysis of each analytical category, theme, and the supporting statements across all of the individual interviews. These themes are discussed in more detail in Chapter 5.

Table 8

Cross-Case Analysis

<table>
<thead>
<tr>
<th>Analytical Categories</th>
<th>Int. 1</th>
<th>Int. 2</th>
<th>Int. 3</th>
<th>Int. 4</th>
<th>Int. 5</th>
<th>Int. 6</th>
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</thead>
<tbody>
<tr>
<td>1. Attitudes and Beliefs Towards Clients</td>
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<tr>
<td>Theme 1: Lack of Commitment</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
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<tr>
<td>Theme 2: Lack of Motivation</td>
<td>x</td>
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<tr>
<td>Theme 3: Mistrust</td>
<td>x</td>
<td></td>
<td>x</td>
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<tr>
<td>Theme 4: Detachment from Reality</td>
<td>x</td>
<td>x</td>
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<td>Theme 5: Untreated Mental Illness</td>
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<td>Theme 6: “trying to better themselves”</td>
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<td>2. Attitudes and Beliefs Affect Perception</td>
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<td>Theme 7: “I don’t know”</td>
<td>x</td>
<td>x</td>
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<tr>
<td>Theme 8: Mixed Feelings</td>
<td>x</td>
<td>x</td>
<td>x</td>
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<tr>
<td>Theme 9: “It is a good thing.”</td>
<td>x</td>
<td>x</td>
<td>x</td>
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<td>X</td>
<td>x</td>
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<tr>
<td>Theme 10: Harming Someone’s Body</td>
<td>x</td>
<td></td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
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<tr>
<td>Theme 11: Uncertainty of Effectiveness</td>
<td>x</td>
<td>x</td>
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<tr>
<td>Theme 12: Lack of Monitoring</td>
<td>x</td>
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<td>x</td>
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<tr>
<td>3. Educational Experiences</td>
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<tr>
<td>Theme 13: Limited Exposure</td>
<td>x</td>
<td>x</td>
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<td>x</td>
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<td>x</td>
</tr>
</tbody>
</table>
Theme 14: Limited Fieldwork Experience  
Theme 15: Lack of Coursework  

4. Other Experiences  
Theme 16: Family and/or Friends in Addiction  
Theme 17: Culture  
Theme 18: Others People’s Stories/Perceptions  

5. Perceptions Affect Client Care  
Theme 19: Increased Curiosity  
Theme 20: No Difference  
Theme 21: Increased Counselor Anxiety  
Theme 22: Increased Monitoring  

6. Professional Career Choices  
Theme 23: Not Enough Knowledge/Unpreparedness  
Theme 24: Lack of Interest  
Theme 25: Fear  

Summary  
This chapter provided an overview of the data explicated from the six key informant interviews. The narratives of each interview provide supporting statements from the participants and illustrate how these statements are related to this study’s theoretical framework and the
identified themes. In addition to analyzing the themes within their supporting statements, my field notes and observations were included in the narratives. The data was organized into tables to demonstrate the supporting statements in relation to the themes, where applicable. At the conclusion of the chapter, a cross-sectional analysis of the themes and supporting statements was developed to demonstrate the commonalities among the participants’ statements. The data that was obtained from the narrative descriptions of the key informant interviews was used in the development of the themes. These themes and their implications for the research questions are explored in more detail in Chapter 5.
CHAPTER V: DISCUSSION

Introduction

The previous chapters provided an inquiry into counseling students’ attitudes toward the use of medication assisted treatments for opioid dependent clients. A review of the problem, background, and rationale was provided in earlier chapters in order to help develop an understanding of how these attitudes might be fostered during the professional education of counseling students. The review of the literature, the research questions, and the methodology of the study were described. The data was collected and analyzed using thematic analysis, and this resulted in the identification of twenty-five themes related to the research questions posed in this study. This chapter will examine these findings and develop insight into how the attitudes that counseling students hold toward the use of medication assisted treatment of opioid addictions is related to their educational experiences and the effects these attitudes may have on the professional counselors’ attitudes toward clients and their career-related decisions.

Discussion of the Findings

The theoretical orientation that was used to inform the analysis of the data produced in this study was cognitive Behavioral Theory (CBT). In CBT, the stimulus influences the development of thoughts, feelings, and associated attitudes, which then affect behaviors (National Alliance on Mental Illness, 2014). In this study, this theory suggested that the stimulus, a client addicted to opioids who includes the use of medication assisted treatments as part of a treatment protocol, stimulates thoughts and feelings in the counselor who, based on these thoughts and feelings, will form attitudes and beliefs that will in turn influence their behavior toward the client and in their career decision-making process.
The themes in this study were developed through an analysis of the attitudes and beliefs reported in response to the associated stimuli. This study found that counseling students’ educational experiences and personal experiences contained stimuli that contributed to the development of counseling students’ attitudes and beliefs surrounding the use of medication assisted treatment for opioid dependent individuals. Additionally, this study found that these experiences also affected their attitudes and beliefs toward clients selecting to participate in MAT, as well as having an impact on their career choices.

**Themes**

The twenty-five themes that emerged from the thematic analysis of the narratives produced by the participant interviews were reorganized and categorized to address the research questions proposed for this study.

**Research Question #1** “What are the attitudes and beliefs of counseling students towards clients who use medication assisted treatments for the treatment of opioid dependence?”

**Theme #1 lack of commitment.** The theme that the clients who use medication assisted treatment lack commitment to recovery was common among the participants. They used phrases such as “[they] want their meds,” “just come in and get their medication,” “just going on Methadone,” and “that is all they want” to indicate their perceptions regarding the clients only wanting to obtain their medication. Participants also indicated that, in addition to only wanting their medications, clients had a lack of commitment to the overall program and recovery. This was implied by the use of phrases such as: “not working their program,” “not really using the facility the right way,” “haven’t worked the whole recovery program,” “isn’t completely 100% into therapy,” “if they want therapy,” and “want to be left alone.” Comparisons were made to
abstinence-based treatment, “whereas others… are trying to work on, get treatment for their addiction.” The use of Narcan was also discussed as a rationale for clients’ lack of commitment to treatment, suggesting “people who overdose are, like, ‘Whoa, I can just go and get this Narcan injection or, ummm, the inhalant and I will be fine, so I can just go out and use; doesn’t really matter.” The participants appeared to lack awareness that Narcan is often distributed in medication assisted treatment programs as part of their programs in order to help decrease the number of deaths from overdoses.

Lack of commitment to treatment was referenced by participants citing the behaviors that clients engage in while at a treatment center. Participants referred to these behaviors in stating that they believe they occur in medication assisted treatment by using phrases like: “use it as a meeting place,” “doctor shopped,” “getting Benzos and other different pills from the Methadone clinic,” and “some may sell it, some may abuse it.” The long-term commitment to treatment and recovery was noted by one participant, who questioned, “what end are they using it towards?” and “are they just going on Methadone, making no other lifestyle changes?” These statements were similar to those presented in a study by Gordon, et al. (2011) which found that staff’s perceptions that clients would be drug seeking and using the clinic as a meeting place presented a barrier to the implementation of Buprenorphine in the Veterans Health Administration.

The participants perceived the clients as using medication assisted treatment as a “crutch,” and “leaning on a crutch to get around” while another described an individual who did not succeed in MAT because they “weren’t 100% into it.” This data indicates that the key informants believed that clients who choose to participate in medication assisted treatment do so with minimal commitment to the treatment process and recovery. This finding is consistent with a study by Kayman, Goldstein, Deren, and Rosenblum (2006), where the counselors in the study
perceived their clients as ambivalent and not really interested in ending their substance abuse. The belief that medication assisted treatment is a crutch has been perpetuated by both counselors and clients. Studies have shown that clients in MAT also feel that medication assisted treatment is a crutch, which further perpetuates this stigma (Brown, Benn, & Jansen, 1975; Conner & Rosen, 2008).

**Theme #2 lack of motivation.** Participants perceived that clients who use medication assisted treatment lack motivation for recovery. Participants questioned the clients’ motivation for seeking medication assisted treatment, suggesting that they are motivated to participate in MAT just to acquire drugs. As a way to question clients’ motivation for getting treatment, they used phrases such as: “are we just going there to get by, you know, to the next?” and “would take other prescription medications to get some type of high.” Participants questioned if clients were motivated by external factors, “whether they are there because of part of a court-mandated type thing,” “if they are doing it for the right reasons,” or to “try something new.” Others noted a perceived lack of internal motivation: “where was the desire for something better in life?,” “I just want to manage life,” and “some people just don’t have the willpower."

The participants’ statements indicate that they questioned the internal and external motivation of the clients for both treatment and recovery. This belief has also been demonstrated in previous studies where the participants – both counselors and staff – have indicated that many individuals see Methadone as a drug substitute and a crutch that does not motivate individuals or allow them to fully recover from their addiction (Brown, Benn, & Jansen, 1975; Conner & Rosen, 2008).

**Theme #3 mistrust.** Mistrust of the patients was a theme identified by the participants. In order to describe their mistrust, they questioned the MAT clients’ commitment to recovery:
“how are they gonna trust them?, “how can you trust them not to misuse anything else?,” and “you can’t trust them.” Another participant discussed how, after they initially gave trust to the patient, eventually, that “trust was kind of broken.”

Participants also used phrases such as “addicts lie,” “they do whatever they can,” “they know how it works,” “telling you what you want to hear,” and “manipulating” in order to describe their mistrust of patients. Others expressed concerns about the clients’ behavior and how the mistrust is connected in part to concerns about their motivation and commitment, stating, for instance, “I think of all the outside stuff. I think about the, you know what happens in the parking lot. Like, are we sharing drugs? Are we sharing information?” Another participant talked about other behaviors they have seen in clients, such as “smuggling them in through various body parts” and “put stuff in the kids’ diapers.”

The acknowledgement of counselor mistrust is important, as it has long been established in the counseling community that counselor trust is a necessary component to the therapeutic relationship (Leach, 2005). Earnshaw, Smith, and Copenhaver (2013) reported that clients in Methadone treatment reported being sterotyped as “untrustworthy” by others, while a study by Ahern, Stuber, and Galea (2007) found that 85% of clients surveyed reported feeling devalued or being seen as unreliable by people because of their drug use history.

**Theme #4 detachment from reality.** Just like any medication, there are side effects of the medications used in medication assisted treatment. Participants in this study described the clients on medication assisted treatment as being detached from reality. Participants used phrases such as “being in a fog,” “just like, out of it, not really there,” “lifelessness,” and “zombie” to describe clients on medication assisted treatment. The sedative effects of Methadone were described as “asleep” and “eyes in the back of their head.” Participants did not
appear to understand the sedative effects that Methadone can have on some individuals, as they identified them as being “in and out” during group therapy.

The words used by the participants to describe their perceptions of clients who use medication assisted treatment, in particular Methadone, are reflective of Methadone side effects which include fatigue, unusual tiredness, and confusion (Mayo Clinic, 2018). The participants’ lack of education and understanding regarding medication assisted treatment most likely contributed to their misunderstanding of the side effects of the medication and affected their perceptions of the clients.

Theme #5 untreated mental illness. It has been documented that there is a strong connection between mental illness and substance abuse (Grant, Goldstein, & Saha, 2015; Nesvåg, et al., 2015). Approximately 7.9 million individuals in the United States had a substance abuse disorder and another mental health issue in 2014 (Substance Abuse and Mental Health Services Administration, 2015). Despite the number of individuals who could qualify as having a dual diagnosis, participants discussed their perceptions that clients on medication assisted treatment might have untreated mental illness. The participants perceived the clients as having symptoms of both mental illness and substance abuse, noting that the mental illness often goes untreated. Participants used phrases to express perceptions such as that the clients have “a lot of anxiety” or “anxiety is real lot higher” with one further describing the clients as “talking a lot faster or just moving a lot” and being “hyper aware.” The participants questioned the connection between untreated mental illness and medication assisted treatment with phrases such as “which came first?” “underlying cause,” “which was the bigger issue at the time, the person’s addiction or the person’s mental health?,” and “they really just need to work on whatever
psychiatric disorder they have.” It was stated that “sometimes you need to fix or work on one problem that hopefully can correct the other problem in the long run.”

These statements indicate that the participants were aware of the symptoms of mental health issues; however, they initially attributed them to the use of medication assisted treatment. The participants questioned the clients’ mental health concerns and their connection to their addiction. They indicated that they believed the clients’ mental health concerns were going untreated in order to focus on the treatment of their addiction.

**Theme #6 “trying to better themselves”**. The five preceding themes indicate a negative perception of clients on medication assisted treatment. While participants did indicate negative perceptions and attitudes towards clients on medication assisted treatment, some of the participants had positive perceptions of clients who chose medication assisted treatment. Phrases indicating this perception included: “courageous,” “they want to get better,” “trying to better themselves,” “trying to make themselves better,” “taking a big step,” and “something they are trying,” demonstrating positive perceptions of the clients. Despite having a negative perception of clients on medication assisted treatment, participants identified a positive attribute. It is possible that their professional counseling education and experiences, even with their limited understanding of medication assisted treatment, promoted the development of this more favorable view of clients who chose to use medication assisted treatment. Despite an extensive literature review, there appears to be a lack of literature related to this theme. This theme may be an area of possible further research.

**Implications of research question 1**. The potential for stigma was the basis of the first research question. The implications of the first research question are that counseling students might have a predetermined view of clients who use medication assisted treatment. These
perceptions of clients who choose this treatment appear to be influenced by participants’ perceptions of medication assisted treatment, which emerged as a result of their counselor education experiences and their work and other personal and professional experiences. Stigma has been found to have a significant impact on the treatment and recovery efforts of individuals dealing with addictions (Earnshaw, Smith, & Copenhaver, 2013; Conner & Rosen, 2008; Matusow, et al., 2013; Hunt, Lipton, Goldsmith, Strug, & Spunt, 1985-86). Conner and Rosen (2008), and Hunt, Lipton, Goldsmith, Strug, and Spunt (1985-86), have found that the development of negative professional attitudes towards medication assisted treatment may affect a client’s willingness to enter treatment and negatively affect the development of the therapeutic relationship, also influencing the therapists’ perception of the client.

Despite the participants in this study identifying negative attitudes towards the clients who use medication assisted treatment, there was also recognition of some positive attributes associated with clients choosing to use MAT as part of their treatment. This is notable because, if knowledge and understanding of the treatment modality increases, there is potential and an increased likelihood that more positive attitudes towards these clients will be developed by counselors in training and, subsequently, in novice professional counselors. Additional evidence to support this conclusion is considered under the analysis of subsequent themes.

**Research Question #2** How do the attitudes and beliefs of counseling students regarding the use of medication assisted treatments for the treatment of opioid dependence affect their perceptions of individuals using these treatment options?

**Theme #7 “I don’t know”.** Participants indicated that they had limited knowledge of medication assisted treatment. They used phrases such as “don’t know,” “not much,” “not
comfortable with the subject.” “I don’t know much about them,” “little less knowledgeable,” and “I don’t know much” when asked to discuss mediation assisted treatment. In order to try to explain their limited knowledge, participants reflected on their limited education on the subject, using phrases such as “snippets,” “touched on it,” and “briefly talked about it,” to describe their exposure to the subject.

Participants’ lack of understanding was further demonstrated when they attempted to describe it with phrases such as “kind of the opposite of what an abstinence based program [is],” “using medicines to help with their, I guess, symptoms or whatever,” and “how you can use different drugs as a medicine instead [of], you know, a recreational drug.” One participant referred to medication assisted treatment as “medically assisted heroin.”

When participants were asked about two of the more common medication assisted treatments for opioid dependence – Methadone and Suboxone, they continued to demonstrate a lack of knowledge. They used phrases such as “I don’t know anything about a Suboxone,” “don’t know,” “not too knowledgeable about everything related to this,” “I don’t know how the clinics work,” and “I wouldn’t be able to describe to someone how a Methadone clinic works.”

The participants referred to their lack of education as a component of their lack of knowledge regarding medication assisted treatment. Madison, Bethea, Daniel, and Necaise (2008) found that, in the offered substance abuse courses, 24% of students were taught about Methadone and 5% were educated about Suboxone in their counseling program. This is consistent with findings that suggest that counselors from abstinence-based backgrounds who report having no education regarding the use of these medications also report having limited understanding of how medication assisted treatment programs work (Caplehorn, Hartel, & Irwig, 1997). The findings of this study and the relevant literature appears to indicate that a lack of
education affected the participants’ understanding and acceptance of medication assisted treatments as a treatment option.

**Theme #8 mixed feelings.** The participants expressed *mixed feelings* about the use of medication assisted treatment as a treatment option. They used phrases such as “I am on the fence,” “in the middle,” “not sure where I stand,” “mixed thoughts,” “it has pros/cons,” and “my jury is still out on how I really think about it” to express their mixed feelings. The participants’ mixed feelings appeared to be related to their lack of knowledge regarding medication assisted treatment and their uncertainty of its effectiveness. The participants used phrases such as “double-edged sword” and “if there are better options out there, that it is horrendous that they’re the only options” to indicate their mixed feelings and how they are related to concerns about treatment effectiveness. Despite an extensive review of the literature, there appears to be a lack of literature regarding counselors’ mixed feelings regarding the use of medication assisted treatment in relation to the effectiveness of this treatment option.

**Theme #9 “it is a good thing”.** The participants expressed beliefs that, despite any concerns they have about medication assisted treatment, it could be a positive factor in the fight against the opioid epidemic. Participants demonstrated their belief in the value of medication assisted treatment by using phrases such as “good thing,” “benefits of it,” “great concept,” “it helps something,” and “helpful for some people.” Participants referred back to their concerns about trusting patients by stating that it is positive “if it is used in the right way” and mentioning the importance of “using it responsibly.”

Participants discussed that having the option to use medication assisted treatment is a positive alternative for treating opioid addiction. They referred to it as “a good alternative” and noted that clients should “have the option to get better” while another participant noted, “I think
it should be available because, if there is someone that it works for,” and suggested that medication assisted treatment was a “wonderful addition to any type of treatment.”

**Theme #10 harming someone’s body.** Methadone and other harm reduction medications have been established as safe medications for the treatment of opioid dependence (Schwartz, et al., 2008; Aletraris, Edmond, Paino, Fields, & Roman, 2016). Despite this research, participants expressed concern about medication assisted treatment having the potential to be harmful. Participants expressed fear of a risk that clients will be prescribed another medication that has the potential to be “addictive” or “abused.” Participants expressed concerns that the prescribed medication had potentially harmful side effects. Phrases such as “any long-term use medication effects organs” and “laundry list of side effects” were used to support this theme. Concerns were expressed about the efficacy of using Methadone on pregnant women with the comments: “repercussions with women who are pregnant or women who’ve just given birth” and “things like that can be researched more.” Participants’ experiences working with clients in Methadone clinics effected their perceptions about harm and were reflected in statements such as “their doses were too high” and “[they] are prescribed too much.”

**Theme #11 uncertainty of effectiveness.** The question of effectiveness of medication assisted treatment has been demonstrated to be a concern coming from counselors. Methadone has been shown to be perceived as the least effective MAT while Suboxone and Naltrexone were shown to be perceived as more effective by counselors (Bride, Abraham, Kintzle, & Roman, 2013). When surveyed, it was determined that two-thirds of counselors surveyed “don’t know” how to respond when asked to rate their perceptions in regard to Suboxone’s effectiveness (Knudsen, Ducharme, Roman, & Link, 2005).
The question of medication assisted treatment’s effectiveness was discussed by the participants in this study, as well. Participants questioned “how much does it work?” and “whether it is effective?” Phrases such as “Band-Aid” and “prolonged the addiction” were used to question the effectiveness of this treatment approach.

Despite Methadone having a significant history of recognition as an effective treatment for opioid dependence (Schwartz, et al., 2008; Aletraris, Edmond, Paino, Fields, & Roman, 2016), participants continued to question its effectiveness. It was stated that “it is evidence based [but] its numbers are just so low there has to be something wrong,” and “[it] needs a lot more research.” Concern regarding its effectiveness was also related to giving additional medication to someone with an addition. One participant questioned if there is “a really big debate if you should give someone with an addiction any additional medication?” while another questioned, “how is giving them more drugs helping them?” The participants’ concerns were similar to those demonstrated in a study by Aletraris, Edmond, Paino, Fields, & Roman (2016), where approximately 20% of the participants questioned the effectiveness of Methadone and Suboxone.

**Theme #12 lack of monitoring.** Concerns regarding a lack of monitoring were demonstrated in two ways by the participants, regarding both a lack of monitoring of clients and a lack of monitoring of facilities. Participants described their belief that medication assisted treatment facilities do not monitor the clients receiving treatment, in particular in Methadone and Suboxone facilities. The title *One Flew Over the Cuckoo’s Nest* was used to describe treatment, and referenced clients as “lining up at the window for their meds.” The counselors perceived the agencies as having limited monitoring of their clients through a lack of counselor engagement. Participants used phrases such as “like a dispensary with, like, you go in, you get it, you go to
your groups, and you leave;” “you through the system and get you in and out;” and the doctor
“just comes in and out, and meets with the clients once in a while;” and “they were like ‘you
should probably go to therapy, too, but make sure you take your pills.’” This lack of monitoring
was described as a “system failure on our part if that’s the way it is.”

While some of the participants expressed concern about a lack of monitoring of clients,
others expressed concern over the lack of monitoring of the facilities themselves. Participants
demonstrated their concerns about the lack of regulation of the facilities by stating that
medication assisted treatment “needs a lot of, like, being monitored heavily” and “they need
more staff, you know, to help regulate,” and through the question, “who’s regulating the
facilities?” These thoughts demonstrate the lack of knowledge that the participants have
regarding the strict oversight of medication assisted treatment providers by several governing
bodies. Medication assisted treatment is regulated by the Federal Drug Enforcement Agency
(DEA), individual state drug and alcohol departments, individual counties, and insurance
providers through both announced and unannounced site visits and audits.

**Implications of research question 2.** The participants’ perceptions of clients who use
medication assisted treatment appear to affect their perception of the clients who choose this
treatment option. The predominant themes among the participants indicate their limited
understanding and knowledge of medication assisted treatment. The perception of Methadone
has received attention in the literature and there is support for the belief that many individuals
seek Methadone as a drug substitute and a crutch that does not permit individuals to fully recover
from their addiction (Brown, Benn, & Jansen, 1975; Kayman, Goldstein, Deren, & Rosenblum,
2006). Many facets of society, including addiction counselors and clients, do not perceive
medication assisted treatment as a legitimate treatment option for opioid dependence. As a result
of the negative perceptions surrounding medication assisted treatment, many clients feel ostracized by their families, friends, peers, and treatment providers, and this creates a barrier to effective treatment (Matusow, et al., 2013; Humphreys, Noke, & Moos, 1996; Conner & Rosen, 2008; Kayman, Goldstein, Deren, & Rosenblum, 2006; Hunt, Lipton, Goldsmith, Strug, & Spunt, 1985-86).

It is important to understand counseling students’ perceptions of medication assisted treatment in order to understand their potential thoughts, feelings, and responses towards the clients who use this treatment modality. A study by Smye, Browne, Varcoe, and Josewski (2011) noted that the negative attitudes of providers towards the use of medications to treat opioid dependence have been identified as a potential barrier for treatment professionals. From the perspective of cognitive behavioral theory, this study suggests that counselors’ perceptions of medication assisted treatment is stimulated by the quality and quantity of their experiences with MAT, and this affects their perceptions of clients who use this treatment option. This finding is consistent with the conclusions reached by Smye, et. al.

**Research Question #3** How do pre-professional counselor education experiences affect the attitudes and beliefs of counselors regarding the use of medication assisted treatments as a treatment option?

**Theme #13 limited exposure.** The participants in this study indicated that exposure to medication assisted treatment was limited. Participants used phrases such as “snippets,” “touched on it,” and “briefly talked about it” to describe their exposure to medication assisted treatment in coursework. Addictions class was identified as a course in which medication assisted treatment was “talked about.” Their limited educational exposure to medication assisted treatment was demonstrated by phrases such as “briefly talked about it,” the professor would
“say it once or twice,” “went over it in a very cursory way,” and “I don’t think we get a lot of information.” Participants discussed what was covered during such conversations with phrases including “opinions,” “pros/cons,” and “went over it in a very cursory way,” as well as saying, “I don’t think we get a lot of information” to describe their limited exposure.

When asked if they thought it would be helpful to have exposure to medication assisted treatment in school, they stated it would. The participants used phrases such as “I think it would be helpful,” “if there is still a way to meet CACREP requirements and put a little bit more on that, it would be helpful,” and suggested “classes or at least more focus on the drugs part of counseling” to indicate that they believed they would benefit from more exposure to medication assisted treatment in coursework.

**Theme #14 limited fieldwork experience.** In CACREP accredited counseling programs, fieldwork is a required component of formal education (Council for Accrediation of Counseling and Related Educational Programs, 2015). Even if some students were not exposed to medication assisted treatment in classrooms, there was the potential for them to be exposed to it in their fieldwork experiences. A study by Salyers, Ritchie, Cochrane, and Roseman (2006) found that 71% of respondents stated that between 11-50% of clients seen by their practicum students presented with substance abuse issues while 18% responded that half of the clients seen presented with substance abuse issues, and 64% reported that between 11-50% of their internship students worked in substance abuse facilities.

Despite these statistics, most participants in this study denied having had exposure to clients on medication assisted treatment. Participants stated, “I actually don’t think I have seen any clients that have been through an assisted,” “that is not something I ever had direct
experience, dealing with somebody,” and “[it’s] nothing I’ve come across” to demonstrate their lack of exposure to clients on medication assisted treatment. A few participants stated they had had exposure to clients on “Methadone” but denied having had exposure to clients on other types of medication assisted treatment. This lack of exposure to patients in their fieldwork is surprising considering that approximately 21 to 25% of all substance abuse users were involved in Methadone treatment, and an additional 32,000 individuals received Suboxone treatment for opioid dependence (Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality, 2013).

Theme #15 lack of coursework. Addictions is a very widespread and comprehensive topic, and all of the participants discussed a lack of coursework. Participants discussed the pre-requisites as a problem by stating: “I wish I had taken, you know [addictions], when I was in Practicum or Internship 1,” “I didn’t take addictions until after my practicum, so that didn’t really help because I didn’t have that class,” and “it wasn’t required before as a pre-req.” One participant stated that taking Addictions before his fieldwork “would have helped me a lot.”

Participants discussed their perceptions that addictions or medication assisted treatment could be specialized. They used phrases such as: “it’s almost one of those, it’s an entire treatment modality;” “it’s almost as if it could have been its own course;” “I would say that [CACREP] requirements should be like, ummm, change them up a little bit. My gosh, allow for specialization for the area;” and “addictions could be a complete degree in itself.”

A study by Lambie and Davis (2007) noted that most professional school counselors do not have the training and supervision to provide substance abuse counseling. As a result, it is important that they increase their personal awareness and knowledge base regarding substance
abuse. This was confirmed by one participant who stated that, as a school counseling student, “I wasn’t taught too much” and that “I didn’t take Addictions counseling.” One participant stated that he felt “the addictions class would have helped.”

CACREP requirements do not specifically require medication assisted treatment education as part of required coursework (Council for Accreditation of Counseling and Related Educational Programs, 2015). Despite it not being required, it has been determined that either formal training related to medication assisted treatment or employment in a program where medication assisted treatment was used were the strongest predictors of knowledge of medication assisted therapy (Bride, Abraham, Kintzle, & Roman, 2013).

**Implications of research question 3.** Several studies have correlated counselors’ levels of formal education to the acceptance of medication assisted treatment (Forman, Bovasso, & Woody, 2001; Rieckmann, Kovas, McFarland, & Abraham, 2011; Fitzgerald & McCarty, 2009; Humphreys, Noke, & Moos, 1996; Aletraris, Edmond, Paino, Fields, & Roman, 2016). According to a study by Bride, Abraham, Kintzle, and Roman (2013), the content of a counseling student’s education is an important factor in their formation of attitudes and beliefs. If a counselor is exposed to and encouraged to adopt evidence-based practices for the treatment of opioid addiction during training, it may increase their acceptance of harm reduction practices. A strong predictor of a counselor-in-training’s accurate knowledge of and attitudes toward medication assisted therapy is formal training specifically related to medication assisted treatment or employment in a program where medication assisted treatment is used (Forman, Bovasso, & Woody, 2001; Rieckmann, Kovas, McFarland, & Abraham, 2011; Fitzgerald & McCarty, 2009; Humphreys, Noke, & Moos, 1996).
The themes associated with this research question that were identified in this study appear to support the conclusion that limited knowledge and experience with medication assisted treatment limits the counselors’ understanding of its viability and effectiveness as a treatment option for opioid dependent clients.

Since the participants reported having had limited exposure to medication assisted treatment during their formal education and training, it seems reasonable to conclude that there is a relationship between this lack of exposure and their demonstration of some misperceptions and distortions of this approach to treatment. This evidence suggests that the participants’ minimal exposure to and knowledge of medication assisted treatment contributes to their questioning of its effectiveness and their having mixed feelings about its use as an effective treatment modality for opioid addiction.

Research Question #4 What other experiences influence the counselor-in-training’s development of attitudes and beliefs towards clients who use medication assisted treatments as a treatment option?

Theme #16 family and/or friends in addiction. Participants discussed personal experiences they had had in their lives regarding addictions. Participants related their experience with addictions based on family and friends’ experiences, using phrases such as: “anyone I know personally has gone through AA or NA,” “a brother that was a heroin addict,” “I know a good amount of people… that have had issues dealing with prescription drug abuse,” “experienced addictions in my family,” and “someone I care for, their brother is addicted to heroin.” One participant stated that their experience had affected their perception of treatment because “that’s, you know, just the mindset I have had for recovery.”
The participants had previously expressed negative sentiments regarding clients who use medication assisted treatment and only one participant who had experience with family and/or friends in addiction perceived them as “trying to better themselves” by using medication assisted treatment. This indicates that personal experience does not have an impact on their perceptions of medication assisted treatment, as they are more aware of the problems that the individuals experienced more so than the treatment modalities available.

**Theme #17 other people’s stories/perceptions.** Some of the participants indicated that other people’s stories and perceptions had an effect on their perceptions of addictions and medication assisted treatment. Participants described: “my father is a police officer and he was in Narcotics,” “most of my understanding of drug addiction came from kinda more my own readings,” “documentaries,” “own research,” and one noted a roommate who “would always constantly talk about people who were prescribed that one.”

Another participant “worked for two psychiatrists who were very anti-medication assisted treatment” and said that “I have heard very few good, good recovery stories about [it], from people who have worked in addictions.” Despite the participant denying that these elements influenced their perceptions, this participant expressed negative themes about the use of medication assisted treatment as a treatment option.

The statements of these participants indicate that, despite believing they are not affected by the perceptions of others, it appears that the perceptions of others do have a relationship to their negative perceptions about medication assisted treatment and the clients who use it. Additionally, if a counselor has not received formal education to suggest the contrary opinion about medication assisted treatment, they are likely to continue to be influenced by outside factors.
**Theme #18 culture.** The effect of *culture* was discussed by some of the participants as something that affected their perceptions of medication assisted treatment as a treatment option. Participants stated: “I think a lot of my attitudes were based in, you know, family and the way I was socialized growing up;” “for most of my life, that, it has been ‘say no’ so ‘just say no to drugs’;”” and “[I] wasn’t really exposed to much information until I went to university.” The culture in which these participants grew up appeared to have helped shape their perceptions of addictions and medication assisted treatment, as it reinforced abstinence-based treatment as the primary modality for treatment.

**Implications for research question 4.** This study explored how other experiences, outside of a counselor’s pre-professional experiences, affected a counseling student’s perception of medication assisted treatment. These other experiences in a counseling student’s life appeared to affect their perception of medication assisted treatment as a treatment modality and their perception of the clients involved. There appears to be a lack of literature concerning how pre-professional or other personal experiences affect counseling students’ perceptions of medication assisted treatment. This lack of literature in this area suggests a need for further study and exploration.

All of the participants who identified the theme *family and/or friends in addiction* expressed negative sentiments regarding clients, and they acknowledged more understanding of the problem as it related to addiction than the treatment modalities available to treat opioid addictions. This indicates that personal experience does not have an impact on their perceptions of medication assisted treatment, as they are more aware of the problems that the individuals dealing with addiction experience, but less accurately informed about the treatment modalities available.
Another theme identified was other people’s stories/perceptions. Some of the participants discussed experiences with other’s perceptions or stories via either internship experience, documentaries, or family members’ jobs. Each of these participants expressed several negative sentiments related to medication assisted treatment as a treatment modality. This indicates that, consciously or subconsciously, the participants may have been influenced by other people’s shared experiences and perceptions.

Culture was another theme identified by participants as affecting their perceptions of medication assisted treatment. Participants stated that they either had limited exposure to addictions and medication assisted treatment or were of the mindset that abstinence was the preferred approach to recovery, and noted that this belief was influenced by experiences with their family culture. The participants’ personal experiences do not have an impact on their perception of medication assisted treatment, as they are more aware of the problems that the individuals experienced more so than the treatment modalities available.

Research Question #5 “How do the attitudes and perceptions affect client care?”

Theme #19 increased curiosity. Increased curiosity was a theme noted by the participants. The participants stated that, when caring for clients, they would have increased curiosity regarding the use of the medication assisted treatment and in regard to the clients themselves. Participants used phrases such as “curious how this actually works,” “get curious,” and “I do wonder if complete abstinence isn’t kind of a little tough for some people.” Some participants expressed curiosity regarding the backgrounds of clients. Participants questioned, “what’s their back stories?,” “wonder if, of all the ways to deal with addiction, why this one for this specific person?,” “are you taking more medication? What are you doing?,” and that they
might “ask them [for]… more background information” and question “what is their background history?”

In addition to curiosity regarding a client’s backstory, curiosity was also related to their motives for treatment: “do they go into being, like, ‘I want another addictions?’” and said that “it would really be interesting to listen to their attitudes about it.”

The participants’ curiosity appeared to be connected to their lack of knowledge regarding the subject. The participants appeared to be seeking out the clients’ perceptions of medication assisted treatment in order gain additional information to form their own opinions and hypotheses regarding treatment.

**Theme #20 no difference.** Participants stated that they did not see a difference between clients who use mediation assisted treatment versus people with another type of addiction or with no addiction. As a result, they did not feel their treatment would be any different. Participants used phrases such as “I couldn’t say that I have seen the difference,” “not very much different,” “a human is a human,” and “here is another person and I don’t really think too much about the medication assisted treatment” when asked if they perceived a difference between clients who chose either modality. One participant expressed concern that she did not want to be perceived as treating clients on medication assisted treatment differently: “I don’t want them to feel I am treating them differently whether they are on it or not.”

**Theme #21 increased counselor anxiety.** When caring for clients who use medication assisted treatment, participants noted increased anxiety when considering the potential for caring for clients who use medication assisted treatment. Participants mainly expressed concern about helping a client continue to abuse medications, which was noted by phrases such as: “helping
someone abuse it,” “what if they’re mis-using it?,” “it’s scary to expose someone who is already in active addiction to another substance,” and “fear of the unknown.”

One participant drew on her previous experience working with clients who use medication assisted treatment, noting that, “I would catch myself feeling very anxious” when providing care, while another stated that they “wouldn’t be relaxed” when providing care.

Increased counselor anxiety demonstrated itself through fear and the unknown. They expressed concerns about mis-use and being part of helping clients mis-use it either directly or indirectly.

**Theme #22 increased monitoring.** Participants suggested that they would undertake *increased monitoring* of clients who use medication assisted treatment. Participants commented that they “did do searches” at their internship, focus on how the client was “feeling,” and “do self-checks,” as well as that they would “be more focused on that, those individuals rather than everyone else” and “keep a closer eye on them.”

The increased monitoring appears to be related to the participants’ previous statements regarding mistrust of the clients and an increased anxiety related to counseling a client on medication assisted treatment.

**Implications for research question 5.** Several studies have reported that the therapeutic relationship is a significant factor that has the potential to influence the efficacy of a treatment (Conner & Rosen, 2008; Hunt, Lipton, Goldsmith, Strug, & Spunt, 1985-86). A common theme among the participants was “I don’t know” in regard to knowledge and experiences with medication assisted treatment, which appears to be connected to the theme of *increased curiosity*. The participants identified the fact that they have limited knowledge of medication assisted treatment and “don’t know” enough about it. The results of this study appear to indicate
that they had limited exposure, limited fieldwork experience, and a lack of coursework related to this approach, but remain curious about its effectiveness in treating opioid addiction. As result, they might be inclined to be more curious about the clients they are treating and attempt to gain more insight into their histories and backgrounds as a way of learning about the clients and the potential effectiveness of MAT as part of their treatment modality. The American Counseling Association Code of Ethics states that counselors only practice within their boundaries of competence as based on their education and training. It is expected that, while working to learn skills in a new specialty area, counselors would seek education, training, and supervised experience in this area. Thus, they may be inclined to be more careful about the treatment they provide (American Counseling Association, 2014).

Another common theme for counselors-in-training was that they believed their perceptions of clients, and the care and treatment they would provide, would be no different for clients who chose to select MAT and for those who did not. These participants believed medication assisted treatment is a “good thing.” By believing that medication assisted treatment is positive and feeling they would not treat the clients any differently, the efficacy of treatment for clients who choose MAT is likely to be at least on par with the treatment efficacy seen with their clients who are not engaged in MAT.

*Increased counselor anxiety* was another common theme. This appeared to be significant and related to their attitudes of “I don’t know” regarding medication assisted treatment. When a counselor has limited experience and knowledge of a subject, it is reasonable to assume that their anxiety will increase. As a result, this anxiety might be the impetus for the counselor conforming to professional ethical guidelines, taking increased precautions to ensure that the care they provide their clients in MAT is consistent with the care they provide other clients.
As a result of their increased anxiety, some of the participants stated they would undertake increased monitoring of the clients as part of their care, which may suggest their increased professional care; however, it may also be related to their lack of trust in clients. If a counselor mistrusts their client, they may be inclined to increase their monitoring. According to Leach (2005), trust is an important component of the rapport between client and counselor. If the rapport and therapeutic relationship is harmed due to a lack of trust, it will ultimately affect client care.

**Research Question #6** How do the attitudes and perceptions affect professional career choices?

**Theme #23 not enough knowledge/unpreparedness.** When asked about whether their education had prepared them to take a job as a counselor working in medication assisted treatment, the participants stated that they did not feel prepared. The participants used phrases such as “I don’t feel I am completely trained,” “unethically prepared,” “not fully,” “underprepared,” “I could be more prepared,” and “I wouldn’t want to go in blind” when asked about their preparation for taking a related job. According to Cellucci and Vik (2001), when individuals feel unprepared to treat clients for substance use disorders, they hesitate to address the co-morbidity of mental health and substance abuse or they may avoid working with substance-abuse clients altogether.

**Theme #24 lack of interest.** When asked about taking a job as a counselor working in medication assisted treatment, participants cited lack of interest as a reason for not taking such a job. Participants commented: “I never really wanted to get into the whole, ahhhh, you know, drugs and psychiatry and all that;” “addictions like that might not be my favorite, umm, branch of counseling;” “I just really don’t want to work in addictions;” “no desire to work in addictions;” and “[it] does not appeal to me.”
When asked about taking a job as a counselor working in medication assisted treatment, some of the participants stated they would because of the employment options. They used comments such as “I mean, I’d do it because it was a job;” “if I had no other options, I would take it;” and “if it is a good job” to indicate that they would take such a position not due to interest, but due to employment options.

**Theme #25 fear.** Fear was expressed by some of the participants in regards to taking a position in medication assisted treatment. Some of the participants indicated that this fear was related to their lack of exposure to medication assisted treatment in regard to fieldwork. Participants expressed their fear through phrases to suggest they would be “apprehensive about it,” “little apprehensive at first because I have never been in that type of environment,” and “would be kind of worried about taking that job.” Participants related their fear back to their lack of experience by explaining that: “without experience you really can’t feel 100% comfortable.” One participant also explained that he “would be kind of worried about taking that job” in part because he felt he had limited knowledge and felt unprepared by his educational experience.

**Implications of question 6.** This question was intended to explore how attitudes and perceptions toward MAT affect professional career choices. When the data related to this question was analyzed, it was discovered that the participants’ lack of education, experience, and exposure to medicaiton assisted treatment affected their potential career choices.

The predominant theme among the participants was that they felt they do not have **enough knowledge** and felt **unprepared** for a career in medication assisted treatment. This is significant, as the participants also stated that their educational experience lacked coursework, lacked fieldwork, and provided limited exposure to medication assisted treatment. According to
Cellucci and Vik (2001), when individuals feel unprepared to treat clients for substance use disorders, they hesitant to address the co-morbidity of mental health and substance abuse or they may avoid working with substance-abuse clients all together.

*Lack of interest* in addictions and/or medication assisted treatment was a common theme among the participants. Participants stated that they had no interest in working with addictions. It is possible that their limited exposure to medication assisted treatment and addictions in general contributed to this lack of interest, as several of the participants indicted fear as a concern. The participants appeared to be fearful of assisting in furthering their clients’ addiction and not having the knowledge or experience to appropriately treat clients in medication assisted treatment. The theme of *fear* was another potential reason they would be hesitant to consider a career working with clients in medication assisted treatment. By failing to provide counselors, and especially counselors in training, with the knowledge of and experiences with clients in medication assisted treatment, we decrease the likelihood that students will choose addictions as a specialty or work with clients in medication assisted treatment as a long-term career choice.

**Implications for the Field**

This qualitative study provides an important contribution to the field. As the opioid epidemic in the United States continues to increase and the use of medication assisted treatments is being included in more treatment protocols for the treatment of opioid dependence, it is important to understand how the next generation of counseling students perceive the use of medication assisted treatment. It is important to understand how their professional education and experience affect their perceptions of clients and this modality, influence their career choices, and ultimately influence the care they provide to clients seeking treatment for their opioid addictions.
As several studies have indicated (Forman, Bovasso, & Woody, 2001; Rieckmann, Kovas, McFarland, & Abraham, 2011; Fitzgerald & McCarty, 2009; Humphreys, Noke, & Moos, 1996), the quality of experiences with MAT in a counselor’s formal education is related to their positive attitudes toward the use and acceptance of it as an efficacious treatment for opioid dependence. The findings of this study, which are consistent with this literature, indicate that a counseling student’s lack of formal education in addictions, harm reduction, and specifically medicated assisted treatments, can distort and negatively affect their perception of this treatment modality. While it may be premature to make significant changes in the curriculum and fieldwork requirements in counselor education programs, if future research supports this emerging opinion, then changes in training standards and practices will be warranted. Counselor educators might begin this process by incorporating more systematic evaluations and analyses of the perceptions that current students in training have toward MAT and the clients who select it as part of their treatment protocol. These results might provide a foundation for adjusting the pre-professional training currently being provided.

Counselor educators might also want to consider adding additional courses to their program to cover addictions-related material more specifically and more extensively. Programs may also want to consider making an addictions course a pre-requisite to fieldwork experiences for counseling students. These additional courses, or modules in existing courses, could provide opportunities for counselor educators to address medication assisted treatment modalities specifically in courses or in supervision. By spending additional time on these harm reduction topics, counseling students would be better prepared to enter the field and might be more open to working with clients in medication assisted treatment as a career choice.
In addition, counselor educators and professional counselors should be encouraged to conduct research to expand our knowledge and understanding of medication assisted treatments. The results of this research could be useful in documenting how to modify training experiences related to the efficacy of MAT. Furthermore, the results of this research agenda might produce results to influence the training standards the counselor education programs must meet if they are to be accredited by Council for Accreditation of Counseling and Related Educational Programs (CACREP). Finally, as the evidence linking effective care to the quality of treatment provided and the expanding demand for appropriately trained counselors grows along with the opioid epidemic, counselor educators can use the data generated by studies of this kind to encourage universities to make resources available to encourage this increased training focus on medication assisted treatment.

Supervisors who work in programs where medication assisted treatment is a potential and viable option for the treatment of addictions may also need to consider being mindful of their new counselors’ educational backgrounds. By understanding the specific educational experiences that novice counselors bring into the workplace, they may be better able to offer continuing professional education and training to help their employees develop a more accurate understanding of this approach to treatment. Additionally, they may want to consider being more observant of their supervisees’ attitudes and beliefs towards this treatment modality as one way of monitoring any potential inappropriate or negative behaviors in the treatment process or in their relationship with clients in treatment. By proactively exploring a counselor’s knowledge and experience with MAT, the supervisor may be more likely to identify potentially inaccurate perceptions which might support negative attitudes and beliefs which, in turn, may produce
behaviors that threaten the quality of care provided for a client as well as the counselor’s job satisfaction.

Finally, professional counselors must assume their professional and ethical responsibility to seek the professional development they need to maintain their effectiveness. According to the American Counseling Association Code of Ethics, counselors should only practice within their boundaries of competence, which are based on their education and training (American Counseling Association, 2014). These ethical standards require that, when a counselor begins work in a new area, they are expected to learn skills in that new specialty area by seeking education, training, and supervised experience in the area (American Counseling Association, 2014). This might be especially significant for novice counselors.

**Implications for Future Research**

The data collected from this qualitative research study indicate the potential need for research in several related areas. Many of the partipant statements support themes related to a lack of knowledge for and experiences with medication assisted treatment. It would be beneficial to determine if this result is similar across all CACREP accredited schools, and how this compares to non-CACREP accredited schools. A possible research question would be, “Are there differences in addictions education between CACREP-accredited schools vs. non-CACREP accredited schools?” A related question would be, “Are there differences in the perceptions of clients who use medication assisted treatment concerning students in CACREP-accredited schools vs. non-CACREP accredited schools?” Since this study was limited to one CACREP university during a particular time period, another possible area of study would be to replicate the study at other CACREP universities in different geographic regions to see if similar results would be obtained.
It would also be beneficial to replicate this study with participants from programs that have an addictions specific track or major. A possible research question to explore is, “Are there differences in the students’ perceptions of medication assisted treatment between counseling programs that offer an addictions major and those programs that do not offer an addictions major?”

A predominant experience reported in this study was a lack of exposure to medication assisted treatment in coursework and fieldwork experiences. Future investigations are needed to describe the outcomes of increased exposure to medication assisted treatment through coursework and field experiences. Investigations into the relationship between course coverage of medication assistant treatments and the students’ perceptions, beliefs, and attitudes toward MAT and clients who choose this treatment need to be reported. Similar studies of field placement exposure to MAT and the resulting outcomes are also needed. These studies would add to our understanding of how these variables contribute to the development of the counselor-in-training. Specifically, these studies would help us understand if and how these curriculum requirements could change the attitudes and beliefs of counseling students towards the use of medication assisted treatment as a treatment for opioid addictions.

Another theme that arose in this study was how a counselor-in-training’s personal experience with addictions affects their perception of addictions treatment in general. There appears to be a lack of research regarding how family or friends’ in recovery or other personal experiences affect their perceptions. This leads to two possible questions that could guide future research: “How does experience with family and/or friends in addiction affect perception of medication treatment?” and “How do the cultural experiences and awareness of the counselor in
training affect their perception of addictions treatment, MAT, and the clients who choose harm reduction approaches such as MAT?"

While several negative themes and perceptions emerged during this study, only one resulting theme was positive, this being “trying to better themselves”. One potential area of further research would be to address the question, “Does exposure to medication assisted treatment and harm reduction practices during formal counselor education training lead to more positive perceptions of MAT and the clients who use this modality?” Another possible research question would be, “Does placement in a harm reduction treatment facility during fieldwork lead to more positive perceptions of the treatment modality and the clients?”

Several of the themes constructed in this study presented with similarities. This, along with the unique perspective on the data provided by the researcher, could indicate the possibility that future replication of this research might yield broader or larger themes that encompass the data used to form multiple themes in this study. Replication of this study would provide the opportunity to compare the current construction of themes and determine if similar themes would be produced, as well as determine any convergence of the data into the same, fewer, or more themes. For example, a future researcher may choose to combine the data that supported the development of the themes Limited Exposure, Limited Fieldwork Experience, and Lack of Coursework into a mega-theme that explains how these data are related to another mega-theme that combines data used to support the themes of I don’t know and Not enough knowledge/unpreparedness. This research could describe relationships between these themes and variables like the university curriculum, field experiences, and personal experiences related to addictions, and specifically harm reduction approaches to treatment, such as MAT.
Finally, in doing this study, I became aware that the 2014 American Counseling Association’s Code of Ethics requiring counselors to work within their scope of training and outlining the professional responsibility to seek professional development to ensure that counselors are able to work effectively with their clients might provide a reason for novice counselors who lack training and experience in working with harm reduction strategies to avoid working with clients in MAT. Even more fundamental to our understanding of how novice counselors’ may feel about working with clients in MAT is the finding that suggests that they consider MAT to be an unethical approach to the treatment of addictions because it violates our professional values of nonmalfesence and benificence. The ACA Code of Ethics states that counselors “act to avoid harming their clients” and, if a counselor perceives medication assisted treatment as harmful, they may avoid it because they believe they are violating their professional code of ethics (American Counseling Association, 2014). In this study, these concerns were revealed in comments related to novice counselors making career decisions and not being attracted to positions working with clients in medication assisted treatment. Future research is needed to examine the relationship between their ethical concerns regarding the use of medication assisted treatment with opioid dependent individuals and their career decision-making process. Potential research questions might include “What ethical concerns do you have regarding the use of medication assisted treatment?” and “How do these ethical concerns influence your career decision-making?”

Limitations

As with any study, this study has several limitations. This research was exploratory, and it provided descriptions of the counseling students’ attitudes, beliefs, and perceptions of medication assisted treatment. When considering the findings of this study, one limitation that
needs to be considered is purposive sampling, and especially the decision to select all of the participants from the same counseling program. The data reflects the perspectives of this purposive sample of individuals who volunteered and agreed to share their experiences. One cannot assume that their perspectives and experiences are representative of all counseling students in their program, nor those who may be currently studying in other counseling programs.

Purposeful sampling is not intended to support broad generalizations, but instead to provide information-rich cases related to the phenomenon of interest (Palinkas, et al., 2015). In this study, I attempted to provide vivid descriptions of the particular details of the key informants’ characteristics and circumstances in order to encourage analysis of these conditions and findings that would allow considerations of transferability (Yin, 2016). Both are valued purposes of qualitative research, but are recognizably different than the statistically and probability-based generalization common in quantitative research. Readers of this study will need to judge for themselves the appropriateness of applying the findings to another sample profile, setting, or case.

While I attempted to bracket my perspective on this phenomenon and keep it separate from the data provided by the informants through the use of journaling and field notes, phenomenological descriptions are always limited by a researcher’s orientation, interest, questions, and circumstances. It is possible that, despite my best attempts at bracketing the data, some of my personal beliefs could have potentially affected the data, leading to another potential limitation of the study.
Conclusion

The purpose of this qualitative study was to examine, describe, and understand how the attitudes and beliefs of counseling students regarding the use of medication assisted treatments develop, and how these attitudes and beliefs may affect client care and professional career choices. This study examined how their professional counselor education experiences played a role in the formation/development of these attitudes and beliefs.

The data from six key informants was collected through individual, semi-structured interviews. Based on the analysis of their attitudes, beliefs, and experiences, a total of twenty-five themes emerged in relation to the six research questions posed in this study. These themes revealed that counseling students may have negative attitudes and beliefs towards clients who use medication assisted treatment options. While these negative attitudes were present, some of the informants provided data to suggest that they were able to identify positive aspects and the utility of this approach to opioid addictions treatment. Specifically, there was some recognition that clients were able to use medication assisted treatment to support their recovery. The participants’ perceptions of clients who choose medication assisted treatment was developed during their professional counselor education experience and their personal experiences.

One factor that appears to be related to the development of attitudes toward medication assisted treatment is the limited exposure to this treatment modality provided during the participants’ formal counselor education and training. This lack of knowledge and experience resulted in the participants having a limited understanding of the modality, and ultimately the clients who use it. In this study, this situation demonstrated the potential to cause misinformation and misperceptions to develop. This finding is consistent with prior research suggesting that the acceptance of medication assisted treatment has been correlated to a
counselor’s level of formal education (Forman, Bovasso, & Woody, 2001; Rieckmann, Kovas, McFarland, & Abraham, 2011; Fitzgerald & McCarty, 2009; Humphreys, Noke, & Moos, 1996). Additionally, it has been found that counselors who are exposed to and encouraged to adopt evidence based practices during their academic training are at an increased likelihood of accepting harm reduction practices (Bride, Abraham, Kintzle, & Roman, 2013).

Other experiences in a counseling student’s life appear to affect their perceptions of medication assisted treatment as an effective and legitimate treatment modality, as well as their negative perceptions of the associated clients. The participants’ appeared to acknowledge that ineffective client care was related in part to their attitudes and beliefs about MAT. The concerns of counselors-in-training regarding their ability to provide quality care appeared to be related to the participants’ concerns over their lack of knowledge and their limited educational experiences with medication assisted treatment. As a result, participants seemed to identify that it is this lack of knowledge and experience that also has an influence on their career choices.

This study provided a unique analysis of how counseling students’ pre-professional education and other personal experiences affect their perceptions of medication assisted treatment and clients who chose medication assisted treatment to support their recovery. In this research, I examined the professional counselor educational experience and how students’ lack of knowledge may be a significant or important factor in their development of perceptions and attitudes toward the practice of MAT. The intent of this study was to provide counselor educators with a richer and thicker description of this phenomenon of how the education they provide may shape the attitudes and beliefs of their students in relationship to MAT and clients who elect to utilize this treatment approach. The hope of this researcher is that the results of this study will stimulate additional research in this area and encourage counselor educators and the
professional associations responsible for defining training standards, including The Council for Accreditation of Counseling & Related Educational Programs (CACREP), to reflect on how the educational content and associated field experiences provided to counseling students can be evaluated and adjusted to better prepare students to address clients with opioid dependence.
References


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http://www.nami.org/Content/NavigationMenu/Inform_Yourself/About_Mental_Illness/About_Treatments_and_Supports/Cognitive_Behavioral_Therapy1.htm


Email invitation

Dear Counseling Student,

My name is Bethany Ackerman and I am Doctoral Candidate in Duquesne University’s Counselor Education and Supervision Program. I am conducting my dissertation research on counseling students’ attitudes and beliefs towards the use of the medication assisted therapy for the treatment of opioid dependence. I am looking for students who are willing to participate in an initial 30-60 minute individual interview. The total time commitment should not exceed 1 hours. You will be compensated with a $10 Starbucks gift card for the interview.

In order to be eligible to participate, you must be currently enrolled in a CACREP accredited counseling program at the Master’s level. Also, you must have completed at least one semester of your fieldwork.

If you have any questions or are interested in participating please contact me at ackermanb@duq.edu or xxx-xxx-xxxx. If you are interested in participating, please include your name, email address, and telephone number so that I may contact you.

This study has been approved by Duquesne University Institutional Review Board.

Thank you in advance.

Sincerely,

Bethany L. Ackerman, MS, LPC, NCC
Doctoral Candidate
Duquesne University School of Education
CONSENT TO PARTICIPATE IN A RESEARCH STUDY

TITLE: A Qualitative Study of Counseling Students’ Attitudes Toward the Use of Medicated Assisted Treatments in the Treatment of Opioid Dependent Clients

INVESTIGATOR: Bethany L. Ackerman, MS, LPC, NCC
Doctoral Candidate
Duquesne University School of Education
Pittsburgh, PA 15282
Phone: xxx-xxx-xxxx
Email: ackermanb@duq.edu

ADVISOR: (if applicable) William Casile, Ph.D.
Duquesne University School of Education
Pittsburgh, PA 15282
Phone: 412-396-6112
Email: casile@duq.edu

SOURCE OF SUPPORT: This study is being performed as partial fulfillment of the requirements for the doctoral degree in Counselor Education and Supervision at Duquesne University.

PURPOSE: You are being asked to participate in a research project investigating the attitudes and beliefs towards the use of medication assisted treatment in the treatment of Opioid Dependent clients.

In order to qualify for participation, you must be enrolled in a CACREP accredited counseling education program and...
also have completed at least one semester of your fieldwork experience.

PARTICIPANT PROCEDURES:

To participate in this study, you will be asked to complete a short demographic questionnaire and participate in an individual interview about your thoughts, feelings, and beliefs about the use of medication assisted treatment as a treatment for opioid dependent clients. The interview will ask about your knowledge of medication assisted treatment, your educational history in regards to medication assisted treatment, your experience with using medication assisted treatment as a treatment option, and your perceptions of individuals who use medication assisted treatment as a treatment option. These interviews will be audio recorded, but any information that identifies you will be removed when the recordings are transcribed. It is estimated the total time of involvement for the individual interview will be 30-60 minutes. The total involvement time of this study should not exceed 1 hour.

These are the only requests that will be made of you.

RISKS AND BENEFITS:

Information gathered through this research project will add to our understanding of how education and experiences may affect a counseling student’s attitudes and beliefs towards the use of medication assisted treatments as a treatment option for opioid dependent individuals. In an interview setting, it is impossible to predict all the topics may arise during the course of the individual interview. Topics discussed will include, but are not limited to, your knowledge of medication assisted treatment, your educational history in regards to harm reduction practices, in particular medication assisted treatment, your experiences with medication assisted treatment as a treatment option, and your perceptions of individuals who use medication assisted treatment as a treatment options. It is likely that these topics are discussed within the counseling profession and within the education community, so we do not expect any risk from such conversations. A trained counselor will be conducting the individual interview and will lead the discussion to minimize risks to participants.
COMPENSATION: At the end of the individual interview each participant will be given a $10 Starbucks gift card for their participation in each interview. Total compensation will not exceed $10 for participation in this study.

Participation in the project will require no monetary cost to you.

CONFIDENTIALITY: Your participation in this study and any personal information that you provide will be kept confidential at all times and to every extent possible.

Your name will never appear on any survey or research instruments. All written and electronic forms and study materials will be kept secure. Your response(s) will only appear in statistical or narrative data summaries. Any study materials with personal identifying information will be maintained for three years after the completion of the research and then destroyed.

The audiotapes, field notes, transcripts, participant codes, and all data backup files will be kept in a secure safe. Once the audiotapes are transcribed, they will be deleted. The researcher will keep the field notes and transcripts for no less than 3 years from the completion of the study.

RIGHT TO WITHDRAW: You are under no obligation to participate in this study. You are free to withdraw your consent to participate at any time by notifying the researcher in writing of your desire to withdraw consent to participate. Any data obtained up to that point will not be used.

SUMMARY OF RESULTS: A summary of the results of this research will be supplied to you, at no cost, upon request.

VOLUNTARY CONSENT: I have read the above statements and understand what is being requested of me. I also understand that my participation is voluntary and that I am free to withdraw my consent at any time, for any reason. On these terms, I certify that I am willing to participate in this research project.

I understand that should I have any further questions about my participation in this study, I may call Bethany Ackerman, MS, LPC, NCC at xxx-xxx-xxxx or Dr.
William Casile at 412-396-6112. Should I have questions regarding protection of human subject issues, I may call Dr. David L. Delmonico, Chair of the Duquesne University Institutional Review Board, at 412.396.1886.

Participant's Signature  Date

Researcher's Signature  Date
Appendix C
Identification Code: _____________

Questionnaire

Please complete the following information and bring to the individual interview.

1. Age: ___________
2. Telephone Number: _______________________
   a. Can a message be left at this number? Yes or No
3. Program (Please circle):
   a. Masters in Clinical Mental Health Counseling
   b. Masters in School Counseling
   c. Masters in Marriage, Couple, and Family Counseling
   d. Other (Please Specify): _____________________________________
4. Are you Part-time or Full- time? ______________
5. How far along are you in your counseling education program?
   a. ≤ 1 year
   b. ≤ 2 years
   c. ≤ 3 years
   d. Other (Please Specify): __________________________
6. Did you transfer from another program? Yes or NO
   a. If yes, was that school CACREP accredited? Yes or No
7. Do you have any work experience in an agency or program where clients receive addictions treatment? Yes or No
   a. If yes, what is the name of the program? _____________________________
8. How many addiction counseling classes have you completed? ______________
9. What were the names of these courses? _____________________________________

10. Did the courses discuss medication assisted treatment? Yes or No
11. Have you completed your:
    a. Practicum? Yes or No
    b. Internship I? Yes or No
    c. Internship II? Yes or No
    d. Do you have any professional counseling experience? Yes or No
12. Have you worked with opioid dependent individuals in practicum, internship, or professional experience? Yes or No
    a. If yes, how much experience do you have?
       ________ number of clients seen _________ months of treatment
13. Have you worked with individuals in medication assisted treatment in practicum, internship, or in any other professional experience? Yes or No
    a. If yes, how much experience do you have?
       ________ number of clients seen _________ months of treatment

Thank you for taking the time to complete this questionnaire.
Appendix D

Semi-structured interview questions

The following questions will be used to structure each individual interview:

1. What do you know about medication assisted treatment?
2. What did you learn about medication assisted treatment in school?
3. What are your thoughts regarding the use of medicated assisted treatment as a treatment option?
4. What comes to mind when you hear medicated assisted treatment?
5. What has your experience been with patients who use medication assisted treatment?
6. How do you perceive individuals who chose this treatment option?
7. Two of the more common medicated assisted treatment options are methadone and Suboxone, what are your attitudes towards these the use of these medicated assisted treatment options?
8. What are your feelings about counseling a patient who uses medication assisted treatment?
9. What would your thoughts be in regards to taking a position as a counselor treating patients who use medicated assisted as a treatment option for opioid dependence?
10. How do you feel your educational experience has prepared you for a possible job as a counselor working with patients who use medicated assisted treatment?
11. Were you exposed to patients on medicated assisted treatment in your fieldwork?
12. If you felt that it hasn’t prepared you, what do you believe may have helped prepare you?
13. What should I have asked you that I didn’t that would help me better understand your beliefs and attitudes regarding the use of medicated assisted treatment as a treatment option?