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# Nurse addiction -- an unexpected journey: a phenomenological study of nurses in recovery

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UNIVERSITY OF NORTHERN COLORADO

Greeley, CO

The Graduate School

NURSE ADDICTION--AN UNEXPECTED JOURNEY:  
A PHENOMENOLOGICAL STUDY OF  
NURSES IN RECOVERY

A Dissertation Submitted in Partial Fulfillment  
of the Requirements of the Degree of  
Doctor of Philosophy

Karen Lee Burton

College of Natural and Health Sciences  
School of Nursing  
Nursing: Education

August 2013

This Dissertation by: Karen Lee Burton

Entitled: *Nurse Addiction--An Unexpected Journey: A Phenomenological Study of Nurses in Recovery*

has been approved as meeting the requirement for the Degree of Doctor of Philosophy in College of Natural and Health Sciences in School of Nursing, Nursing: Education, PhD Program.

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## **ABSTRACT**

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Abuse of drugs and alcohol occurs across all cultures, generations, and occupations, including nursing. Nurse addiction is a topic of serious concern that is often dismissed or ignored in the profession. Impaired nurses can become dysfunctional in their ability to provide safe, appropriate patient care. This qualitative study explored the lived experience of nurses who were addicted to substances. Knowledge of this phenomenon may help guide nurses, nurse educators, and nursing students more accurately understand the reality of substance use disorder in the profession. In this qualitative study, 14 nurse addicts in recovery were interviewed about their experiences and risk perceptions. Five themes were identified from the study: (a) Fear was a significant part of the experience of being a nurse who was addicted; (b) Shame and guilt were felt by nurses who were addicted; (c) Poor coping: Addicted nurses reported having underdeveloped coping skills; (d) Control: Addicted nurses felt an increased need to control their environments; and (e) A core problem inherent in nurses who were addicted was a belief that addiction would never happen to them. Discussion of the five identified themes was followed by a discussion about addiction risk, prevention, and suggestions for application in nursing education. Participants discussed their experience with nurse addiction in their nursing education experiences and offered suggestions for more effective ways to teach the

subject in nursing school. Implications for nursing education were then discussed, including using peer educators, namely, recovering nurse addicts, as teachers of this subject. Finally, the overall theme identified was that addicted nurses often felt misunderstood and judged, and they desired to be accepted among others in the profession.

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## TABLE OF CONTENTS

CHAPTER		
I.	INTRODUCTION .....	1
	Introduction to the Problem .....	1
	Background .....	3
	Statement of the Problem.....	5
	Purpose of the Study .....	6
	Significance of the Study .....	7
	Research Design.....	10
	Research Question .....	11
	Definition of Terms.....	11
II.	LITERATURE REVIEW .....	15
	Theoretical Basis for Study.....	15
	Literature on Addicted Nurses .....	18
	Literature and Nurse Addiction Education .....	23
	Conclusions.....	27
III.	METHODOLOGY .....	28
	Introduction.....	28
	Research Problem and Purpose.....	29
	Research Design.....	29
	Target Population and Sample .....	30
	Sampling .....	30
	Recruitment of Subjects .....	31
	Procedures .....	33
	Methods for Data Collection.....	33
	Data Analysis Procedures .....	36
	Validity and Reliability .....	37



## CHAPTER

### III. continued

Ethical Considerations .....	39
Disclosed or Discovered Relapse.....	39
Risks and Benefits to Participants.....	41
Protection of Human Subjects .....	43
Measures to Ensure Trustworthiness .....	43
Audit Trail.....	44
Summation .....	46
IV. RESULTS AND DISCUSSION .....	47
Introduction.....	47
Study Data.....	47
Interviews.....	48
Participants.....	48
Participant 1-AL.....	52
Participant 2-ANNIE. ....	53
Participant 3-ASHLEE.....	54
Participant 4-BEN.....	56
Participant 5-BETH .....	57
Participant 6-CRAIG .....	59
Participant 7-DAN. ....	61
Participant 8-LACEY.....	63
Participant 9-LINDA. ....	65
Participant 10-MELISSA.....	67
Participant 11-MIKE.....	69
Participant 12-TAMARA.....	71
Participant 13-TERRY.....	73
Participant 14-VALERIE.....	75
Results and Findings .....	78
Presentation of Themes.....	78
Theme 1. Fear is a Significant Part of the Experience of Being a Nurse Who is Addicted .....	78
Theme 2. Shame and Guilt are Felt by Nurses Who are Addicted.....	89
Theme 3. Poor Coping: Addicted Nurses Report Having Underdeveloped Coping Skills .....	95

## CHAPTER

### IV. continued

Theme 4. Addicted Nurses Feel an Increased Need to Control Their Environments.....	105
Theme 5. A Core Problem Inherent in Nurses Who are Addicted is a Belief that Addiction Would Never Happen to Them.....	114
Discussion .....	121
Lived Experience of Nurse Addicts .....	121
Perception of Risk, Access to Drugs.....	121
Is There Anything that Might Prevent Nurse Addiction? .....	127
Nurse Addiction in Nurse Education .....	130
Recovering Nurse Addicts as Peer Teachers .....	135
 Overall Finding: Nurses in Recovery Feel Misunderstood and Judged, and Just Want to be Accepted.....	144
Summation of Analysis.....	151
 V. CONCLUSIONS AND RECOMMENDATIONS .....	153
Conclusions.....	153
Significance of the Study .....	156
Limitations .....	157
Recommendations for Further Research.....	159
Summary .....	160
 REFERENCES .....	162
 APPENDICES	
A. IRB Approval Letter .....	175
B. Letter from State of Utah Department of Commerce Agreeing to Help Recruit .....	177
C. Recruitment Flier .....	179
D. Participation Demographic Form.....	181
E. Interview Guide .....	183
F. Consent Form.....	185
G. Referral Sources for Participants .....	188
H. NVIVO® Query Graphics .....	190

## LIST OF TABLES

Table	
1.	Demographic Form Response Table.....49

## LIST OF FIGURES

Figure		
1.	Interaction Between Factors in Social Cognitive Theory .....	16
2.	Maslow's Hierarchy of Needs .....	81
3.	Mert's Adaptation of Maslow's Hierarchy of Needs into Hierarchy of Fear .....	82
4.	Photo of a Narcotics Anonymous (NA) Meeting in 1954 .....	143
5.	Comparison of Relapse Rates Between Drug Addiction and Other Chronic Illnesses .....	148

## **CHAPTER I**

### **INTRODUCTION**

#### **Introduction to the Problem**

A gap in the literature has existed related to nurses who were suffering from addiction and how they perceived their lived experience. This phenomenon has largely been overlooked from a qualitative standpoint, yet has continued to be a serious issue in the profession. Nurses need to understand the reality and experience of nurse addiction in order to recognize warning signs in colleagues as well as in themselves. Effective methods of educating nurses about nurse addiction has largely gone unexplored as well, though a need definitely has existed to change the way this sensitive subject was approached. The negative consequences of drug abuse and alcoholism have affected not only individuals who abused drugs but also their families, friends, employers, and associates. Government resources are frequently drained as a result of drug and alcohol abuse as well. Although many of these effects cannot be quantified, in 2007 it was estimated that the monetary cost of drug abuse to tax payers was nearly \$534 billion. These costs have come from increased health care, loss of productivity, premature deaths, crime, and auto accidents related to alcohol and drug abuse (National Institute on Drug Abuse [NIDA], 2007). Substance abuse has almost always caused problems in thinking clearly, in remembering, and in paying attention and staying focused. They often developed poor social behaviors as a result of their substance abuse, and their work

performance and personal relationships suffered. When science began to study addictive behavior in the 1930s, addicts were thought to be lacking in will power as well as in being morally flawed. Even in today's society, this view of addicts has often continued. Society has often viewed drug and alcohol abuse as a moral failing rather than a health problem. Despite advances in science, many people today do not understand why individuals become addicted to substances or what it was like to experience addiction (NIDA, 2007). The consequences of substance use have been vast and varied and have affected people of all ages and demographics.

With nurses specifically, substance abuse has not only decreased productivity in the workplace but has presented a risk to the patients being cared for by these impaired nurses. Increased patient risk and decreased nurse productivity has placed a heavy burden on employers. Nurse addicts are a unique population that have been explored from punitive and treatment perspectives but have rarely been explored from a qualitative standpoint. A more accurate knowledge and understanding of this population of nurses was needed in order to more effectively educate students about this issue in nursing school. The substance use patterns of nurses and their responses to addiction have been understudied phenomena, especially the relationship of substance use to the work environment (Trinkoff & Storr, 1994). In 1997, a need was identified and documented for continuing education in the area of addiction as it related not only to patient care but also to nurses who were susceptible to abusing substances (Pullen & Green, 1997). In 1998, the American Association of Colleges of Nursing (AACN) formalized this need in a position paper encouraging nursing schools to address this critical issue (AACN, 1998), yet nothing major has changed since these needs were identified. An accurate

understanding of nurses' experiences as addicts needs to be pursued in order to more effectively educate nursing students about this serious reality in the profession. Nurses have lacked knowledge regarding chemical dependency and were often unable to recognize the related risks, warning signs, and interventions in themselves or in their peers.

### **Background**

Substance use disorder has been and continues to be a primary, chronic, progressive, and often fatal health problem (Dunn, 2005). Substance abuse among nurses has existed for at least 150 years, with intoxication or substance impairment on the job existing even back when Florence Nightingale began her work in the mid-19th century (West, 2002). For each nurse who has admitted to having a substance abuse problem, there are surely many other impaired nurses who have remained unidentified and continued to practice (Pavlovich-Danis, 2000). The literature has suggested nurses are at similar risk for substance abuse disorders as the general public, but patterns of drug use among nurses were unique to the profession (Clark & Farnsworth, 2006). Substance impairment by nurses has often undermined their physical, psychological, social, and professional functioning and needs to be addressed from a prevention and health promotion standpoint as early as nursing school (Monroe, 2009). Nurse addiction can also cause strain to individuals and increased turnover in the nurse workforce.

The problem of nurse drug abuse was largely ignored until the late 1970s when the American Nurses Association (ANA) began its efforts to increase awareness on this issue and assist affected nurses (Clark & Farnsworth, 2006). While the exact percentage of addicted nurses in the United States has remained unknown, the ANA estimated that

approximately 10% of nurses were currently affected to the extent that job performance was impacted negatively (Copp, 2009). It is believed the percentage of nurses impacted by addiction closely resembles that of the general population at 10%, although this has not been fully documented. However, some estimates have placed rates of substance abuse and addiction rates as high as 20% among practicing nurses (Monroe & Kenaga, 2010). It is believed nurses have used prescription drugs (rather than illicit drugs) more often than the general public and were more likely to access drugs at their places of employment (Clark & Farnsworth, 2006). Left unchecked, substance abuse can exert profound effects on public safety and patient care.

Social Cognitive Theory (SCT) has been the underlying theoretical model which was considered as a basis for the study at hand. SCT has described the interaction between a person and behavior and has involved the influences of a person's actions and thoughts. Over time, life experiences form the basis for sets of beliefs and expectations that people have. These beliefs and expectations have operated to influence behavior. This often has happened without people's full knowledge and awareness of them. SCT has explained the ways in which people acquired and maintained certain patterns of behavior and even provided the basis for some intervention strategies (Bandura, 1997). Psychological interventions related to motivational learning and relapse prevention in the field of addiction have been traced back to social learning theory (McCusker, 2001). These therapeutic approaches have suggested that addictive behavior has been maintained by a biased belief system, with interventions aimed at cognitive restructuring. SCT has described a process in which personal factors, environmental factors, and human



behavior all influence one another, and this three-way relationship has been explored in the context of addiction recovery.

### **Statement of the Problem**

Though some quantitative studies on nurses and addiction existed in the literature, very little has been done to explore the actual feelings and lived experiences of addicted nurses in qualitative studies. Quantitative studies have discussed rates of treatment, alternate-to-dismissal policies, or other statistical information, but no articles were found that addressed the problem from the perspectives of the nurse addicts themselves. The experience of addiction is foreign to most non-addicted nurses.. Trying to understand it from a non-addict's viewpoint may not be the most effective way to gain understanding of what addicted nurses experience. Nurses and nurse educators need to have a better understanding of what it is like to experience nurse addiction in order to better assist and teach other nurses in the profession and to possibly prevent future problems with addiction among themselves and their students. Implications of understanding the lived experience of nurse addicts could include improved nurse education related to this topic in the future. Not only was there a shortage on qualitative studies describing lived experience of nurse addicts, but a disparity also existed between the prevalence of drug and alcohol problems in the profession and the attention being paid to the topic in nursing education (Hyman, 2004). Analysis of what nurse addicts have experienced could change current ways of thinking and teaching about nurse addiction. Management of substance abuse has depended upon education (AACN, 1998). Substance abuse content needs to be included in the nursing curriculum, and this education should be provided to nursing students, faculty, and staff. A more accurate understanding of the experiences actual

nurse addicts have had could potentially add greater understanding and unique knowledge that could then be used in educating about the experience of addiction. It could also potentially help plan treatment approaches for those affected.

### **Purpose of the Study**

The purpose of this study was to investigate, explore, understand, and describe the lived experience and risk perceptions of nurses who were addicted to drugs and/or alcohol. Another purpose for the study was to increase the knowledge base that nurses, nurse educators, and nursing students have regarding the phenomenon of nurse substance use and abuse and to explore the possibility of whether or not a more effective way of teaching this subject could be identified. In a position statement, the International Nurses Society on Addictions (IntNSA, 2002) asked that basic undergraduate nursing programs educate nurses on addiction knowledge, attitudes, biases, and fears. Deehan, McCambridge, Ball, and Strang (2002) suggested a majority of nurses would probably be interested in learning more about just what was a substance use disorder. A greater understanding of this phenomenon could assist practicing nurses in working with their peers who may struggle with drug addiction. There was an ongoing initiative to promote greater dialogue and communication about what nurses, administrators, and students could do when they suspected someone in their profession was abusing substances or when they themselves may have been suffering from addiction (Monroe, 2009; Monroe & Pearson, 2009). More vigilant efforts toward identification, intervention, and retention of nurses with substance use disorder should become a priority. Awareness needs to be followed by actions. Learning more accurately about substance use disorder could not only help nurses help addicted peers but could also help them understand and identify

risks they themselves may have related to becoming addicted. Knowing what actual nurse addicts experience would provide insight into those thought processes and aid educators and nurses in more accurately recognizing and understanding this phenomenon. Further, insights from nurse addicts would be elicited regarding what may have prevented them from falling into addiction and what they may have felt to be a more effective way to teach this topic in nursing school. Learning what nurses who have experienced addiction thought about possible education and prevention strategies may be instrumental in improving the way the subject of nurse addiction could be presented in nurse education.

### **Significance of the Study**

Nursing schools have been and continue to be challenged to integrate substance abuse and addiction content into both their undergraduate and graduate curricula (Hagemaster, Plumlee, Conners, & Sullivan, 1994). It has been proposed that, for many nurses, substance abuse has begun while attending nursing school (Coleman et al., 1997). Governing nursing education bodies have issued challenges to address the issue more thoroughly (AACN, 1998). All of these efforts to improve education on this topic could not be done without special attention being given to understanding the experiences and perceptions nurses struggling with addiction have had. Nurses who have lived the experience would be able to share their knowledge and unique perspectives to further the knowledge of this often ignored or masked topic. No literature was found addressing the lived experience of nurse addicts specifically, yet educators have had a charge to teach this vital information to students. The significance of the proposed study was that a different perspective on the phenomenon of nurse addiction may become available to help nurses, educators, and students understand the realistic experience of addiction. This

different perspective, should one emerge, could aid nurses in avoiding or recognizing the pitfalls of substance use should they arise in themselves or others. Students and faculty need to be able to understand the contributing factors of addiction, as well as be able to assess the reality and extent of this problem. They need to be able to recognize the signs and symptoms of addiction in order to effectively intervene or teach about it (Coleman et al., 1997). Drug and alcohol addiction are influenced by many risk factors, both in the affected individuals and in their environments (Nurco, Hanlon, O'Grady, & Kinlock, 1997). Certain individual factors such as a nurse's substance use, knowledge about abuse, and access to drugs may have influenced the presence or absence of a substance use disorder (National Council of State Boards of Nursing [NCSBN], 2011). Understanding the lived experience of nurses who were addicted may help students identify their own risk factors for addiction before entering the workforce. They may have a more realistic and accurate picture of what it would be like to be a nurse and have access to drugs and how to work with these drugs appropriately.

Many risk factors have been identified related to substance abuse and addiction in nursing. Some nurses have reported risk factors including high achievement in school and numerous consequences, including failing grades and physical symptoms. These events have ended up resulting in drug use (West, 2002). Others showed that nurses who became addicted often had a family history of alcoholism or addiction or had problems with depression (West, 2002). Some had experienced sexual abuse. Others had been academically and professionally successful but had extensive medical histories which put them at risk. Burnout, anxiety, and stress have also been suggested as risk factors for substance-related problems (West, 2002). Many students have experienced some of these

risk factors for addiction but may not realize it. Having nurse addicts describe and make sense of their own addictions may help other nurses, nursing students, and nurse educators. Quite a bit of research could be found on risk and on addiction in general. Very little research could be discovered on the assessment of risk for addiction as it has related to nursing students, however. Risk for addiction in nurses has not specifically been addressed recently as much as it was in the 1970s and 1980s, yet the problem has continued to impact the profession with dire consequences. Some have looked at risk for addiction in nursing, but most of the literature related to current use of drugs, not the risk of future use. Understanding the lived experience of nurse addicts may help educators recognize some of these risks in their students and even in themselves. It would also help them teach the seriousness and complexity of addiction more realistically, hopefully thus, improving the chances for future risk identification.

Nurses' understanding of how nurse addicts feel and act has remained very limited. Often students and nurses have chosen not to think about nurse addiction because it was not something they understood, and they felt uncomfortable with the subject (Kunyk & Austin, 2012). Not only have many people felt uncomfortable with the subject, but biased attitudes toward addicted individuals still have prevailed in contemporary nursing (Lovi & Barr, 2009). The stigmatizing attitude of nurses and other healthcare professionals has been shown to affect the retention and recruitment of those in treatment for addiction (Lovi & Barr, 2009). Additionally, stigma has limited access to resources, thus contributing to the problem of people with dependency not receiving the quality of care they deserve.

Currently, curricula to help nursing faculty and students understand the current societal and professional demands and standards related to substance abuse in nursing is being implemented in some nursing programs worldwide (Hyman, 2004). However, the need for more education on this subject has become more and more apparent in recent years. In addition, more research is needed, especially qualitative research on this topic, so nurses and nursing students can have a more accurate understanding of phenomenon of nurse addiction. Nurse educators must do more than just provide information about substance abuse. Understanding why nurses have misused substances would add a more human dimension to the experience of addiction, which could ultimately prevent nurses from demonizing their colleagues who are affected with the problem (Dunn, 2005). It could also help nurses realize their own risks for becoming addicted to drugs or alcohol. According to the National Council of State Boards of Nursing (NCSBN, 2011), education on this subject must become a vital part of all programs' missions.

### **Research Design**

Giorgi's (2009) method of phenomenological investigation was used in this qualitative study. This design was chosen in order to achieve the purpose and aims of the study. The approach for this research design was built upon Husserl's phenomenological philosophy, which has a purpose of studying the "life-world in its appearing" (Ashworth, 1996, p. 146). This life-world embodied all the immediate, self-evident, and given experiences, activities, and contacts that a person has with reality. Husserlian phenomenology has adopted a philosophy which has aimed to explore the experiences of a specific population, arguing that, to understand a phenomenon, one must examine personal experiences and the meaning that one attributes to those experiences (Lovi &

Barr, 2009). According to Crotty (1998), to become aware of a phenomenon by way of this method as important as “what is known is in the knower,” which was aligned with Husserl’s idea he called the intentionality of consciousness (Husserl, 1970). In the report of findings in this study, descriptions has been provided describing what it was like to experience the phenomenon of nurse addiction. These descriptions were based on what the nurses expressed and communicated about it in their interviews--both verbally and non-verbally. A non-probability, purposive sample of 14 nurses experiencing addiction were recruited. Participants were interviewed until saturation of data occurred--meaning no new information was being discovered.

### **Research Question**

The research question explored in this qualitative study was the following: What is the lived experience of nurses who have been addicted, and how do they perceive their risk was for addiction?

### **Definition of Terms**

In 2011, the National Council of State Boards of Nursing (NCSBN) released a resource manual and guide for substance use disorder (SUD) in nursing. They defined the term *substance use disorder* as the “. . . full range of complaints from abuse to a dependency or addiction to alcohol or drugs” (NCSBN, 2011, p. 1). The term *addiction* referred to any compulsive use of substances or chemicals (drugs and alcohol) and the inability to stop using them despite the problems that occur as a result of their use. The NCSBN (2011) further explained a person with addiction was unable to stop drinking or taking drugs despite serious economic, health, legal, vocational, spiritual and social repercussions. The terms SUD, addiction, and substance abuse describe the same

phenomenon, but SUD was the most recently accepted term by the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders DSM-IV-TR (NCSBN, 2011). Some people felt the labels given to people with alcohol and drug problems could contribute to stigmatization, de-medicalization, and criminalization of these problems (White, 2007). For example, one recent study found that, when an individual was referred to as a "substance abuser" rather than having a "substance use disorder," they were less likely to be treated therapeutically and more likely to be treated punitively (Kelly, Dow, & Westerhoff, 2009). For the purposes of this study, the terms *substance use disorder*, *addiction*, and *substance abuse* were used interchangeably but refer to the same thing.

To theoretically define *risk for addiction*, it was necessary to look first at the definition of *addiction*, and separately at the definition of *risk*. With a better understanding of the two separate concepts, the more specific concept of *risk for addiction* could be explored. First, in order to define *addiction*, the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) provided valuable information about the definition and criteria for substance dependence (or addiction). Substances were usually interpreted as drugs of abuse, such as cocaine, ethanol, opiates, and so forth. These types of substances cause habits or addictions to form. For a person to be considered dependent on (or addicted to) a substance, at least three of the following seven criteria must be met within any part of any given year: (a) tolerance (more drug is needed for the same effect), (b) withdrawal, (c) taking a larger amount of the substance or taking the substance for a longer period than was intended, (e) experiencing a persistent desire for the substance or an inability to reduce or control its use, (f) spending much time



seeking or consuming the substance or recovering from its effects, (g) use of the substance interfering with important activities, and (h) use of the substance continuing despite known adverse consequences (American Psychiatric Association [APA], 2000). As this list of criteria suggested, addiction generally has psychological and physiological implications. Addiction describes dependence on substances--both physically and psychologically.

*Risk* has been defined as a “. . . measure of the probability and severity of adverse effects” (Aven, 2010, p. 623). Another definition given for risk was “. . . the combination of probability of an event and its consequences” (Aven, 2010, p. 623). That which was common for these and other definitions of risk was that the concept comprises events, consequences (outcomes) and probabilities. Risk defines a situation or event where something of human value (including humans themselves) was at stake and where the outcome was uncertain (Aven, 2010). Outcomes, usually negative when related to risk, were also uncertain and vary in severity.

In Utah and several other states, there were two different pathways nurses may have to take when a substance abuse problem had been identified. For nurses (or any licensed professional) who has been caught that did not have any legal charges and have never been disciplined before, a program titled *URAP* (Utah Recovery Assistance Program) was available. It was a 5-year program in which qualifying licensees contracted to do certain things. If completed successfully, no record would exist related to the substance abuse breach on the license. *URAP* was also often called *Diversion* or the *Diversion Program*. These three things all described the same program. The other program in Utah was called *DOPL* (Department of Occupational and Professional

Licensing). This program was a 5-year probationary program for second offenders or those who had legal repercussions from their addictions. DOPL was also sometimes called the Board or the Disciplinary Board. References to *URAP*, *Diversion*, *DOPL*, and the *Board* were throughout the interviews, so an understanding of these two programs was useful.

*IOP* was mentioned frequently, and stands for Intensive Outpatient treatment. This was usually about six to eight weeks of substance abuse treatment which took place for about four hours a day, five days a week in an outpatient setting. *Aftercare* referred to the support groups that met for up to two years wherever graduates of IOP met weekly to follow up their IOP treatment. Aftercare took place at the many different IOP sites and facilities.

Finally, according to the Merriam-Webster Online Dictionary, the definition of experience (2013) was “a direct observation of or participation in events as a basis of knowledge” (para. 1). This definition was the foundation of exploring lived experience of any population, and specifically the experience of nurse addicts. However, the word *experience* had special meanings in Husserlian phenomenology, according to Giorgi (1997). It was a special kind of awareness--a conscious acknowledgement of the presence of a situation, person, place, or thing that was experienced. In this research study, the term *lived experience* meant an awareness or actual presence in the experience of each participant in nurse addiction. The experience they had lived as it related to nursing, risk perception, and addiction would all be included in their *lived experience*.

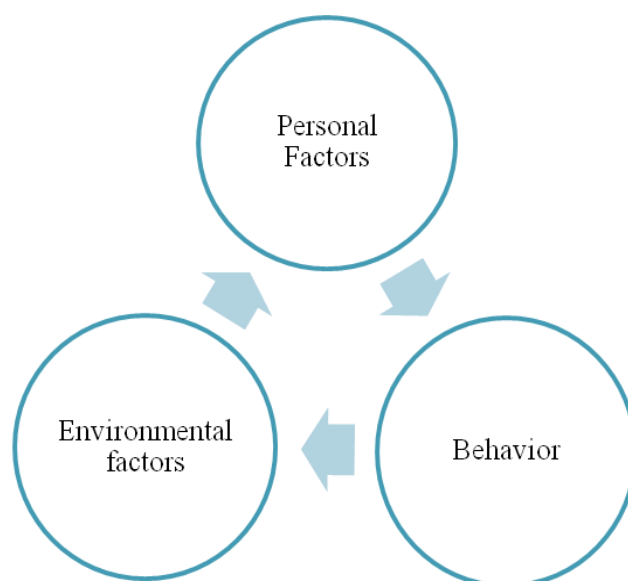
## **CHAPTER II**

### **LITERATURE REVIEW**

#### **Theoretical Basis for Study**

Theoretical or conceptual frameworks have often been necessary foundations for all types of research studies (Houser, 2008). Theory and practice, together with research, help define the science and art of nursing (Wilson-Thomas, 1995). Some theories and/or frameworks which have attempted to explain addiction exist, but because qualitative literature on nurse addiction is rare, very little could be discovered in the literature as a foundation for this particular type of study. Related to addiction in general, some people suggested “genetic” theories while others considered “exposure” theories. In addition, some considered addiction to be a “disease of the brain” while others considered it a “psychiatric illness”. Some people have even continued to believe the foundation of addiction was “moral flaw”. “Adaptation” theories related to addiction existed in the literature. Current interventions relating to relapse prevention in addiction and motivational interviewing have sometimes had their roots in social learning theories (McCusker, 2001). Because the literature was so varied related to nurse addiction, theoretical frameworks relevant to what literature is there was difficult to synthesize. For the study presented in this dissertation, a general social learning theoretical framework was chosen as the foundation for the study. That theory was Social Cognitive Theory

(SCT). Social Cognitive Theory is particularly relevant to a study on nurse addiction as it has been applied across psychology, education, communication, healthcare, and other settings. SCT has suggested people acquire knowledge by observing others in social interactions, experiences, and other outside contexts such as the media. SCT's roots originated in the work of social learning theory in 1941, and were then expanded upon by psychologist Albert Bandura beginning in 1962 to the present time (Miller & Dollard, 1941; Bandura, 1997). The theory has provided a framework for understanding, predicting, and helping with the change of human behavior. SCT was built upon the idea that people learn by observing others and what they will and will not do. Within the context of SCT, a person's behavior, actions, and thoughts interact with one another (Bandura, 1997). Bandura (1986) suggested human behavior could be explained visually in terms of a 3-way reciprocal model, which is portrayed in Figure 1.



*Figure 1.* Interaction Between Factors in Social Cognitive Theory

As the model portrays, SCT describes an ongoing, interactive process where personal factors, environmental factors, and human behavior all influence one another. Glanz and Bishop (2010) have added to former knowledge of the theory by suggesting the key parts that are especially relevant to health behavior and change are *observational learning, reinforcement, self-control, and self-efficacy*. SCT has suggested people learn not only by their own experiences, but also by observing the actions of others and the results of those actions. According to the National Cancer Institute (2005), within the theoretical framework of SCT the three main factors that would affect a change in health behavior were *self-efficacy, goals, and outcome expectancies*. Further, a key aspect of SCT has included the idea of personal agency and choice as vital in contributing to the ability to change behaviors—especially when faced with challenges or obstacles. When people felt they could not choose to exercise control over a health behavior, they were not motivated to act or to persist through certain challenges they may have faced. Personal agency and power to choose have been a key component of behavior change within the context of SCT.

Based on the aforementioned concepts and factors related to SCT, the theory has been chosen and presented as the theoretical framework underlying the phenomenon of nurse addiction in this study. Only one article was found connecting SCT with addiction specifically. Heath, Andrews, Kelley, and Sorrell (2004) saw the connection between these two factors when they said, “Inherent in most addictive behaviors is a framework of social learning in which several psychosocial factors initiate, maintain, and/or contribute to the relapse of an addiction” (p. 396). Because recovery from addiction was a dramatic example of behavior change, including the need to exercise agency, this theory related

well to the population of recovering nurse addicts. Substance use disorder, like Social Cognitive Theory, has integrated concepts and processes from cognitive, behaviorist, and emotional models of behavior change. This is why the framework works so well with addiction. SCT supports the need for this study because of its application not only in psychology but in education. The theory has been used in the past for designing health education and health behavior programs (University of Twente, 2010), so it was chosen as a foundation for the study exploring nurse addict behavior and its resultant discussion on nurse education.

SCT offers an explanation of how people obtain and maintain certain behavioral patterns and how they can be used for providing the basis for intervention strategies. The concepts in this social cognitive approach relate well to phenomenology because the theory offers a way to describe personal experiences in terms of thinking patterns and patterns of social interaction. The phenomenological approach focuses on individuals' subjective experiences as he or she encounters those events. The Social Cognitive Theory provides a framework in which to view the phenomenon of nurse addiction in terms of a response or reaction in a social context. Whether or not nurses felt being in the profession puts them at risk for addiction related to this social context as well as other environmental contexts. To obtain a useful starting point for applying this Social Cognitive Theory to this phenomenological study, a search of the available literature was necessary. Discussion of some of the discovered literature follows.

### **Literature on Addicted Nurses**

Extensive review of the literature was done to determine and document the need for this qualitative study. In an effort to understand what literature existed on the topic of

nurse addiction, a preliminary review of the literature was conducted on the subject of nurse addiction. Studies exploring lived experience of addicts and other aspects of the phenomenon were sought out. Several quantitative studies were discovered, however, qualitative studies were rare in this area of review. Very little research, especially qualitative research, could be identified. No other qualitative study on nurse addiction from the perspectives of the nurses was found. Once again, because the literature varied so greatly in the focus of the studies on nurse addiction, a synthesis of available research was difficult to achieve. The only qualitative study related to the topic looked at the experiences of tobacco-dependent nurse practitioners (Heath et al., 2004). This study was the closest thing the researcher could find to a qualitative approach to nurse addiction. The purpose of the Heath et al. (2004) study was to see how nurse practitioners who smoked and were dependent on tobacco would describe their experiences with health promotion/disease prevention practices with their patients who were also smokers. As healthcare providers who taught health promotion to patients yet smoked themselves, they talked about their own experiences in these situations. Because tobacco is legal, lived experience of these nurse practitioners would most likely be different than the experience of nurses who were addicted to narcotics, but no studies on nurses addicted to narcotics could be found.

Three themes emerged in the study about tobacco-dependent nurse practitioners which included living as an insider in the world of tobacco addiction, having the outside-in view of living with a tobacco addiction, and being caught in the middle of a tobacco addiction (Heath et al., 2004). As mentioned already, though, no other qualitative research studies could be located with *nurses* describing the lived experience of

addiction. Some qualitative studies were found which presented lived experiences of drug addicts in general, but the addicts studied were not nurses. One such study by Järvinen and Andersen (2009) explored drug addicts and their formations of meaning in the experience of drug addiction. They specifically studied the “labeling” of addicts--and whether or not addicts felt this labeling caused them to relapse, fulfilling, in essence, a form of self-fulfilled prophecy. Themes were discovered in this study involving self-determination, replacing one type of drug for another and the principle of stabilization.

Further exploration of the literature revealed a few more qualitative studies on addicts of different types. Haight, Carter-Black, and Sheridan (2009) sought to explore the lived experience of rural, Midwestern women who had experienced methamphetamine addiction by implementing a case-based analysis method. Another group of researchers also looked at women, but in this case the addiction was to alcohol (Thurang & Tops, 2012). This study, unlike that of Haight et al. (2009), used a phenomenological method to study lived experience of women who experienced alcohol dependency. Women have not been the only subjects studied qualitatively, however. In a study by Zakrzewski and Hector (2004) looked at the lived experiences of men addicted to alcohol and participating in alcoholics anonymous.

In a paper by Larkin and Griffiths (2002), the argument was made that subjective accounts related to addiction and recovery are needed in order to fully understand the experience of these phenomena. Though this paper was not a research study, the authors made many points arguing that psychology specifically needed to acquire more accurate, subjective knowledge about addiction. They submitted this needed to be done by obtaining and studying more personal, qualitative reports from addicts.



Although more qualitative studies could not be found related to the population of nurse addicts specifically, many quantitative studies were discovered addressing this topic. Studies with nursing *students* were addressed first. A study by deAbarca and Pillon (2008) explored nursing students' perceptions regarding what the predicting factors of drug use were. The participants in this study identified family factors and drug use history as predictive factors of substance abuse in nurses. Baldwin, Bartek, Scott, Davis-Hall, and DeSimone (2009) also looked at health professions students by assessing alcohol and other drug use behaviors in this population. With a large sample size of 2,646, this study presented students who identified family history and past alcohol abuse as major risk factors in becoming addicted to drugs later on. In both of these studies where health professions students were asked about risk for addiction, they both concluded the result of students believing family history was a major indicator of risk in themselves or other nurses. These two studies would indicate healthcare professions students were aware of risk related to family history and past substance abuse as important when considering their own risk for addiction. This aspect of risk for addiction is a part of the study being explored in this dissertation, but it is only a part of the study. Neither of these studies collected any qualitative data.

Nothing more recent could be located, so the search for literature was expanded to include studies dating back a few more years. A study titled "Early Risk Indicators of Substance Abuse among Nurses" (West, 2002) provided useful information related to student nurses and their perspectives of their risks for nurse drug addiction. This quantitative study sought to investigate early risk factors leading to substance abuse and/or addiction. Unlike the studies by deAbarca and Pillon (2008) and Baldwin et al.

(2009), another purpose of the West (2002) study was to predict group differences between impaired and non-impaired registered nurses. Nurses who had been impaired were at least studied in this effort. In her study, she found the nurse addicts and non-addicts differed significantly on risk predictor instrument findings. Her main conclusion was that early identification of nurses who were at risk for addiction or impairment would allow for earlier intervention with these nurses and possible prevention of nurse drug abuse.

Moving from students specifically to nurses in general, Monroe and Kenaga (2010) wrote a discursive paper titled “Don’t Ask Don’t Tell: Substance Abuse and Addiction among Nurses.” Although this was not a primary research report, it synthesized results from three previous papers that independently reported on substance abuse policies in nursing. The authors also discussed ways in which healthcare providers and students could assist in bringing to light a colleague or co-worker who was suspected for substance use. The article brought to light the topic of nurse addiction by discussing challenges these nurses faced with different types of policies and interventions being utilized currently in the profession. The authors concluded that intervening early with substance-abusing nurses was essential in helping them recover from addiction. They also suggested providing a non-punitive atmosphere of support which could be an imperative, life-saving first step for these nurses. They suggested poor policies were at the core of poor outcomes for affected nurses.

The next study did not look at policies specifically, but did look at past documentation for their database. Clark and Farnsworth (2006) conducted a study which looked at 207 state nurse addict files in Idaho and made recommendations for early or

regular screening for nurses, more financial assistance, and greater publicity concerning the availability of state programs like the ones in Idaho. A similar study which looked at records of nurses and physicians with substance use disorders was done by Shaw, McGovern, Angres, and Rawal (2004). They found nurses and doctors showed comparable results in some areas, but they displayed differences in others. Doctors and nurses in this study were similar in demographic variables (race, age, religious affiliation, and marital status) and both identified occupational distress as being a precipitant to substance abuse. They showed comparable results on most areas studied, though nurses showed much less personality disturbance than the physicians did. Both groups attributed their recovery success to effective treatment programs and professional follow-up.

### **Literature and Nurse Addiction Education**

Since at least the 1950s, nurse educators have been encouraged to include formal content on substance use and abuse in their curricula. In 1998, the American Association of Colleges of Nursing (AACN) released a position statement addressing proposed guidelines and policy for managing substance abuse education in nursing curricula. Ironically, nothing has been proposed since that time by a nurse education authority addressing nurse addiction and education. The position statement that was issued has gone largely unnoticed by the profession, yet the problem of nurse addiction and the need to include it in nursing curricula has continued on.

The 1990s presented a time of increased awareness of nurses and drug addiction, with the literature of that time stressing concern for the problem of nurses and substance abuse. Ironically, the AACN's statement came out during that time period as well. In that decade, nursing schools were being challenged to integrate alcohol and other drug abuse

content into both their undergraduate and graduate curricula (Hagemaster et al., 1994). In fact, they recognized that, for some people, the abuse of substances began while going to nursing school (Coleman et al., 1997). The 21st century seemed to have lost some of that focus on nurse addiction education and has focused more on statistics, treatment, and dismissal policies of nurse addicts, with little attention being given to nursing students' need for education. However, Monroe (2009) suggested that substance abuse among nurses often began before or while they were in nursing school. He cited studies reporting nursing student stress and burnout being related to an increased rate of substance abuse, with up to 14% reporting a problem with alcohol, but the studies cited by him all took place in the 1980s. Rates of nursing students who use or abuse alcohol and/or drugs were extremely difficult to find in recent literature, so the extent of this problem was difficult to estimate. Though the exact extent of the problem of nursing student addiction was not fully understood, educating these students about the pitfalls of becoming addicted as nurses could be an important step in bringing this important subject to light.

This study looked at nurse drug addicts with a purpose of exploring new information that could contribute to providing a foundation or improved education in nurse programs related to this serious topic. As mentioned before, substance use and abuse could lead to serious psychological, physical, and social problems including everything from the loss of employment to death. The AACN asserted high school and college students were in the segment of the population most at risk for addiction, stating that, of the 13.9 million illicit drug users in the United States, the highest rate of use was for those between the ages of 16-20, with the same age group having the highest rate of alcohol abuse as well (AACN, 1998). Substance abuse was a major issue for nursing

students, faculty, and staff, and could significantly compromise the learning environment. Impaired nurses, students, or faculty may have impaired judgment and skills, so appropriate education and management of abuse and addiction are critical for nursing education and practice. Education on nurse addiction may help identify nursing students as well as working nurses who were at risk for becoming addicted. Having nurses with experience in dealing with addiction in their own lives share their experiences may bring some clarity into the lives of nurses, educators, and students. It may also facilitate application in their own lives and practice. They could then relate what they had learned from the nurse addict(s) to their own level of risk related to substance abuse and addiction (Hyman, 2004).

Having knowledge of the lived experience of addicted nurses would not only provide information about addiction and risk for nursing students, but also hopefully aid in *prevention* of future problems with substances for those students. According to the AACN (1998), education on this topic would not only prevent future problems with addiction, but it could also assist with existing problems of substance abuse in nursing students, faculty, and staff. It may also assist students and employees in recovery, should a problem already exist (AACN, 1998).

Hyman (2004) took a historical look at the history of addiction education in nursing. She asserted that nursing students need and want to personalize information about addiction for themselves and their families and friends. She further suggested that time for group discussion on this topic was necessary. She also stated that “. . . invited guests with real-life experiences are essential” (p. 54) when teaching nursing students

about addiction. According to Hyman (2004), a creative, learner-centered design was needed along with implementation of substance abuse educational experiences.

In an article by Spencer-Strachan (1990), 86 senior registered nurse BSN student nurses were studied in order to discover their levels of awareness regarding the effects of substance use in the nursing profession, and to determine their attitudes toward education specific to substance abuse. The authors also sought to discover what the nurses' attitudes were toward substance-abusing peers. Twenty-one schools of nursing located in the states of New Jersey and New York were included in this study. The author administered a questionnaire which she had developed.

Even though this study was older than desired for an exemplar, it was one that addressed nurses and students specifically and was included since nothing more recent could be found. After gathering and analyzing the data, the researcher concluded a significant percentage of the student nurses believed there was a substance abuse problem in the profession and supported the idea of having an educational program on substance abuse in the nursing curriculum. Many of the respondents felt a specific educational course might be a deterrent to their own potential abuse of substances as nurses.

Spencer-Strachan's (1990) study also presented a link between student risk assessment and having an educational program about drug addiction. In her study, the participants were asked whether they felt they had risk factors for addiction. Many of them (63%) actually felt a sense of invulnerability to drug abuse--or in other words, they had a sense of "insulation" from drug addiction. This showed that nursing students may not be facing drug addiction realistically and that a self-assessment of their risks for addiction would be beneficial to them. Spencer-Strachan (1990) identified job-related

stressors, low self-esteem, family problems, job dissatisfaction, and lack of knowledge as the major potential predisposing factors leading to substance abuse in nurses. She suggested taking the knowledge of these risk factors and providing courses that were relevant to substance abuse in nursing education.

### **Conclusions**

Qualitative research studies addressing lived experiences of addicted nurses were extremely difficult to find in the literature. While it was acknowledged that nurse education on addiction was needed in nursing schools, using real nurse experience to guide that education was not being done. The body of knowledge related to nurse addiction needs to be expanded. Not enough is known about this phenomenon. Nurses understanding of the phenomenon needs to be strengthened in order to provide better education to students and to build better prevention and/or treatment programs for nurses. More effective and accurate education could not only educate students about the risks and realities of nurse addiction for themselves but could aid in their understanding of and interventions with peers who may be suffering with these issues. Understanding lived experience of nurses who are addicted could aid significantly in building this needed body of knowledge related to nurse drug addiction.

## **CHAPTER III**

### **METHODOLOGY**

#### **Introduction**

In this chapter, the design and methodology of this research study is described. The study sought to answer the research question: What is the lived experience of nurses who have been addicted, and how do they perceive their risk was for addiction? Chapter I presented the rationale for the study with the reasons why a descriptive phenomenological method was appropriate in answering the research question. In this chapter, a detailed description of the methodology is given. Research question, target population and participant selection, study design, data collection procedures, and data analysis are presented. Ethical considerations are also presented as well and measures to ensure trustworthiness. The researcher obtained approval from the University of Northern Colorado (UNC)'s Institutional Review Board (IRB) before proceeding with any data collection (see Appendix A). The Board ensures that UNC researchers conform to ethical standards. Once the researcher received the IRB's approval, semi-structured interviews were conducted and methodology for the study was executed as described in this chapter. Transcripts from the interviews have been analyzed and the findings presented in Chapter IV.



### **Research Problem and Purpose**

The research problem was that nurses and nurse educators did not have a good understanding of the phenomenon of nurse addiction. No qualitative studies on the phenomenon could be found in the literature. Descriptions of the phenomenon from the addicts themselves were nowhere to be found as research studies. An occasional editorial could be identified, but no efforts had been made to study and analyze the experiences of these people. The purpose of this study was to investigate, explore, understand, and describe the lived experience and risk perceptions of nurses who were addicted to drugs and/or alcohol and to find out whether or not a more effective way of teaching this subject could be identified.

### **Research Design**

Giorgi's (2009) method of phenomenological investigation was used in this qualitative study. The aim was to explore the phenomenon in order to provide descriptions of what it was like to experience addiction from the unique perspective of nurse addicts in recovery. Semi-structured interviews coupled with rigorous systematic data analysis were performed by the researcher. Saturation of data emerged when no new information was forthcoming and this determined the number of participants interviewed. A total of 14 nurses in recovery were interviewed at which point it was determined data saturation had been reached. Constant comparative analysis was conducted throughout data collection to determine emerging themes and decide when saturation was reached. Open-ended interviews with participants lasted approximately an hour and, if more time was needed, a request was made for a second interview. No additional time was needed

for any of the 14 interviews. Interviews were transcribed and coded, both manually and with the assistance of NVivo® software. Themes were subsequently identified.

### **Target Population and Sample**

The target population for this study was of nurses in the greater metropolitan area of the State of Utah, in the Western region of the United States of America. Nurses in the target population had experienced addiction to drugs and/or alcohol. Efforts were made to include women and men from a representative sample of the area as far as race, social, religious, and cultural demographics were concerned. In the end, of the 14 study participants, 9 were female and 5 were male nurses. One was Hispanic and the other 13 identified themselves as Caucasian. This sample of 13 Caucasians and 1 Hispanic reflected the ethnicity of the population of the area--with 80.1% of residents of Utah in 2011 reported themselves as “White, not Hispanic,” and 13.2% reported themselves as “Hispanic or Latino origin” (United States Census Bureau, 2011). These nurses all had different lengths of time in recovery as well as different amounts of time as practicing nurses. One was currently practicing as an Advanced Practice Registered Nurse (APRN). In order to participate in the study the nurses needed to be abstinent from substances when the interviews were done so they could reflect on the phenomenon from a recovering standpoint. The participants self-reported being in recovery and stated they were currently not using drugs or alcohol. A more detailed introduction to each of the participants is presented in Chapter IV.

### **Sampling**

Sampling refers to the process of selecting cases to represent an entire population so that inferences about the population could be made (Polit & Beck, 2012). For this

qualitative study, purposive sampling, a type of non-probability sampling in which the researcher consciously selects specific elements or subjects, was performed. This purposive sampling was done in order to ensure the participants had certain characteristics relevant to the study. The participants needed to be nurses who had experienced addiction and were currently in recovery. In phenomenology specifically, participants need to be selected based on their ability to help others gain a deeper understanding of the nature or meaning of the everyday experiences they have had as a part of this specified population (van Manen, 1990). Finding participants for this study involved recruitment and referral by the nursing board working with nurse addicts. Another method used was snowball sampling, which has also been referred to as network sampling. This type of sampling represented a variant of convenience sampling (Polit & Beck, 2012). The snowball sampling involved identifying early sample members (called seeds) and then asking them to refer other people who met the eligibility criteria. This sampling method has often been used when the population was a group of people with characteristics who might otherwise be difficult to find. Some sampling bias may be present because the study was limited to the State of Utah, whose nurse addicts may vary slightly from nurse addicts in other areas. Every possible effort was made to keep sampling bias minimal.

### **Recruitment of Subjects**

One recruitment method used in this study involved the assistance of the Utah Department of Professional Licensing's (DOPL) Utah Recovery Assistance Program (URAP) committee. URAP is comprised a sub-group of DOPL that is often called the "diversion" program. Some members of the URAP committee agreed to help with finding

nurses to help with the study by distributing a flier with a description of the study and the researcher's contact information on it. The URAP committee has worked with many of the nurses in the state that have been treated for addiction. The addicted nurses have met and spoken with the committee on a regular basis and were presented with the study opportunity flier during their scheduled visits with URAP. They were given the opportunity to contact the researcher voluntarily if they were interested in participating in the study. They did not tell URAP whether or not they would participate, and no special incentives were given for participation by URAP. Full names were not required and did not need to be known by the researcher in order for participants to feel safe participating in this study. URAP agreed to aid in the recruitment of subjects as described here. They provided a letter to the researcher before distributing fliers detailing their intent to maintain strict confidentiality as they participated in this recruitment effort (see Appendix B). The flier provided the request for nurses in recovery from addiction to participate in the qualitative study (see Appendix C). The researcher's contact information was included on the flier. URAP was not notified by the nurses who chose to contact the researcher and participate in the study.

Once nurses started responding to the fliers received from URAP, recruitment was fairly easy. Only 3 of the final 14 study participants were actually nurses who contacted the researcher as a result of the fliers distributed by URAP. Those 3 nurses referred other nurses, who referred other nurses, and the snowball sampling occurred. Six participants were introduced to the researcher by other participants and got into the study that way. Another way subjects were recruited was in "Professionals in Recovery" (PIR) support group meetings. Each PIR support group has several nurses in recovery who could be

potential study participants. Nurses in recovery attending these groups all differed in where they received treatment, whether or not they were still practicing as nurses, and how long they had been in recovery. Information on how to find these recovery groups were found on URAP's website (<http://www.dopl.utah.gov/programs/urap/index.html>). The researcher did not end up utilizing the PIR groups personally but did send the same recruitment fliers used by URAP to the PIR groups by way of the nurses that had already agreed to participate in the study. Nurses recruited through URAP and their referrals all took flyers to three different PIR groups in different areas of the state. Two of the 14 participants came as a result of PIR recruitment efforts.

The last way participants were recruited was by word of mouth. The researcher asked nurses and nurse educators to refer anyone they might know who would qualify and be interested in participating in the study. Several people did know recovering nurse addicts and agreed to give the researcher's contact information to those people. Three of the 14 participants were found this way--where a colleague or friend of the researcher referred someone to the study.

### **Procedures**

Procedures for data collection and data analysis also had to be considered before completing the qualitative study on nurse addiction. Detailed methods and procedures in handling data are presented next.

### **Methods for Data Collection**

Before the actual interview began with each participant, he or she was asked to fill out a brief participant demographic form (see Appendix D). They were instructed to write a first name only that they wanted to be known by in the study. It did not have to be

their real name. The demographic questions were asked in an effort to find out certain attributes of the participants like age, gender, specialty area, number of years as a nurse, and time in recovery. Answers to the questions on the participant demographic form were not necessarily part of the interviews but were taken into consideration in the data analysis phase that is discussed later. All of the information gathered on the demographic forms was compiled into one table after all interviews were complete.

A semi-structured interview method was employed in this qualitative study. An interview guide created by the researcher was used as a guide for the interviews (see Appendix E), though each interview did not necessarily unfold in exactly the same way. All of the questions on the guide were asked to all of the participants, but additional questions were asked based on answers that were given by individual participants. Interviews were recorded and transcribed verbatim. The researcher worked to identify and bridle her own beliefs, feelings, and perceptions about nurse addiction in order to be more open and faithful to the phenomenon being studied. Bridling, as well as bracketing, was important in this research project. In an effort to keep researcher bias at a minimum, transcripts and data analysis were reviewed by two other nurse researchers with experience in qualitative methods. Dr. Lory Clukey, the primary research advisor and Dissertation Chair in this study, reviewed data and analysis techniques throughout the entire process of the study and analysis phases. A second doctorally-prepared nurse researcher with experience conducting qualitative research also reviewed the data and analysis at specific points throughout the process. Using peer reviewers also supported the credibility of this study.

After approval was received from the IRB, consent from participants was acquired and the interviews conducted individually. Before the interviews began, the participants were given a non-signature consent form (see Appendix F). The non-signature form was used in an effort to guard confidentiality and not have the participants' names anywhere in the documentation. Before the interview questions were started in each interview, the consent form was thoroughly explained by the researcher to the participant. Each participant was given time to read the consent form in its entirety and then given the opportunity to ask any questions they might have about the study. The researcher then explained the study and what was on the consent form. This explanation of the consent form by the researcher was recorded, followed by the voice of the participant giving his/her consent (since there were no signatures acquired). This way consent by each participant was documented on the recordings. All of the interviews took place in a neutral setting. Public library study rooms were reserved for most of the interviews. A couple of them were conducted in participants' homes, and one was in a university professor's office. Interviews lasted between 30 minutes to an hour depending on the experiences and topics identified by the participants. If more time was needed, a second interview was requested and scheduled. No second interviews were needed. A handout with referral sources was made available to each of the participants should they choose to take one (see Appendix G).

Once interviews were completed, they were transcribed verbatim, checked, and rechecked for accuracy. Transcripts were read and re-read, and then manually coded by the researcher using a color-coding system. Qualitative data analysis software called NVivo® was also used in organizing and analyzing data. Transcripts were imported into

the software program and organized accordingly. All data analysis, including that which was run through NVivo®, was reviewed by the researcher's advisor Dr. Lory Clukey.

### **Data Analysis Procedures**

As mentioned, once interviews were completed, analysis commenced with manual coding followed by computer coding. From each transcript, significant phrases or sentences that pertained directly to the lived experiences of addicted nurses were identified. Risk perceptions were considered, as well as whether or not the nurse addicts felt they were at greater risk for addiction by virtue of being nurses. Further questions related to their experiences regarding education about nurse addiction were asked, as well as what they thought would be the most effective way to teach this subject in nursing schools. Participants were asked if they felt anything would have been helpful in preventing the addictions from occurring. Finally, all of the participants were given the opportunity to sum up their feelings and give any "last words" for the researcher to include in the study.

Within NVivo® each interview question was "autocoded" in order to look at all 14 respondents' answers to each individual interview question. Text search queries were run within the software program and word frequency queries were explored. Several of the visual representations of these NVivo® queries can be found at the end of this dissertation (see Appendix H). Themes that emerged from the computer analysis were compared to what emerged from the manual coding. Meanings were then formulated from the significant statements and phrases in both the manual coding and the computer results. These formulated meanings were then clustered into idea groups allowing for the emergence of themes common to all of the participants' transcripts. Codes were



categorized and final themes were identified. Five themes were identified throughout the data analysis process. Discussion and implications relating to nursing education and prevention topics resulted from the five themes and from the literature review which followed. An overall theme in the study resulted from the five themes and discussion items that were identified. The five themes, discussion, implications for nursing education, and the overall theme of the study are presented in Chapter IV of this dissertation.

### **Validity and Reliability**

Validity and reliability are terms used to describe accuracy of results in research. These terms are generally used in quantitative research but have been considered important enough in all studies that they have been included here. Validity and reliability in this study have been pursued and achieved by certain measures employed by the researcher. Validity is used to describe whether or not the interpretations placed on the data was accorded with common sense and was untainted with the personal or cultural perspective of the researcher. Validation means an idea has been well grounded and well supported (Creswell, 2007). As mentioned before, one measure that had to be employed in this study was the bridling of the researcher from her own experiences and thoughts on the subject being researched. In an effort to ensure the interviewer did not influence the contents of the participants' descriptions of their experiences, an interview guide was used and reviewed by other nurse researchers prior to the initiation of interviews. The interview guide served as a foundation for all of the interviews, though additional questions were added based on responses given by individual participants. Design flexibility was needed in the qualitative inquiry in order to allow the researcher to pursue

inquiries on new topics or questions that emerged as a result of the questions asked from the interview guide. The researcher did not offer personal opinions or ideas about the phenomenon during the interviews but acted only as a listener and questioner and recorded the thoughts and statements of the person being interviewed. Every effort was made to ensure the descriptions given by participants truly reflected their actual experience (Creswell, 2007).

Credibility or the researcher's ability to demonstrate that the phenomenon being studied is accurately identified and described was also necessary. Credibility was strengthened as the study and data analysis were reviewed by two other experienced nurse researchers with expertise in qualitative research. The primary researcher did not make assumptions based on personal bias or opinion and having two other qualified nurse researchers review the study increased the likelihood of credibility in the study. Accuracy was ensured in transcription of the interviews by comparing tape and computer recordings with transcripts for exactness. Procedures of data analysis appropriate for phenomenological studies were used (described later). The general structural description of the phenomenon provided a portrait of the common features and structural connections that were manifested in the examples collected (Creswell, 2007). Observations such as non-verbal communication (like loss of eye contact, crying, wringing of hands, looking away, etc.) made by the researcher during the interviews were also noted and included in data analysis.

Trustworthiness in qualitative research by accurately representing the data was meticulously sought. Transparency was confirmed by having other researchers review the transcripts, analysis, and representation of data. This clear, understandable representation

of data was vital in augmenting the credibility, validity, and accuracy previously discussed. Comparability in research has always been one of the ultimate goals; however, due to the fact that a study like this had not been done before, it was difficult to compare it to other studies at this point. Confirmability could only be reached when another person or persons conducts the same study again, so efforts for accuracy and reliability were especially vital in this unique study. Translatability, or the ability to make comparisons confidently by clearly explaining the research methods, analytic categories, and characteristics of the group studied, were a priority. The researcher ensured this translatability by employing accepted qualitative data analysis methods and by having these methods and results reviewed by two other experienced nurse researchers.

### **Ethical Considerations**

#### **Disclosed or Discovered Relapse**

One of the qualifying characteristics of the nurses being interviewed for this study was that they were “in recovery.” This meant they were not currently using drugs or alcohol. Whether or not they had a relapse in the past was really not relevant as long as they were not using substances at the time they were interviewed. If they were currently clean, they were considered to be in “recovery.” However, this qualification was something that was completely based on self-report from the participants. The researcher did not formally confirm the recovery status of participants with any outside source and relied solely on what the person said about him/herself. The possibility of the participant not being truthful was a viable possibility but, unless it was disclosed by the participant, the researcher had no way of knowing this. It was hoped that, because of the confidential nature of the study, the participants would feel they did not need to lie about their status

in recovery. If any of the participants had admitted to currently being involved in a relapse, this would have disqualified them as participants and that nurse (or nurses) would not have been included in the study. None of the 14 participants in this study admitted to currently using drugs or alcohol, so none were excluded from the interviews.

The researcher felt the only way these nurses would agree to participate in this study was if they could be assured complete confidentiality. They needed to know they could be completely honest or they would not share their true experiences. That included the disclosure of any relapse, whether current or past. Should a participant have admitted to being currently involved in a relapse, they would not have been used for the study, but they would not have been reported to the nursing board (DOPL). Disclosure of discovered drug abuse is not legally required. This was confirmed with a compliance officer who worked with the nurses in diversion or on probation. The Department of Professional and Occupational Licensing (DOPL) has been working closely with these clients and requiring frequent random drug screens. It would be very difficult for a nurse to be in relapse and not be discovered by DOPL. It has happened on occasion, though. It is DOPL's responsibility to discover when a relapse has occurred, and ethically, the researcher would not have to disclose that information should it be discovered. Anything reported to the researcher would be completely confidential, so job status and status with DOPL (licensure) would not be threatened. However, should a relapse have been admitted, the researcher would have stopped the interview and provided the list of resources (see Appendix G) for the nurse to get the treatment needed to stop using. The nurse would be encouraged to quit using but would not be turned in by the researcher. If

the nurse was in crisis, the researcher would escort him/her to the closest emergency room to ensure their safety.

If a nurse had harmed a patient as a result of a relapse, DOPL would most likely know about it and that person's license would have been restricted already. Anytime there was a negative patient outcome, the institution files a complaint with DOPL. If there was an instance in which a participant disclosed this type of event, and the event had gone unreported, the researcher would react based on the specific circumstance. If significant harm occurred as a result of the nurse being impaired, this information would need to have been disclosed to DOPL and/or the institution where the incident took place. In fact, "harm to a patient" was one of the criteria considered when a nurse was placed in either the "diversion" (URAP) program or the "disciplinary" program, so it was definitely a consideration that would be relevant to the nurse's status with DOPL. The nurse would be informed by the researcher that legally this type of information needed to be reported and that it would be. If any type of patient abuse had occurred or was currently occurring, legally this information would have also been reported.

In most cases, if a nurse had reported having a current relapse, the information would have been kept confidential and the nurse would have been excused from participation in the study. The only instance in which the relapse would have been reported would have been if patient harm and/or abuse were suspected or had been occurring as a result of the nurse's relapse.

### **Risks and Benefits to Participants**

Risks to participants in the current study were minimal. Some minor emotional discomfort could have foreseeably been the result of participants having had personal

experience with drug abuse or addiction. They could have felt anxious or frustrated answering the questions about their addictions, especially because this topic may have brought back painful memories or have caused embarrassment for the participants. They may have worried that the stigma associated with addiction would cause the researcher to look down upon them. Personal experience with the subject of addiction could have brought uncomfortable thoughts or memories to the surface for them. In an effort to minimize anxiety in this often sensitive situation, strict confidentiality was reinforced. Confidentiality and protection of information with these subjects was vital in order to help them feel safe and more comfortable in sharing their experiences openly and honestly. Referral resources were made available to the participants should they have needed outside help in dealing with talking about the experience of the addiction (see Appendix G). The researcher realized these interviews could be emotionally-charged experiences for participants and had referral resources available for them in the event that they were needed. Names and phone numbers of several counselors across the state were made available for participants should they have desired to seek outside help in dealing with the experience of talking about their addictions. Interviews would have been stopped immediately should a participant have become distressed or traumatized in any way by the experience.

A benefit to participants was the opportunity to reflect upon their experiences as nurse addicts. They may have felt like they had been misunderstood in the past and may have benefitted from the opportunity to express what had happened to them. The researcher realized these reflections could have caused positive or negative reactions for the participants but anticipated it would be very beneficial to participants. Participation

was hopefully beneficial to them because they had an opportunity to verbalize feelings that helped them bring meaning to their own experiences and increased their own understanding of what they had been through. It may have also been beneficial to them to talk about it because they might have felt like others could learn from their experiences, and they may have felt they had helped make a positive change for the future. Hopefully the reflections and insights of the study participants found in this study would be useful in helping other nurses identify their own feelings about the reality of nurse addiction. Knowing their experiences could help build nurses' knowledge base about addiction in the profession may have been of great benefit to participants.

### **Protection of Human Subjects**

In order to protect human subjects, IRB approval was obtained before any data collection took place. It was the policy of the University of Northern Colorado (UNC) that all research and research-related activities in which humans were used as subjects would be subject to review under current Public Health Service regulations (UNC, 2012). The interviews did not take place until the IRB had reviewed and approved the research protocol. Participants were provided with an explanation of the research and given a consent form before being interviewed.

### **Measures to Ensure Trustworthiness**

High quality recordings were obtained on a laptop computer with a microphone. Backup recordings with a pocket electronic recorder were used simultaneously with the laptop computer recorder. Recorded interviews were all stored as electronic files on a jump drive in order to prevent unintentional loss of recordings. The recordings (two for each interview) were all backed up on a second jump drive and locked in the researcher's

desk drawer when not in use. One set of recordings was erased once transcriptions had been verified as being accurate. Confidentiality of participants was maintained by using names that were not actually theirs, unless they chose to use their real first names. About half of the participants wanted to use their real first names, while the other half used names that were not really theirs. No last names were acquired, recorded, or used in order to assure strict confidentiality and security for participants sharing sensitive information. All communication was done using first names only in order to guard this strict confidentiality. E-mail addresses were voluntarily given by all of the participants because they all wanted to receive any follow-up information about the study. E-mail addresses were not required. Any electronic files were password protected and were not able to be retrieved by anyone other than the researcher and research advisor Dr. Lory Clukey. Transcripts that were printed for review and coding were stored in locked cabinets or offices that only the researcher had access to when they were not being used. Electronic transcripts were only accessible on a flash drives in the possession of the primary researcher and the research advisor. After analysis, and for two months after transcription, the transcripts and recorded voice consent of participants was kept in a locked cabinet. Data and electronic consent files will be retained and stored for appropriately a minimum of three years.

### **Audit Trail**

Bridling, as well as bracketing of the researchers' bias, was especially important in the construction and analysis of this research project. The researcher made every effort to bridle her own ideas when research questions were formulated and when the data were



analyzed. In order to bracket the feelings of the researcher, those feelings were identified before data collection took place.

An audit trail has been maintained in order to document the research process as suggested by Lincoln and Guba (1985). It has provided a means for authenticating the findings in this qualitative research study. Audit trails in qualitative research have been utilized in order to log or describe in detail how data were collected, how categories or themes were derived, and how decisions were made throughout the inquiry (Merriam, 2009). In an effort to construct the audit trail for this particular research study, the researcher kept a detailed binder and journal documenting every step of the process. Field notes, reflections, literature search queries, NVivo® education, analysis, queries, and communication with research advisors were all logged in this audit trail binder. All steps and correspondence related to the IRB approval process were also included in this binder. Financial documentation including grant applications, awards, and receipts for expenses related to the study were also organized in this audit trail binder. In addition, pictures were taken along the way of the coding process, as well as screen capture pictures taken at different stages of processes in NVivo®. The official audit trail binder was compiled as a separate book, as most of it is done in handwritten notes, and was available to be viewed upon request.

In order to document the thought processes of the researcher, ensure appropriate bracketing in this study, and to increase credibility for the qualitative process, notes were taken before, during, and after the data collection process. Before starting, perceptions and pre-conceived notions were identified and written down in an effort to check any emerging themes against as data were analyzed. Once data were analyzed, the themes

were formulated based on actual statements of the participants and were checked against the pre-conceived notions identified by the researcher in order to prevent bias or inaccurate data analysis. Once coding and theme identification process was completed, the researcher again wrote down her thoughts about nurse drug addiction based on her personal experience. She then compared it to the identified themes and made sure her ideas and perceptions were separate from the information gleaned from the data.

### **Summation**

A qualitative phenomenology method of data collection, organization, analysis, and reporting was used for this descriptive study exploring the lived experience and risk perceptions of nurses who have been addicted to drugs and/or alcohol. This method was used in an effort to provide richly detailed data about the phenomenon of nurse addiction. This qualitative research study focused on this human experience through systematic and interactive approaches and was especially appropriate because little was known about the phenomenon of nurse addiction. The Giorgian method specifically was used in this study (Giorgi, 2009). Giorgi agreed with most of the different variants in phenomenological research, but felt there were core characteristics that held across the variations. These core characteristics were that the research was descriptive, it explored an intentional relationship between persons and situations, and it provided knowledge of psychological essences or structures of meaning immanent in human experience (Wertz, 2005). Interviews were conducted and observations were made in an effort to better understand the lived experience of recovering nurses. Data were analyzed using sound and proven qualitative methods with research and results being reviewed by two outside nurse qualitative research experts.

## **CHAPTER IV**

### **RESULTS AND DISCUSSION**

#### **Introduction**

This study on nurse addiction set out to answer the question: What is the lived experience of nurses who have been addicted, and how do they perceive their risk was for addiction? A qualitative design was realized. Fourteen nurses recovering from addiction were interviewed and asked to describe their experiences as nurse addicts in recovery, as well as their perceptions of risk. They also discussed ideas about what they felt might be useful in preventing addiction in other nurses and how they felt this subject could best be taught in nursing curricula. As a result of the data obtained, five themes were identified and described here and followed by a discussion on the themes and some implications for nursing and nursing education.

#### **Study Data**

In this qualitative study, the data gathered for analysis was interview transcripts, observation notes, and running impressions and observations made by the researcher. Interviews with the 14 participants were the main source of data. Presented below is the interview process along with a description of each of the participants.

## **Interviews**

Interviews took place in private settings chosen by the study participants. Five took place in public library study rooms across the State of Utah. Three took place in the participants' homes (per their own request), five were in private offices, and one was in a hospital conference room. All 14 interviews were in enclosed private rooms where talking and recording could be done without distraction or interruption. Participants were observed during interviews for demeanor, eye contact, and other non-verbal cues. The participants acted in one of two ways--they were either both very open and uninhibited or they were more reserved and guarded. In all cases, if a participant started out guarded and with very little eye contact, by the end of the interview they had relaxed and appeared more comfortable. A couple of them stated they were much more comfortable when they realized they would not be talking about graphic details about the practice of their addictions. They were surprised to find the study was looking more at the overall experience and feelings related to being addicted. Most participants were very open and seemed to be excited to share their experiences and feelings. Interviews lasted between 30 minutes and an hour. The interview guide with the standard nine questions were used as the basic structure for all of the interviews. Follow-up questions were often asked based on responses from the participants.

## **Participants**

Each one of the participants filled out a demographic form before the actual interview began (see Appendix D). All of the demographic form data were compiled into Table 1. Of the 14 participants, 9 were female and 5 were male. One of the male nurses was an Advanced Practice Registered Nurse (APRN), and another one of the males was a

Table 1

*Demographic Form Response Table*

Participant Name	Age	Gender	Race	Hospital Unit worked (s) on	# of years been a nurse	Educated in school about nurse addiction	How long been in recovery	What was drug of choice	How long nurse before started using	Used drugs or alcohol while nursing school	How long used while in active addiction
<b>Lacey</b>	38	F	Cauc	Jail, Adolescent. treatment	19	N	2.5	Opiates, Benzodiazepines	16	Y	3
<b>Tamara</b>	37	F	Cauc	Home health	14	Y	6	Methamphetamine	7	N	1/5
<b>Ben</b>	38	M	Cauc	N/A, Didn't use at work	0.25	Y	1.5	Opiates	0, Used before a nurse	Y	2
<b>Mike</b>	39	M	Cauc	Surgical	10	Y	3	Alcohol, Opiates	5	Y	1
<b>Al</b>	30	M	Cauc	Med/Sur	5	Y	2.75	Alcohol, Marijuana, Cocaine, Ecstasy	0, Used before a nurse	Y	11
<b>Terry</b>	45	F	Cauc	Outpatient Recovery	17	N	7	Opiates	6	Y	5
<b>Valerie</b>	33	F	Cauc	L & D	15	Y	1.5	Opiates	7	N	2
<b>Craig</b>	35	M	Cauc	ER	9	Y	3.5	Opiates	6	N	0.75
<b>Annie</b>	55	F	Cauc	Surg	21	N	5	Alcohol, Opiates	2	Y	5
<b>Melissa</b>	38	F	Hisp	L & D	20	N	2.25	Opiates	11	N	4
<b>Beth</b>	48	F	Cauc	NICU	22	N	4	Alcohol	5	N	17
<b>Linda</b>	52	F	Cauc	ED	30	N	4.5	Opiates	23	N	3
<b>Ashlee</b>	35	F	Cauc	OB/PP	14	N	3	Opiates	10	N	0.5
<b>Dan</b>	57	M	Cauc	OR	32	N	19	Alcohol, Opiates	10	Y	25

nursing Assistant Professor. Both of these men were working as RNs while in their active addictions. Number of years working as a nurse varied from 3 months to 32 years. Age ranged from 32 to 57 years old. Some of the nurses were heavily using substances or addicted *before* becoming nurses, and this pre-disposing factor did seem to affect the answers of these participants specifically related to nursing as a risk for addiction.

The perceptions and experiences of these 4 pre-nursing users (2 male and 2 female) were a little bit different from the other 10 nurses because of their pre-nursing alcohol and/or drug addictions. The other 10 nurses became nurses before becoming addicted to drugs or alcohol, and their viewpoints about occupational risk were different than those who used before becoming nurses.

As indicated in Table 1, one of the participants was Hispanic and the other 13 were Caucasian--which was generally representative of the population in the State of Utah (United States Census Bureau, 2011). Eight of the participants said they were not educated about nurse addiction in nursing school, while 6 stated they were. Of the 6 that did learn about nurse drug addiction in school, all of them stated they felt that education was neither adequate nor helpful in preventing them from becoming addicted. The specialty areas or units where the nurses worked varied and did not provide any conclusive results. However, studies have been done on this in the past suggesting that nurses working in higher acuity areas were more at risk for becoming addicted (Marcus, Rickman, & Sobham, 1999). Higher acuity areas included emergency departments, intensive care units, and labor and delivery units. The participants had varied work backgrounds, so this consideration was not really factored into this study. In other words, no pattern was identified in this study group related to the type of nursing jobs these

nurses held. A study examining the relationship of work type and addiction could be a direction for future research.

Further demographic information collected showed the amount of time the nurses had been in recovery, what their drugs of choice were, how long they had worked as a nurse before starting to use drugs/alcohol, and how long they used the substance(s) while they were in their active addictions. As indicated by the demographic form responses, opiates were the most often abused substances in this particular sample population, which was generally true in the population of nurses as a whole. This was probably because of accessibility to and knowledge of opiate medications (West, 2002). Alcohol use and abuse was very common in this sample population as well. One nurse only abused alcohol while all of the others who used alcohol used it along with other substances. Time in recovery ranged from 2.5 to 19 years. Exactly half (7) of the nurses reported having used drugs or alcohol while in nursing school, while the other half said they did not. Amount of time in active addiction ranged from 6 months to 25 years.

While all of this demographic data collected indicated differences between the different nurses in this study, many underlying characteristics were similar among all of them. Feelings, perceptions, and thoughts were strikingly similar despite different backgrounds and experiences. These similar characteristics emerged throughout the interviews and five themes and were identified through the data analysis process. Implications for nursing education both in the academic and workforce settings also surfaced throughout the data analysis process. Because of the rich details of each participant examined in this study and the nature of descriptive, qualitative research, a

brief overview of each of the 14 participants are provided. All of the names have been changed from their real first names and are presented in alphabetic order.

**Participant 1-AL.** Al arrived at the interview at the Salt Lake City Library eager and willing to participate in this study. He had a beaming smile and personality, and came across as being truly happy. Al was a 30 year old Caucasian male. At the point of the interview, he had only been a nurse for 5 years, 2 3/4 of which he had been in recovery. As a nurse, he worked on a medical/surgical unit. He, like Annie, was one of the 4 nurses who came into nursing already having been a heavy user of substances. His addiction was not directly related to nursing. Al started using drugs at the age of 14 when he was in a friend's basement and started smoking some marijuana. At first he would just use it periodically but stated as soon as he got a job as a young teenager he starting buying and using it very frequently. He reported never abusing opiates or other drugs in his nursing position but used only marijuana, alcohol, cocaine, and ecstasy. Even though he did not use narcotics from the nursing workplace, he was in the program with DOPL (nursing board). When asked what it was like for him to be using substances as a nurse, he stated:

It kind of made me mad at first. . . I had guilt and shame over it. Knowing that I was a nurse and I was a professional and I was using and I guess in a sense professionalism as a nurse, you're not supposed to drink and use out of control, so I had a lot of guilt and shame as I was using but I guess after a while it just went away. But then it always creeps back up. But once you learned how to deal with it, making amends to yourself, to your boss, and strive to do better. So I guess as I was drinking and using I had guilt and shame over it, but I don't have guilt and shame now because I'm not drinking and using and I'm determined not to drink and use again.

Al remembered learning about nurse drug addiction in nursing school but did not pay much heed to it since he was already using substances. He was one of the few in this



study who did recognize his risk for becoming addicted as a nursing student, because he was already using substances. However, he had some very insightful suggestions about what may be more effective in teaching nursing students about drug and alcohol addiction in nursing, which will be discussed at length later. Al always knew he was at risk for addiction and stated:

I knew it was a problem I just didn't want to face it. So I guess that there's a point to where I knew there was a problem, I just didn't care about it. I just had to manage with it until I really had to really confront it. . . It was baffling that I was no longer able to manage my life so I had to learn how to. . . so it was frustrating. . . I guess if I'm able to manage nursing or manage my life [it's] a feeling. . . of knowing that you're an alcoholic and a drug addict and yet I have a professional license [I] have to learn how to combine them both together and realize that I can't have both worlds. I have to learn how to put them together and deal with them. You can't just be like, oh on the weekend I'm just going to be [Al], and then during working hours I'm going to be a nurse. So I have to learn how to separate them and exclude bad--well I shouldn't say bad--the non-appropriate behaviors.

Al seemed to have a positive attitude about being in recovery and found comfort in knowing his addiction was an “actual disease” that he had to deal with whether he was a nurse or not--but as long as he worked his “program” and kept a spiritual contact than his addiction was “usually put at bay.”

**Participant 2-ANNIE.** Annie was a surgical nurse who came to the interview feeling a little bit nervous but eager to share her story. She was a 55 year old Caucasian woman who has been a nurse for 21 years. She was never educated about nurse drug addiction while in nursing school. She primarily used alcohol and opiates. Annie was one of the 4 nurses who had an addiction problem before becoming a nurse, though she worked for 2 years as a nurse before she began abusing substances as a nurse. When asked how her alcohol and drug abuse began, she gave the following response:

It started when I was about 15, and I started just, you know, dabbling in it, stealing from my parents, stuff like that, and I got pregnant when I was 15, and after I had her, when I was 16 it really wasn't a hassle to not do it. It really didn't appear or occur to me to use until I started hanging around some people, because I wasn't. . . I didn't fit in with my friends anymore cause they were still going to school and I wasn't. . . I didn't have a place where I fit. So I started hanging around with another girl and it just escalated to where I just started drinking and having fun and not caring. Then it got really out of control when I met my ex-husband. That was probably around '91 or '92. And he drank a lot, and I drank a lot, and it was just a way of life. Drink to have fun and go to bed and do stuff to get up. Do your daily thing. That was my life for a long, long time. That's the only way I knew how to live.

Annie reported always wanting to do nursing ever since she was “a little kid.” She had not finished high school and was very proud to have acquired her GED and to get very good grades in nursing school. She reported having used drugs and alcohol during nursing school. She has been in recovery for 5 years and stated:

I'm very proud and I don't take anything for granted. My license and my job and those people mean everything to me now. I can see the difference in how I've behaved before or how I've felt before even though I did still care and I was proud to be a nurse, this means so much more to me this time around. I had to work hard to get it back.

Annie used drugs and alcohol actively as a nurse for 5 years. Though timid in demeanor for the interview, she was extremely open and confident. She appeared very happy to be in recovery and eager to help nursing students become better educated about the reality of nurse addiction.

**Participant 3-ASHLEE.** Ashlee was a 35 year old female Caucasian who worked primarily in obstetrics and postpartum nursing. She had been a nurse for 14 years, with the last 3 being in recovery. She stated only being in her active addiction for 6 months and that she worked for 10 years as a nurse before becoming addicted. Opiates were her primary drugs of choice. Ashlee stated she did not learn about nurse drug addiction in nursing school, nor she did use drugs or alcohol while in school. She actually

started college as a pre-medical student but felt it was taking too long and decided to go into nursing since it was “. . . something that you could always find a job, it’s good money. . . and I’d be helping people and everything.” Because she never used substances when she was in high school or college, she stated never really feeling like she was at risk for addiction as a nurse. In hindsight, she recognized that she had been at risk and stated:

Looking back when I first became a nurse I would say no [not at risk for addiction], but I think just, like it was 10 years for me before this even came about, and I think my life changed so much in that 10 years. You know, your relationships change if you get involved in unhealthy relationships, things like that that contribute to it. I don’t know at the time, I could see definitely why people definitely look to something else to help them if they feel like that’s all they have to do. So at the time when I started definitely could see why I’d be at risk.

For Ashlee, her circumstances seemed to be the biggest pre-disposing factor; an abusive relationship, stress, and poor coping skills all contributed to a feeling of powerlessness and hopelessness. She stated now that she was in recovery she really did not have difficulty working around the substances in her workplace as long as she stayed on top of her mental health issues and could “. . . go now and get my anti-depressants or what I need for anxiety and stuff like that.” She felt life situations put people more at risk for addiction than the occupation they happen to work in.

Now that Ashlee had quit using, she felt a great sense of responsibility for herself and commented a couple of times about how she was the only person that could keep her clean and sober. Though she did not feel the drugs at work were a temptation now, she did still worry about what her co-workers would think if they found out about her history of addiction. She reported feeling a lot more empathy for her patients and others who struggle with addiction.

**Participant 4-BEN.** Ben was a 38 year old male Caucasian with “. . . 2 kids who worked security before going to nursing school because [he] was so miserable in his job.” He stated he had always had it in the back of his mind to be a nurse. Ben was one of the four nurses who used drugs and/or alcohol before becoming a nurse. He states stated having struggled with anxiety disorders and PTSD, and:

I always had great interest in the kind of pills that would make me feel calm. . . make me feel normal, but I knew that I wouldn't be able to reign in if I found something that made me feel like I was invincible.

He did not feel that nurses were at any higher risk for addiction than anyone else, other than the fact that the drugs were so much more accessible to nurses. (This question of access causing risk actually came up in several interviews and will be discussed later.) Ben started abusing opiates when he had kidney stones a few years ago. A legitimate need for pain medications gradually progressed into addiction when he realized the pills helped him feel better about things causing anxiety in his life. This happened before becoming a nurse. He said he was never actually in active addiction while he had been a nurse, though he did use pills while he was in nursing school. He was educated in school about nurse drug addiction but that the education was very limited and not very helpful. He stated they “. . . talked about how big of a problem it was. . . and what nurses do and that type of thing. . . they just said it's a bad, bad thing.”

Ben had been in recovery for 1 1/2 years and stated he actively used drugs for 2 years before that. At the time of the interview he had only been a nurse for 3 months, so the majority of his active addiction and recovery all took place before becoming a nurse. When asked if anything would have been helpful in preventing him from becoming addicted, he replied:

I guess it's all about yourself. If I would have tried to seek channels to help with my anxiety and stuff like that and not just try to look for a means to cover up the fact that I had a predilection to being addicted. . . See I always knew, I had this little negative, not negative, just prophetic, but I was just, before I got fired I would just think every day I was thinking you're going to get busted but it won't be today, you know. I mean that's all I thought, you're going to get caught, but tomorrow's another day. You know they always say one day at a time and I was the reverse of that. Just like one more one more stoner day and we'll deal with it tomorrow.

Because Ben had been a nurse for such a short period of time, it was hard to know just how much, if any, the profession of nursing related to his addiction, but he seemed to have experienced many of the same feelings, fears, and consequences of being an addict despite the fact that it did not originate in nursing. It did still impact him today because he had to work around and have access to the very drugs he was addicted to.

**Participant 5-BETH.** Beth was the only nurse in this study that became addicted to only alcohol and no other drugs. She did have to work with the Utah Recovery Assistance Program (URAP) to maintain her nursing license since the addiction affected her nursing job. She was a 48 year old white female who worked in the newborn intensive care unit (NICU). She never had the problem of diverting drugs from the workplace as a nurse. She was a nurse for 5 years before she became addicted to alcohol. She has been a nurse for 22 years, with the last 4 being alcohol-free and in recovery. She did not use drugs or alcohol in nursing school and stated she was not educated about nurse addiction while in nursing school. She stated she was actively addicted to alcohol for a total of 17 years.

Beth was very laid back and happy in her interview and seemed happy and grateful to be a nurse. She was addicted to alcohol before becoming a nurse. She reported coming from a family of nurses. She worked as a clerk at a children's hospital in the area

and decided to become a nurse when her employer offered to pay for her schooling. She never believed she would work with children but now she cannot imagine doing anything else. She never considered herself to be at risk for addiction even though her father was an alcoholic. She did not consider people to be at greater risk for addiction by virtue of being nurses. In fact, she said, "It wouldn't have mattered what career I had. It was just one day I tried harder alcohol and liked the feeling I got. So to me it didn't matter what career I was in." Though alcohol was the only things she claimed to have abused as a nurse, she did say that after having her babies she really liked the Lortab (hydrocodone/acetaminophen) and Percocet (oxycodone/acetaminophen) the doctors gave her. She said, "I remember thinking to myself, if I could have a lifetime supply of Lortab or Percocet, I wouldn't have the desire to use alcohol." She stated she always used the opiates until they were gone even if she was not in pain because she "liked the feeling," but she never felt tempted in the workplace since she worked with infants and all that was available were small amounts of Versed and Fentanyl. When asked how the addiction to alcohol began, she said:

I remember it being 1995 and it was December and it was a couple weeks before Christmas and I thought I'm going to get some liquor in the house for the holidays. And I lived alone and I remember trying a couple shots and immediately liked the feeling it gave me. When before then I went out to eat or socially drank with people I could just put it down. But it seemed like that day in December 1995 a switch just went off. And from there soon I was going to the liquor store once a week, then twice a week, then every other day, then I didn't go a day without it.

Eventually she started drinking right before work and would take the alcohol to work in the NICU. She had been to treatment before but continued to drink heavily. One night at work, she fell asleep by a baby's isolette and the staff could not awaken her. They reported smelling alcohol and after requiring a breathalyzer test, she was escorted out of

the facility in front of everyone. Beth stated being in total denial and shaking and withdrawing regularly at work. She was reported to the state's Department of Occupational and Professional Licensing (DOPL) board and was required to do the URAP program like other nurses addicted to substances.

Recovery had been good to Beth. When asked how it felt to be a nurse in recovery, she stated:

It feels really good and it's amazing to me, I was just thinking the other day even after 4 years I didn't think I could think more clearly, you know, I thought maybe after a few months your mind clears up and now I see that I'm a smarter person, I make good decisions and I'm thinking 'gee it took years to get your brain back to where you were or even better than you use to be.' I feel smarter, more confident, my coworkers like me, I like to joke around, and I have good friends that know my whole story and I feel really good. My boss is very supportive, she knows everything. . . And I'm just happy and confident and I love my life and my job. Right now it's wonderful to say you've come through and that you've gotten a lot of what you lost in your life back. That there is hope, when I thought there was none for me. I didn't see my life without [alcohol]; how could I live day to day without it? I never want to go through that hell again. I lost everything--kids, family, license, job. You know, I was working at Kimberly Clark when I lost my nursing license, stacking diapers for \$9 an hour. I was working at a golf course flipping burgers for \$6.50 an hour and maybe get \$10 in tips on a good day. And once you've experienced that then it motivates you even more to work harder to get back your nursing license where you have the insurance and the ability to support your kids and do things in order to enjoy life. To live a normal life.

Beth wanted every person who learned of this study to know there was hope for people who struggled with addiction. She stated that, even when things seem far away and unattainable, if people just lived each day the time would go by and they would be surprised at how good life really could be.

**Participant 6-CRAIG.** Craig was a very successful Advanced Practiced Registered Nurse (APRN) working in an urgent care clinic who was eager to talk about his experience with addiction. He was a 35 year old white male who was recovering from a drug addiction he engaged in while working as a Registered Nurse (RN). He never

considered himself to be at risk for addiction even with some family history of alcoholism and drug addiction. He did believe that, because of the easy access to narcotics, nurses were at a greater risk for addiction than someone without that type of access. He became addicted to opiates when he was in the military and sustained an injury to his ankle which eventually resulted in his discharge. He dealt with the pain of that injury for “quite some time” long before he went into nursing school. He stated he did not use drugs in nursing school and that he was educated about nurse addiction there. Eventually, he stated:

I was working in the ER, emergency room setting, and being exposed to lots of different pain medications, [where] I eventually came to the point where I actually tried some to see what it would do for the discomfort in my ankle. And of course it worked, and I would use it periodically if the pain got worse, not thinking about the possibility of addiction. There was a point in time during that 8 month period when I had been using that I realized that I was looking forward to going to work just so I would be around that medication and possibly have the opportunity to use some. That’s the point in time where I realized there was a problem and I talked to my manager about that and that’s the point in time where I started the act of recovery.

Craig stated he was only in his active addiction for 9 months and had been in recovery for 3 1/2 years. He reported having been a nurse now for 9 years. When asked about the experience of addiction overall, he stated:

From my own experience. . . if I was to talk to somebody that just walks into my clinic about my experience I would just have to tell them that what I’ve gone through is the same or similar to anything anybody else would go through as far as a personal crisis--whether it’s an addiction of a sort or any other type of a disease, because that’s exactly what it is--a disease. It is treatable and it’s a lifelong condition. And you put it up against diabetes or something else, they have similar things, and as long as the person or patient is compliant with the treatment plan they are fine; you don’t need to be afraid of them or think of them in a negative way because you wouldn’t think of your grandparent who has diabetes in a negative way.



Craig was very open and seemed comfortable in his interview. He did feel strongly about some ways this subject could be more effectively taught in nursing school, which will be examined in the discussion portion of this report.

**Participant 7-DAN.** Dan was the nurse who had been in recovery the longest out of the participants in this study. He was a 57 year old Caucasian male who had been in recovery for 19 years. He was actively addicted for 25 years before his recovery years began. Dan had almost always worked in an operating room setting--first as an orderly and then as a nurse. He had been a nurse for 32 years. Dan used primarily opiates and alcohol while he was actively addicted. He stated he was not educated about nurse addiction while in nursing school and that he did use drugs and/or alcohol as a nursing student. He was a nurse for 10 years before starting to abuse drugs. He stated he had always been drawn to service positions:

Out of necessity get a job, I ended up working at a nursing home as an orderly and I had the head nurse that was there on my unit, on this rehab unit I worked on, was just great with me and I have really got interested in nursing and taking care of people and at that point thought that might be something I want to do. And I then moved down to Florida for a year just to do some traveling and what not and just fell into a job in an O.R. working as an orderly there and I fell in love with it. And that's when I said I want to work in the O.R. I want to be a nurse. So when I came back to Utah and it took a year or so to get things together but got into school and became a nurse. And I've been an O.R. nurse ever since.

Although Dan did not say he was addicted before becoming a nurse, he did say that he partied quite a bit and used drugs and alcohol quite frequently before becoming a nurse. He said that, even though he realized he did a lot of partying with his friends, he never considered himself to be at risk for addiction. He started getting frequent headaches as a nurse in the operating room and actually received prescriptions from the O.R. doctors that he worked with. This was when the addiction began to take hold. He said that, for him

personally, being a nurse did not place him at higher risk for addiction, even though it was at work where he was getting his narcotic prescriptions. He stated that an addict would be an addict no matter what their profession is. He did introduce an interesting idea, however, related to the personalities of nurses. He basically stated that nurses tend to have a personality that lends itself to becoming addicts--so people were not at higher risk for becoming addicted by virtue of being a nurse, but people with addict-type personalities were drawn to nursing, so the opposite was true: Addicts were more at risk for addiction by virtue of being nurses rather than vice versa. This very intriguing concept is explored later and further research on this subject is recommended.

Dave was very active in the recovery community. He attended frequent 12-step meetings and felt that, even though he still worked in the same O.R. where he became addicted, he was safe now because he was very open and honest about his addiction. He felt it was important for his co-workers to know about his history, and he had even helped other people struggling with addiction at his workplace because of his experience. He stated:

I think if anything my recovery has made me a better nurse. I've had the opportunity to share with other people and help in their recoveries and like I said, I've talked to my internist about the whole thing, and every year I go in and the first thing he asks me is, 'Are you doing meetings?' Not 'how's your blood pressure' and all these things, but 'are you still doing meetings'. . . I felt really guilty for a long time about letting my team down and the docs I work with because they're all friends. I was able to show that I can do that and show I can do a good job of it. And I think God's put me there for a reason because every time I turn around somebody's, whether they've got somebody in their family that needs help or them themselves, I've given more of those big books [Alcoholics Anonymous Basic Text] at my work than I have at most meetings I go to. That also showed me that there are a lot of people with addiction problems in the healthcare field.

**Participant 8-LACEY.** Lacey was a beautiful 38 year old Caucasian woman who had been a nurse for 19 years. She was in her active addiction for 5 years and had been in recovery for 2 1/2 years now. At first she abused opiates and quit using those, only to find that benzodiazepines were also effective in giving her the desired feelings she wanted. For a while, she justified her benzodiazepine use, telling herself that her problem was with opiates so it was okay to use these other pills. She soon realized she had been fooling herself and had to begin recovery all over again--this time from benzodiazepines. Lacey still struggled with the difficulty of staying clean. Although she stated she had not used for over 2 years, she fought with cravings and the desire to use the drugs still. She worked in a jail setting as a nurse when she was abusing drugs and was then currently seeking employment. Lacey never believed she was at risk for addiction before it happened. She stated she felt, when she was younger, that addiction was something that happened to other people--“. . . people who were weak, people that had problems.” That is how she perceived it. Even though she stated her father was a “functional alcoholic” and her “brother used pretty much every substance known to man and has been through rehab 7 times,” she still did not consider herself to be at risk for addiction. She defined her father’s alcoholism as “functional” in that:

He still managed to get up and go to work every day, do everything he needed to do. He never missed work, he ran his household, he did everything he needed to do, but he was a tremendous drunk during that whole period.

Lacey felt like nurses were at greater risk for addiction because of the accessibility to drugs. When asked how she had become addicted, she replied:

I had some chronic medical issues. I was diagnosed with rheumatoid arthritis after my little one was born and we were having a hard time getting it under control and my doctor threw a lot of narcotics at the pain. I learned that I really liked them and it was a way to escape. And then my husband started having chronic

medical problems, and I really didn't like my job anymore. I did initially for a long time. And there was a lot of financial stress and stress with juggling my husband's medical problems, and still going to work, and still taking care of my little one. It was my way of not feeling those frustrations and stresses and I started using it more for that than I was actually using it for the pain . . . I really was in denial about it until it got really bad and I started doctor shopping and pharmacy shopping. And when I really knew I had a problem was when I started stealing it from work.

Because she was working at the jail and had been exposed to drug addicts quite a bit there, she felt a heightened sense of shame and guilt when she realized she had become addicted. She reported that “. . . probably 90% of everybody that came into the jail had offenses that could be traced back to being addicted to drugs.” Because of this knowledge and history with the inmates at the jail, she realized her own job would be in jeopardy if she admitted she was an addict, so she felt doubly ashamed. She had always felt in the past that addiction was very “black and white.” Speaking of addiction, she said:

It was a weakness of the mind. . . . It was just something that people had control over whether they continued to choose to do these things . . . So as far as I was concerned it wasn't a medical necessity anymore; it was that they just wanted to do it.

Because she had always felt this way about addiction, admitting her own problem was difficult. She said it was even depressing. It really “. . . weighed heavily on me to know that I was doing the same thing as all of the people that I took care of. But nobody was taking care of me. So I felt very hopeless.”

Lacey has continued to look for employment but stated it had been much more difficult to get a job than ever before. She believed this was because there was a stigma attached to nurses who had problems with addiction. She also had to be very picky about where she would accept a job:

It's very difficult for me to go to a work place that has narcotics and avoid them. It's definitely been an added stressor on my career and I've left more than one job because of that. And I did end up using benzos instead of opiates and was already

on probation for that . . . and I had started stealing from work as well to support my habit.

Lacey said she accepted the fact now that she was an addict. She knew she could never “dabble with substances at all.” She was just trying to get her “life back on track and find a job that suits me that I’m not around narcotics.” She said that mostly she had to change how she dealt with things so that she did not feel the need to turn to substances ever again.

**Participant 9-LINDA.** The next participant to be described is Linda. She was a 52 year old female Caucasian who had been a nurse for 30 years. She reported having been in active addiction for 25 years and had been in recovery for the last 4 1/2 years. She had worked primarily in the emergency department (E.D.). Her primary drugs of choice were opiates. Linda stated she worked as a nurse for 10 years before she became addicted, but she did not feel people were at greater risk for addiction by virtue of being a nurse. In fact, she did not ever consider herself to be at risk for addiction--nurse or not--even with a strong family history of addiction. Her drug use began with narcotics prescribed for headaches. After initially receiving controlled substances for these headaches, she started asking for them every time she would go on a trip, “just in case” she might need them. She ended up with some other chronic health problems over the years and continued to receive prescriptions for opiates. At the same time all of these health problems were going on, a bad marriage was very stressful for her, and she stated she started using the medications to numb “. . . the pain of my injury and it was working for my failing marriage as well.”

At this point, Linda considered her family history for addiction and worried about the possibility of her being a drug addict. She said:

I was worried because of my family history and that was probably the pivotal moment that I realized that I come from a family of addicts. My biological father used cocaine and died of alcoholism. My older brother was an alcoholic, my sister used meth and cocaine and she was an alcoholic. My younger sister was a cocaine addict and still is. My mother was a closet drinker, but back in the day in the 60's she was addicted to Valium and so I knew that we had a family of addicts, but I still didn't look into this as a genetic thing. . . or is there some sort of a genetic component to it? I didn't think that at the time so I didn't worry because I was just justifying my use of it was normal.

Linda mentioned one thing that nobody else did that she felt would be helpful in preventing addiction. Her answer was: "Probably my physician saying no." She said:

My physician gave me 150 every month at the time and I could justify taking probably 6, 7, 8 a day and could justify it because, oh I have a bit of an arm pain that 20 years ago would not have been a big deal. . . you took Tylenol for it or didn't take anything. But I could take it and justify it because he gave it to me. . . I had my primary care doctor, another physician who I was transitioning [to] that I knew would give me more medicine and then a sports medicine orthopedist who had treated me for some orthopedic injuries, so I used the 3 of them to get medicines from. So I doctor shopped for probably 2 years until one of them discovered by something I had said. . . and at that time, that's when I was accused of being impaired at work by our physician and then having to do a random drug test.

Ironically, Linda stated having a doctor say "no" may have prevented her from falling into addiction, but then right after that stated when one would not give the drugs to her, she "doctor shopped," or went to another one. The line between legitimate narcotic use and addiction seemed very faint to Linda, as she still felt she needed to use narcotics on occasion. She felt, as long as they were prescribed and she took them as prescribed, she was not engaging in her active addiction. Some of the other interviewees would definitely have disagreed with this viewpoint, but Linda did not feel this was a problem. Most of the other study participants acknowledged the fact that they could not go anywhere near the drugs they had been addicted to--but DOPL was aware of Linda's prescriptions and was

allowing her to use them if she did so appropriately. She did acknowledge the fact that her thinking about addiction was a little bit different:

It wasn't nursing that got me there [into addiction] . . . it's your own choice and it also, I think, doctors need to be educated on it and about how much medicine they give. Other than that it's hard for me because, it's hard for me to answer that. . . because I'm a little bit different from other people that are addicts.

She was very excited to have this study being conducted and stated she felt it was a “great thing. . . a good topic and one that needs to be shared with nursing programs.”

**Participant 10-MELISSA.** Melissa was a vivacious, excited woman with 20 years of nursing experience behind her. She was not currently working as a nurse because her license had been temporarily suspended, but she planned to get her license reinstated as soon as she was able to (in 2 1/2 more years). Melissa was a 38 year old Hispanic female whose primary specialty area had been labor and delivery (L&D). Her addiction was to opiates. Melissa worked as a nurse for 11 years before ever using drugs. She stated she never even wanted to be numb when delivering babies or having dental work done. Her story was a fascinating one. She grew up in a very devout Catholic family where strict rules were enforced. She did not drink or use drugs in high school or college. She stated she wanted everything done naturally and did not even want to color her hair. Her addiction began while working as a nurse on a labor and delivery unit and was so intriguing the whole recollection of it will is here:

When I was about 28 years old I worked full time night shifts as a nurse. I chose to so I could be home during the day with my kids to be available to take them to school every morning, make them dinner, do everything like a normal stay-at-home mom and then be at work at night while they were sleeping. When I was at work one day, one of the physicians came out and started talking about this wonder drug that all of us night shift nurses should try, and it was called Ambien. And he, just on his own, nobody asked him, he wrote out about 8 prescriptions and left it on the counter for all of us nurses. . . So he left these 8 prescriptions with no names on them and he said all of you night nurses need to try this, it's

going to save your life, you're going to be able to handle these night shifts better. . . it's just a great drug. So everybody took their prescriptions and there were maybe only 4 of us working that night so everybody ended up taking two and just stuck them in their purse. Mine stayed in my purse for months, it wasn't dated either-- he just told us we could write our name on it when we went to fill it. I gave one of them to a sister of mine and then I eventually filled mine. That one prescription of 30 pills lasted me for about a year. I would take maybe half here and there and it did work good but I preferred not to take them.

And then one day I got home from my night shift, I took all my kids to school, and went back home and took a half of one of those pills, I was still on the same bottle about a year later. I took a half of one and then lay down and I remembered I was supposed to volunteer that day at my daughter's school for their lunch hour as they ate in the classroom. . . they went to a private school. So I got back up and I was just hoping and praying that that half a pill wasn't going to leave me too loopy, and I got to the school and what it did instead was it just made me a really relaxed and happy and fun--just a happy-go-lucky mom. And I had the kids--we just had so much fun--at one time we were doing a conga line and doing all sorts of crazy things because in my drug-induced state it made sense just to have a lot of fun with them. I had them on the tables and they just thought I was the funnest mom in the world. And then I went home and I slept great and from that point on I realized that if I just took a little bit of one and didn't go to sleep, doing housework was more pleasant, and dealing with my husband who I disagreed with all the time was more pleasant. Dealing with anything that I thought was unfair in my life at the time was a lot more pleasant. And so that is when it started, and after a while, a half of one just didn't have the same affect so I would take a whole one. And then after a while a whole one didn't have the same affect so I would take one and a half. . . And eventually over time it actually got up to where I could take 15 easy in a day and there were even days where I took an entire 30 'til I would take that in a 24 hour period. That's when it all began is with the Ambien.

Eventually it became too difficult to maintain this volume of Ambien use, so Melissa switched to opiates. For the majority of her active addiction she took only pills but, near the end of her active addiction, she started using intravenously. She had now been in recovery for 2 1/2 years. Melissa was never educated about nurse addiction in nursing school and never used drugs or alcohol as a student. She never considered herself to be at risk for becoming addicted, even though her father was an alcoholic. She did feel that



being a nurse definitely put her at higher risk for addiction because she never drank alcohol or used drugs until she got them at her place of employment. She stated:

If I wasn't a nurse I wouldn't have gotten them from anywhere else. Even in the hardest part of my addiction I still never went to a drug dealer or anything. . . no matter how bad I felt, no matter how much I wanted it even at those really low points I never allowed myself to get it from anywhere that would cause even more trouble. So I wouldn't have gotten it from anyone else. So definitely. . . being in a hospital setting where drugs were accessible and being around physicians where you can just ask for prescriptions and they'd give them to you. . . Huge risk there. Had I not been in a hospital I wouldn't have ever asked for drugs. I don't think I would have ever taken them. But I don't blame being a nurse on becoming an addict.

Melissa has been through a lot with her addiction but was so positive and grateful for the opportunity she would have to be a nurse and have an active license again soon:

I've never been one of those nurses who wishes I had chosen another profession or one of those nurses that you hear telling the new nursing students 'uh good luck'. You know, I had nurses who told me that when I was in nursing school. They'd say, 'why are you choosing this?' I always always always loved my job, loved being a nurse. I'd achieved the ultimate goal that I wanted to achieve in life. That's all I wanted to do was be a bedside nurse taking care of people, and so after going through addiction and then still being able to practice as a nurse in recovery and not have it taken from me, I appreciate it even that much more. Like I didn't think I could love it anymore, but I did. And because then it was so precious to me because it wasn't taken from me, even though I'd done all that I had done, and I'd gotten in trouble with the law, and I'd gotten in trouble with the department of professional licensing and I still got to be a nurse and I still got to keep my license.

**Participant 11-MIKE.** Mike was a 39 year old Caucasian male nurse who had been in recovery from drug addiction for 3 years. He had been a nurse for 10 years. He primarily had worked on a surgical unit. A couple of years ago, he received his Master's degree in nursing and had been working as an Assistant Professor in a large state university in Utah. Mike worked as a nurse for 5 years before he became addicted to substances. He did receive education on nurse drug addiction in nursing school and actually suggested the method he was taught as a potential method of teaching students in

more nursing schools. This method will be discussed in the discussion portion of this paper. He did use drugs during nursing school, so even though he learned about nurse addiction, he was currently using substances so did not internalize what he was being taught. He was one in the minority in this study who felt he was at risk for addiction before he ever became addicted. He did not feel that being a nurse placed one at greater risk for addiction, though. He felt his risks were related to outside issues like a divorce and other stressful life circumstances. He did state the increased access to drugs was a risk factor for nurses even though just being a nurse did not place someone more at risk for addiction.

Mike became involved with nursing as a result of a situation which impacted his life greatly:

I became involved with nursing basically after. . . a specific incident where I was first on scene of an accident where me and my parents saw a wreck which involved a mother and some of her children. . . her 3 children--a baby in a car seat and 2 other children. It was a pretty devastating wreck. And I don't know what ever happened to them but I just remember standing there with my parents basically in shock and wanting to help but not knowing what to do. I had no idea. But then an off duty doctor and nurse came on the scene and they started speaking some weird language and were able to help and able to offer help and since that time I thought I want to know what they know. And then after living in South America for a couple years I came home and just had decided that my career would be a service oriented career because of my experiences in South America and combined with this specific situation. Nursing just always fit me and it's been a good 10 years.

Mike acknowledged "certain life experiences" were what caused him to become addicted to multiple things:

I was in. . . the last year of graduate school where there was high stress and high expectations. I had also at that time accepted an administrative position for an oral surgery group practice where my role as an administrator wasn't clearly defined. If anything it was fragmented and I don't think the partners in the group had spent the necessary time in articulating what each of their expectations would be. . . it was a highly lucrative position, at the same time, high stress. So on top of that

was when my wife had filed for divorce and so at that point in my career, point in my personal life, was when for me the addiction became something that I fell back into and held on to for some time to be able to get through that.

Now that he had quit engaging in addictive behaviors, Mike felt very empowered knowing he would be in many different clinical settings, sometimes around narcotics, and not have the desire to use them. He said it was comforting to know that, in spite of temptations, at this point of his career his focus was on his students and the relationships that were being developed and maintained in the community. He felt a lot of fulfillment in his job as a nursing instructor and stated it “feels good to be able to be in recovery, to be sober, and to find a lot of joy in my career that actually feels a lot better than the drugs that I’ve ever taken or the addictions that I’ve indulged.”

**Participant 12-TAMARA.** Tamara was a very colorful and energetic nurse from a smaller, rural community in Utah. She was 37 years old and stated she was educated about nurse addiction in nursing school. She was unique in this study in many ways. Because she came from a small town, she actually did not know any other nurses who were in recovery, so did not have that support system available to her. She became addicted after being a nurse for 7 years, but her drug of choice was methamphetamine. She denied ever using prescription drugs (or any other type of drugs for that matter) as a nurse. She had worked primarily in home health and long-term care and had been a nurse for 14 years. She has been in recovery for 6 years. She stated she was active in her addiction for 1 1/2 years. She denied having used drugs and/or alcohol while she was in nursing school. She experimented with methamphetamine for a number of reasons:

Well, I call it my mid-life crises, is really what I call it. I was getting ready to turn 30 and I was freaking out. I was like, oh my God I’m getting old--this is horrible. And I was married at the time. My husband was always telling me that I was fat and ugly and had pretty much told me that my whole married life. I had a

girlfriend who was overweight, and I knew that she had been using meth and supposedly she was clean and needed some help--place to stay--and she had two little boys. They were friends of ours prior to using. But she kind of made it look glamorous like this wonderful thing, and she had lost a lot of weight, and I had tried weight watchers, diet pills--I mean you name it--I'd done it. And I couldn't drop any weight, so I thought, what the hell I'll try it out.

I was already kind of in the party mode because I was freaking out about being 30 so I had started drinking quite a bit initially--like when my birthday was coming closer and stuff. I think it was probably around February that [my girlfriend] got some and I tried it. And I thought, oh I'm smarter than everybody else, I'm a nurse, I know how to do it and not get caught and I'll control it and I'm not going to use on days that I work and I'm not going to use while I'm working and I'm not going to get addicted because I'm smart. I'm a college girl. And within a year and a half I was shooting up a hundred dollars a day. . . I was married at 19 so I didn't really get the whole lets hang out and party stuff. So it kind of started off as that and then it just kind of took off. I ate it, smoked it, oh I also stopped smoking cigarettes at the time, so I kind of swapped one addiction for another and went from smoking cigarettes to smoking meth and then figured out oh I'm a nurse, I know how to do IV's, I know how to draw blood, so I started shooting it up.

Dealing with stressful life situations and a worry about weight were the reasons behind the use of drugs and alcohol for Tamara. She stated in the interview that she never really considered herself as being at risk for addiction but that she "didn't really care." She said, "I was going to do it and lose the weight and be sexy and beautiful and party. So I wasn't interested. I just didn't care flat out." She admitted that now that she was in recovery she was definitely at risk. She did not believe being a nurse placed people at higher risk for addiction and that she did not ". . . think it really matters what your occupation is or what you choose to do." She then stated she would have used meth whether she was an "attorney or a McDonald's worker or a nurse. . . it wouldn't have mattered."

While in her active addiction, Tamara experienced things a bit differently than many of the other study participants. While others were feeling a lot of fear and guilt, she was feeling like she was "superwoman." She said:

I could do it all. I was super nurse, super mom, super wife. The big problem that I went through a lot prior to addiction was that I was so exhausted all the time to the point where on my days off all I would do is sleep. So when I started using and all of a sudden I had energy, I could play with my kid, I could go and do several visits a day with my job and actually visit with the patients, it made me a little more talkative. Yeah, I thought I was superwoman. I mean I look back now and think what a fool I was, I mean, how could anybody not know because I can see it now and I can see the behavior changes. But at the time I didn't.

She was very open and upfront about her addiction at the time of the interview, and did not appear to be ashamed by it. She was not proud of it either, she said, but she said she did not feel she needed to hide it or be embarrassed by it anymore. She still felt angry at herself for her actions when she "knew better" but stated that, for the most part, she had made peace with her addiction.

**Participant 13-TERRY.** Terry was a 45 year old white female who had been in recovery for 7 years. She was actively addicted for 5 years. She had been a nurse for 17 years. She stated she did occasionally use drugs and alcohol in nursing school and was not instructed about nurse drug addiction as a nursing student. She was working in outpatient recovery when she was engaging in her addiction. She did not consider herself to be at risk for addiction, but she did consider nurses to be at higher risk for addiction because of the access of narcotics. She did state that, before she personally became addicted, she did not think being a nurse put her at risk for addiction, but after the fact she felt that it did.

Terry's drug use started with the introduction of opiates after she had cesarean sections. She would use her leftover pain medications when she would get a headache or some other random pain and, instead of taking an over the counter analgesic, would just take the opiates. Then she started noticing the drugs made her feel better all around:

They made me feel good; they helped me clean the room. Most people would be like, 'I just pass out on those things'. Uh uh, nope. It woke me up and my house was the cleanest house, I swear. And now it's a total disaster. You can tell I'm on drugs if my house is clean, the car is clean, and the kids are clean. Now everything's a mess.

She did end up diverting medications from the outpatient recovery unit where she worked and eventually was fired from there and referred to DOPL. She stated her experience with addiction had really helped her relate better to people that had addiction issues, and she could spot the problem much easier in others after having experienced it herself. She has chosen to work in a different setting now where there was not the kind of access to narcotics that there was in the outpatient recovery setting and felt she was doing very well in her recovery. While she was working on her baccalaureate degree in nursing a couple of years ago, she decided to do her honors project on educating nursing students about nurse addiction. She made a video of herself telling her story and showed it to the cohort of nursing students that semester. She and the professors who were a part of that project stated the students responded very favorably to the presentation and seemed to really appreciate hearing her story and being able to put a face with a person who had been through the experience of addiction. Students commented it made an impact on them to see someone who looked so "normal" as being one who had struggled with addiction.

Terry stated she did not think there was really anything that might have prevented her from becoming addicted. The addiction crept up slowly and started with legitimate prescriptions for pain medications. She did not view her behavior at the time as being risky or inappropriate, so she did not think she would do anything differently if it were to

happen again. She wondered if seeing or hearing from a nurse addict in recovery (like she did in her project) would have helped but stated she just did not know:

I don't know if somewhere along the line it would have clicked. But if somebody saw their life in my little story, maybe, because that was never told to me. Nobody ever sat me down and said here's this video and said before you become a nurse you better watch this. I don't know if it will help but if they used something similar to that in every single school setting and you noticed that nursing and addiction went down, maybe we would know. But my little video here at this school isn't going to make a dent in the problem.

She felt the most effective way to get this topic discussed and understood in nursing school was to just “. . . discuss it! Just bring it up and have people come in and talk about it or do videos like I did.” She said that, while she was in nursing school, they did get taught about street drugs but were never introduced to the reality of nurse drug addiction.

**Participant 14-VALERIE.** Finally, Valerie was a 33 year old Caucasian female who worked as a nurse in labor and delivery (L&D). She was not working at time of the interview, and was actively seeking a new job as a nurse. Valerie had been a nurse for 15 years. She practiced for 6 years before becoming addicted to opiates and had been in recovery for 2 years. She actually ran a “Professionals in Recovery” (PIR) meeting once a week in a large hospital in the state. She was instrumental in identifying participants for this study and referred three of others who ended up being interviewed. Valerie was very quick-witted and was able to express herself very well in her interview. She denied having used drugs or alcohol in nursing school and said she was educated about nurse addiction in nursing school. When asked how she became involved in nursing, she replied:

I've always been a very giving and caring person in general, and I knew early on I wanted to do something where I worked with people, not computers or objects. I liked people. I signed up in a CNA course on a fluke just because I needed the extra credit just to graduate early; I wanted to be done with high school. Found

out I loved it, got hired at the first place I did a clinical at, they asked if I could work there, and I did and never looked back. I loved it and kept doing that. I've never worked in anything but healthcare.

She never considered herself to be at risk for addiction because she had "seen firsthand what it did to people." She stated that, before she found herself in the situation of recovering from addiction, she actually had made fun of addicts:

Everybody would joke about that, 'frequent flyers' as it were, and 'I can't believe they said this', 'that was so stupid', or 'did this', 'why would you do that'-- it made no sense to a sane person. And I just thought there was no way that I could ever fall into something like that. I thought that I was educated enough that that would protect me from the danger of it. And even as I went down that path and recognized some of the red flags, that helped contribute to my denial because I thought I'd be too smart and strong for it. . . like, oh, I'm not going to be like that person.

She did not realize until after she had started her own recovery that there was quite a family history of addiction in her family. She was not aware of that history before she herself became addicted. She did feel in retrospect that she was at risk by virtue of being a nurse. When asked why being a nurse placed her at greater risk, she stated:

Being around [the drugs] and feeling a superior sense of control over [them]. We know how they work, we know how the dosaging works, so we can use safely. It's a dangerous mix of knowledge thinking we had power of it and we can use safely and not knowing we are at risk for it because that wasn't discussed in nursing school. It was very briefly mentioned. They very slightly skimmed over it one day I remember but it wasn't anything we delved into. Just access and familiarity with drugs. Knowing what pills worked for what and what you can take to fix this problem and counteract the bad effects of this drug so that even the negative effects of the drugs you we're able to minimize like nausea. Being able to learn to inject easily, there's no learning curve there. That right there will put you right at risk.

Her addiction started very gradually. She stated she would justify using strong pain medication for every little ache and pain that came her way. She would start by just taking a half of a narcotic pain medication and that would progress to a whole, and then at some point the "lines got blurred to where it was take a whole one more days than not.



. . and then rapidly it turned into take one every day just to get through all the stuff because you realize how great it works.” When asked what the experience of being addicted was like on a daily basis, she said:

Horrible--physically, mentally, socially horrible. You physically feel horrible and we know what it does to our bodies, the highs and lows and just feeling crappy. You get to the point where you just feel crappy and you don't even feel good from the drugs anymore. You feel very isolated. I didn't even know who to talk to about my problem. I didn't know anybody else in recovery. A lot of people that get into drugs have a culture of drugs. They have friends that they use with and that's how it starts; a party atmosphere. We don't usually have that with nurses; usually it's a very private thing. We haven't ever seen anybody get well and start going to AA meetings or whatever. Oh I can reach out to that person--how do you get out of this? We don't have that. There is no peer and we don't dare. Who do we talk to, we're going to get in trouble, and we're going to let people down because they hold us so high. I mean I was the go to person in my unit for all the problem solving. I was the one the doctors called when they had a difficult case when they wanted somebody highly skilled. Let's call and see when Valerie's scheduled we'll do that when she's there. As that person I wasn't going to be the idiot who, because you know, we went back to the way we view addicts; they're stupid, they got themselves into this and they're stupid. So I felt stupid, I felt isolated, very berating myself. I very much berated myself.

Valerie stated she still fears working in an environment where she has access to narcotics.

She has had to be in two different contracts with DOPL and was very wary of being in any environment which would be risky for her. She felt like her situation of being an addict “cheated” her out of working in her favorite places. She said she loved doing E.R. and L&D and felt like she had “been cheated out of working those environments now because [she] can't be around drugs.” When asked to describe what it felt like to be a nurse addict, she stated:

It's hell while you're going through it and coming out from the other side, I'm so glad that I've gone through it. It's made me a better person and a better nurse. But I still wish that I never had to deal with this. I hate the fact that it's always going to be there. It's not something that I can conquer and move on. It's been very broadening. I've learned a lot about myself and others. So overall it's been good.

She stated she felt like she had really limited her career options because of her addiction and was, therefore, struggling to find a job that she felt comfortable engaging in as a nurse.

### **Results and Findings**

The original research question for this study was: What is the lived experience of nurses who were addicted, and how do they perceive their risk was for addiction? In this unique qualitative study, a wealth of experience and insights were shared by the 14 nurse addicts that were interviewed. Despite differences in age, specialty area, years addicted, years in recovery, and other characterizing factors, some common ideas and findings emerged through the process of data analysis. In response to the research question presented above, five themes emerged from the data. These themes have been identified from both manual coding and analysis using NVivo® software. The five themes are: (a) Fear is a significant part of the experience of being a nurse who is addicted; (b) Shame and guilt are felt by nurses who are addicted; (c) Poor coping: Addicted nurses report having underdeveloped coping skills; (d) Control: Addicted nurses feel an increased need to control their environments; and (e) A core problem inherent in nurses who are addicted is a belief that addiction would never happen to them.

### **Presentation of Themes**

#### **Theme 1. Fear is a Significant Part of the Experience of Being a Nurse Who is Addicted**

A common thread through each of the interviews with recovering nurse addicts was the presence of fear--both during active addiction as well as while in recovery. Fear was not always easy to define. It may have been something innate or learned and it could

be very complex to understand. Fear could manifest itself in many ways throughout addiction. Sometimes fear was the precursor to drug abuse. It almost always came as a result of drug abuse while the addict was engaging in his or her addiction. Sometimes it was worry after the drug abuse has stopped. Fear was undeniably a survival mechanism in some instances but could also psychologically immobilize people who were chronically afraid. Nurses who were addicted experienced a lot of fear. Their fears were legitimate and clearly caused significant anxiety for them. The words “fear” as well as the synonyms--worry, afraid, scared, anxiety, care, and concern--were frequently used throughout the interviews. For several nurses, fear of being caught while in active addiction was a major concern for them. Craig said:

Early on I didn't have any feelings of fear but toward the end of my active use I felt like I was constantly . . . flying under the radar, but then again I always thought, 'when are they going to come ask me about my possible use?' . . . 'Who's noticed anything?'. Really when it comes down to it I always wondered if maybe that was going to be my last day at work. I feared for my license but I feared more for the inability to provide for my family if I did lose my job. But that alone wasn't necessarily [all]; I had those feelings long before I actually stopped. So that wasn't enough motivation for some reason.

Along with fear of being caught, Craig said he worried about losing his job or his nursing license. He worried about not being able to provide for his family. These were all big concerns. Mike also worried about similar things:

That was a very, it was very scary. In fact it was overwhelming for me because of using outside of my career. . . I couldn't function in my responsibilities and in my role as an administrator. And it was because. . . it was overwhelming to go to work and I wasn't effective and because I was facing that demon, for lack of a better word, because I was facing that head on, kind of recognizing what it was, going to work was scary. . . I was afraid that it would be perceived that something was wrong or that someone would recognize signs or symptoms of my using. That was more concerning and scary for me. I was worried about losing my job. I didn't understand what it would take-- I had never been around anybody else truly losing their nursing license. So that was not something that I sat and processed in my mind that I could lose my licensure. I was more concerned about losing a

lucrative position and I was more concerned of issues outside of the work environment like my marriage and my family and I was definitely concerned about losing those things in my life. I think as a result of being consumed with the thoughts of losing my family, losing my wife that it just made me ineffective in my role as a nurse.

Al expressed similar fears as well:

I was definitely worried that I'd get caught. Because if I made a big enough mistake at any time they could turn around and say let's go down to the ER and have you pee in a cup for us. A patient or a client that recognized any symptoms of addictive behavior could at any time turn around to DOPL and say hey he has odd behavior. And I guess my dealer could call technically if he really wanted to and say hey this guy is drinking and using and he's doing a community service to us he could kill people. DOPL could easily call me aside at any time, so yeah I definitely had fear. Fear, shame, guilt was running my boat. I wasn't in denial, I'll tell you that. I was well aware of my addiction.

According to Borgna (2005), fear was an emotion that was caused by situation or a person perceived as threatening and/or dangerous, where one felt one's safety was being compromised. Whether that situation truly was dangerous or threatening was not relevant if the person perceived that fear. In order to better understand why humans experience fear, a research study was conducted by Nevin Mert in 2012. His study attempted to describe fear in terms of developmental, humanistic, behaviorist, and social aspects. His ideas went right along with the theoretical framework identified for this study on nurse addiction--Social Cognitive Theory (described earlier). Mert (2012), like Social Cognitive Theory, looked at the interaction between personal factors, environmental factors, and behavioral factors. The experiences of addiction and fear were both significantly relevant to social and behavioral theory. Mert (2012) also brought Maslow's hierarchy of needs as a means of illustration in how fear interacted with different levels of human development. According to Maslow (1943), there was a

pyramid representation of human needs--from the most basic at the bottom to the most personal and advanced at the top (see Figure 2).



*Figure 2. Maslow's Hierarchy of Needs*

Each approach is different and important for understanding the reasons of fear and where it originates. When fear was considered in the levels of Maslow's hierarchy, each level of human relationships with others could provide different foundations for experiences of fear. Mert (2012) proposed that each level of fear, like levels of needs, was different from the other levels. He actually adapted Maslow's pyramid to his own "Pyramid of Fear" (p. 36). Mert's revised pyramid is depicted in Figure 3. All of these "stages" of fear manifest themselves in different stages of life. Mert (2012) acknowledged that, if socio-psychological factors were being considered, different areas of the world had to be studied in order to gain an accurate representation of the concept of fear and how it was experienced by human beings. His study, along with many other studies on fear in the literature, attempted to understand and describe the very complex idea of fear, which seemed to be experienced universally yet differently by all people.



*Figure 3. Mert's Adaptation of Maslow's Hierarchy of Needs into Hierarchy of Fear*

All of the participants experienced significant fear in one way or another. When the literature was explored further related to fear and addiction, interesting facts were discovered. Not only did fear and addiction appear to be psychologically related, they have also been shown to possess a physiological relationship. One group of researchers reported evidence that both addiction and fear overlapped in the prefrontal cortex of the brain; they were physiologically related (Peters, Kalivas & Quirk, 2009). Both fear and drug-seeking were responses that were considered to be “conditioned”, and when they were expressed inappropriately, could both lead to behavior that could cause problems for individuals. This study further presented information about “extinction,” which was defined as “a form of inhibitory learning that suppresses a previously conditioned response” (Peters et al., 2009, p. 279). The authors presented recent evidence that the medial prefrontal cortex (mPFC) was critical for the extinction of both fear *and* drug-seeking behaviors.

Another group of researchers studied the relationship between fear and the brain in methamphetamine users (Goldstein et al., 2002). They used Tellegen's Multidimensional Personality Questionnaire (MPQ) harm avoidance (fear) scale and the

constraint superfactor in order to measure inhibitory control in methamphetamine addicts who had recently become abstinent. The researchers took these measures and examined their association with glucose metabolism in the orbitofrontal gyrus of the brain in their subjects when they were at rest. The researchers found that higher MPQ (fear) scores were associated with higher relative orbitofrontal gyrus metabolism in the methamphetamine-dependent subjects. The results of this study suggested the role of orbitofrontal cortex in inhibitory control has been seen in stable personality predispositions. This has further supported the implication that this region of the brain has been closely linked to the characteristics of drug addiction (Goldstein et al., 2002).

The American Psychological Association (APA) published a press release in 2007, titled “Mental Illness and Drug Addiction May Co-Occur Due to Disturbance in the Brain’s Seat of Anxiety and Fear.” They presented research revealing that dual diagnosis (depression and drug addiction) may stem from a common cause: namely, developmental changes in the amygdala, a part of the brain linked to fear, anxiety, and other emotions (APA, 2007). They even suggested early injury to this area of the brain could cause addiction and/or dual diagnosis. They presented a study done on rats with amygdalas damaged at birth. These rats with damaged amygdalas showed abnormal adult behavior related to fear, as well as a greater sensitivity to cocaine. This significant relationship between fear, the brain, and addiction were important enough to merit a press release. It was clear that fear and addiction went hand in hand.

Another study actually sought to understand which came first with addiction--the physiological, environmental, or psychological (including experience of fear) factors. Their conclusion was that more emphasis should be placed on the psychological aspect of

addiction than the physiological in an effort to decrease and control the incidence of addiction (Mosavi Amiri, & Homayouni, 2010).

Fear has been shown to be physiologically related to addiction in the prefrontal and orbitofrontal cortexes of the brain but also has many psychological components in the addicted person. Fear has even been used as a tool in an effort to prevent addiction. A study was done in New Zealand in 2008 which explored the effect of using fear as a method of discouraging addiction to nicotine (Thompson, Barnett, & Pearce, 2008).

Because addiction to nicotine was perceived very differently than addiction to other substances, it was difficult to know how a fear-focused campaign would work with drugs and alcohol, but fear was definitely a key factor in addictions of all types and was recognized as such. In the study at hand on nurse drug addiction, Terry expressed her experiences of fear in this way:

Well you're constantly looking over your shoulder because you go to the machine, somebody needs 1 pill, you get out 2, walk down the hall and stick it in your pocket. . . nobody saw. . . and hope they didn't fall out of your pocket during your shift. You're just. . . constantly paranoid of getting caught. Just think about how it would feel and what it would be like and it was completely not what I expected when I got caught. I would just think about it all the time, "what is going to happen if I got caught?" So I just thought for sure that I would lose my license and that would be that. I'd be done for. . . it's very scary when you're in the middle of it. So scary, paranoid, guilty. . . You are naive and then one day you just say, 'oh crap, what have I got myself into?' and then you get caught and you're relieved, and now you're just like, ok, I hope this never happens again and you have to just be vigilant. But it's very scary. Every day is kind of scary thinking, 'yeah there's some pills over there.'

Another cause of fear in the addicted nurses was the fear of working impaired and making mistakes. Dan expressed this concern in the following quote:

That last year I was always worried that they were going to call me in for a trauma and I wasn't going to be able to show up or get something wrong. As far as I know a patient was never harmed, but that was as far as I know. It's not like something directly happened. Just worry and it was so tiring trying to act like



everything was ok. And most everybody knew something was going on. I was losing weight, and not many people could tell because I'd be like this all day because I was taking pills about every hour. They'd watch me go down, and they told me later they said we knew something was going on. . . we didn't know if. . . although I did quit drinking for the last 9 months before, I was scared I was going to wake up dead if I drank and kept taking the pills.

Valerie expressed similar worries and fears about harming others as well as losing important things in her life and practice:

[There's] a lot of fear, fear of myself, fear of where is this going am I going to hurt someone. Can I lose my job? I was more concerned about my job. I didn't even fathom that would affect my license. I took that for granted. I thought I did the work it took to get it and it's mine forever. . . I worried a little bit, I feared a little bit but I felt like I didn't get to the point that it was so out of control that. . . I still fear ever working in an environment where I have access to narcotics or doing like home health or something even though I feel like I'm in a perfectly good place right now to be able to do that and I'd be safe right now, I have seen relapses too many times in people that I felt were in such a good place, so I just don't feel like it's worth the risk. Like it happens to the best of us, so why is it worth the risk being in that situation? I don't know if I'll ever be strong enough to do that. It scares me. So I feel like the situation cheated me after working in my favorite places. I love to do ER too and I love labor and delivery and I feel like I've been cheated out of working those environments now because I can't be around drugs. So that stinks. I feel like I've really limited my career options now.

Valerie's expressions of worry and fear extend beyond the fear she felt while she was using. She clearly felt fear and worry related to her future. She was one of the nurses that still had not found another nursing job since going through the process with DOPL and a lot of apprehension and concern still resided in her. Other nurses in the study also expressed still having fear after having stopped using the substances they were addicted to. Interestingly, while fear was strong throughout the experience of active addiction, in many addicts it appeared to carry on in recovery. When asked how it felt to be a nurse now that she was not using, Lacey responded:

I was afraid that I wasn't as good as I had been; I was afraid of how other people would have perceived me. I was afraid of being a nurse and making a mistake and that that would be looked at that much different than it would have been if I had

been completely sober. Even though I was in recovery and I was sober I still was always afraid that if something happened it was going to be that much worse for me because I was in recovery.

Ashlee also expressed fear even when she was in recovery:

Honestly, I'm still scared to say, that people where I work are going to find out and I'll be embarrassed, and they'll want to fire me if they ever found out I had an issue. I don't know. . . I just can't imagine going back and feeling all the anxiety and being scared to death and like I was being afraid of being caught or anything like that. But I would have thought that before I started using too, you know.

Annette, even after being in recovery for over 5 years, stated:

I do worry about people finding out or I worry about that the management does know my situation and that they pretty much have me over a barrel. So you know they could let me go, they could blame it on anything really. Or I worry about them being suspicious even though I'm not doing anything. You know I have random UA's every month and I have to go to a professionals in recovery [meetings]. . . or worried if they find out or if they're watching me because they do know.

This study suggested addiction was full of experiences of fear. That fear often came from uncertainty and worry about many things. It came from not wanting to quit using the substances. It came from not wanting to lose a license or a job. It came from the thought of people finding out what was really going on. The lives of the nurse addicts studied here have been full of fear and worry.

Another article found in the literature related to fear and addiction argued that fear could block the recovery process (Sandoz, 2002). Fear could be seen as a normal human emotion in the addicted and the non-addicted, which was designed to get the person's attention in a potentially dangerous situation. However, for individuals who were new to recovery, fear often could breed a series of emotional and behavioral responses that could lead to a relapse, according to Sandoz (2002). He argued the emotion of fear must be

overcome if sobriety and serenity were to be found in recovery. In the study at hand,

Ashlee expressed the following fears:

For me I was always scared to death. I never took anything before work. I was never at work on anything. I would like. . . I don't know, you feel like a liar and I would like wait, like I knew when I was going to be at work and when I had off, when it was kind of safe to take it. So I'd just kind of take it like after my shifts for the week were done; where I wouldn't be back for a few days. But I would take it near there at work. And every time before you take it you're like oh what if I get caught, what if I lose my license? And you are, you're scared to death and when you're leaving you're wondering oh is someone going to stop me, are they going to know, are you going to be judged? It is, it's nerve racking. Why you still do it, I don't know. But it's like I'll have it and I'll feel better and I won't take anymore.

This comment brought up another fear that came with drug use--the fear of *not* getting the next fix and being sick as a result of that. The researcher in this study was amazed at the absolute fear these participants seemed to feel at the thought of having to quit and get sick or go through withdrawals. The nurses were afraid of *not* using, but they were also afraid *of* using and the consequences which may come. Melissa talked about how she feared quitting the drug use because of its physical effects:

Oh [I worried] every day. . . my life revolved around it and I can think of many, many, many nights--I just think about those really bad nights where I was sick all night, crawling out of my skin, waiting for the sun to rise so that I could figure out a way to go get more of what I needed. So it was a daily maintenance thing. So yeah, I was worried every day and I was picking up extra shifts. I did everything I could to ensure I had access. I took home an entire prescription pad, but there were still several nights where during the day I wasn't able to use more cautiously and I would use everything I had and then suffer all night long. . . without drugs I do have anxiety, but not to where it's debilitating. The funny thing is I took [drugs] because of anxiety, but what became the biggest problem was the drug induced-anxiety. It was all from the actual drugs and then I needed more, and so huge anxiety--always crawling out of my skin, always panicking, but all drug-induced. And then it required more drugs to take care of it.

Studies have actually been done where the fear of detoxification from drugs was measured. One study several years ago by Milby (1986) examined the prevalence of

detoxification fear in 271 addicted patients participating in methadone maintenance programs. Out of the 271 subjects, 77 showed a “pathological” fear of detoxification. Those particular 77 with higher fear levels also had longer histories of addiction and been addicted for a larger percent of their life spans and were older than the subjects without this fear. Females had this fear more often than males, and a greater proportion of the subjects with this fear had drug-free urinalyses (Milby, 1986). Several other studies of detoxification fear were published in the 1980s and early 1990s but very few current studies could be found on this topic. One was found from 2005 in which alcohol detoxification fear was explored (Allen, Copello, & Orford, 2005). Unlike the quantitative study done on the methadone addicts in 1986, this study by Allen et al. (2005) employed a qualitative method and analyzed descriptions of fears during one-on-one interviews about the experience of alcohol detoxification. Fears in this study centered around four main areas: the setting in which the process took place, the physical consequences of withdrawal, the medication given to manage the detoxification, and the experience of future daily living without alcohol. A major finding from the study was that attention should be paid to the environmental setting of where patients detoxify. In addition, more effort to integrate relapse prevention work into the earliest stages of substance treatment was found to be a possible way to reduce fears about the process.

Fear has been a significant part of the experience of the nurses studied who have experienced addiction. Lacey remarked:

As a nurse I was always afraid to OD. I didn't want to overdose on mixing alcohol with my drugs. And it was always my biggest fear that my son would find me. . . that was always my greatest fear. Not that I would die because that seemed at the time like a welcome end to it all, but that I would leave my son and that he might be the one to find me.

All of these varying statements from participants in this study demonstrated the significance of the experience of fear in nurses who were addicted. They experienced fear in many aspects of their lives, both while they were using as well as after they had quit using the substances.

### **Theme 2. Shame and Guilt are Felt by Nurses Who are Addicted**

All of the participants in this study at some point made mentioned of feeling ashamed, guilty, or embarrassed as a result of their drug abuse and addictions. These feelings of guilt and shame often came as a result of personal morals and values being violated, from self-condemnation, from having to deal with people who knew what had happened treated them differently as a result, and from several other sources or experiences. All of the nurses interviewed admitted to feeling ashamed in some way or another--whether it was ashamed of being an addict, ashamed from being discovered, or ashamed to have taken medications from their employers. Many felt ashamed they could not stop the drug use on their own. Craig made the following statement relative to his experience of being an addict while using:

Once I realized the problem, the guilt involved. . . not only knowing that hey I've got a problem, but diverting medication that didn't belong to me . . . there's a lot of both moral and ethical. . . lot of people think about the ethical aspect of that, and depending on personal values and stuff there can be a real moral issue based on one's personal beliefs. That was probably the biggest thing for me, was realizing that something needed to change. I needed to make that change before it was too late. I had the guilt more on the days that I'd used rather than days not, but it was always there. Shame and even feelings of depression. . . sadness. I mean, I loved my job, but then again I hated it at the same time because of what I'd become.

Like Craig, Annie questioned how this could have happened to her:

I felt bad, you know. I felt guilty. I felt very guilty. I never took anything from anybody that was in pain or anything like that. I would never do that. I'm a real

caregiving person and I love to help people. And I could see that the other nurses around me were working, but in my mind I'm thinking, 'they can't be all straight'. I can't be the only one. Do they know? Or I would have to watch how close I got to somebody so they couldn't see my eyes or if it was on my breath or something like that. I was real careful about that. But I always wondered, am I the only one? You know, why is this happening to me? . . . but I did feel guilty. And I didn't want to shame the unit, and I didn't want to put shame on the fact that I was a nurse either.

Lacey also expressed feelings of shame and guilt when asked what the overall experience of being a nurse who was addicted was like. She worked in a jail and had been interacting with inmates who were addicted on a regular basis. She had even admitted to thinking her addicted patients were weak, so realizing she herself was addicted was very shameful:

There was a tremendous shame because I was supposed to be helping other people with their medical problems and I couldn't even help myself with my own. And especially because I was working with law enforcement in that point in time and there was an extra layer of holy crap I just fell into something that I despise.

As the researcher discovered such prevalent feelings of guilt and shame in these recovering nurses, she began to wonder if the shame was a result of the unique circumstances of nurse addicts or if guilt and shame were common in addicts of all walks in life. The literature was once again investigated related to guilt and shame in addiction. In one study, 108 recovering addicts in a residential treatment community were compared on levels of depression, guilt, and shame (Meehan, O'Connor, Berry & Weiss, 1996). The idea that drug-addicted clients suffered significantly from problems related to shame and excessive guilt--especially guilt derived from altruism and the fear of harming others (Meehan et al., 1996). That finding from several years coincided with what these nurses felt about the harm that could have happened to their patients. Lacey said:

I felt like I had to hide it even more because I didn't want to tell people about it. I could relate to a lot of my clients because a lot of them had a huge history. There are a bunch of people who are clients so I could relate to them. I felt different because there's not a lot I guess. I guess I felt separated from other nurses because

I guessed that they weren't addicts or alcoholic. I guess I felt separated in some forms. Or I guess I didn't feel worthy enough to practice because I knew I was putting them at risk.

In another study on clients recovering from drug addiction by O'Connor, Berry, Inaba, and Weiss (1994), addicted subjects scored significantly higher in proneness to shame than non-addicted subjects. This study also showed that women were significantly higher on shame and depression than the men, while men were significantly higher on detachment.

In an article in *USA Today*, a distinction between shame and guilt was made. It made the assertion that only shame (and not guilt) was linked to addiction. Shame was defined in this article as "the tendency to feel bad about yourself following a specific event," while guilt was defined as "feeling bad about a specific behavior or action" ("Shame, Not Guilt Linked to Addiction," 2005, p. 12). Shame certainly had *resulted* from drug abuse in the study on nurse addiction and had even been said to *cause* substance abuse. A researcher quoted in the article about shame and guilt stated:

Whether or not shame is a cause of problematic substance use, other problems that go hand-in-hand with shame--such as anger or interpersonal difficulties--are sufficient justification for implementing shame-reduction interventions into treatment. Successfully reducing shame is likely to result in better treatment outcomes" ("Shame, Not Guilt Linked to Addiction," 2005, p. 12).

Guilt and shame were separated and presented as not both being present in addiction in the aforementioned article, but no research was found to substantiate that claim. In this study on nurse addiction, the two feelings were often used interchangeably, as seen in this quote by Mike:

My acting out has always caused immense guilt and shame, I guess for multiple different reasons. So it was kind of a double whammy where I was consumed on one end with the factors of divorce and of knowing that I wasn't good at my job and I wasn't effective and that I was going to lose the job, which I eventually did.

But also the guilt and the shame that was associated with the behaviors of my addiction that mostly took place when I went home from work. So it was kind of two-fold for me. So definitely guilt and shame and again, an overwhelming feeling of being in a situation, that situation being divorce. But I never felt those types of feelings before.

It was interesting to note that, in more recent research, both shame and guilt were associated with sexual addiction (Gilliland, South, Carpenter, & Hardy, 2011). These researchers reported treatment-seeking populations of patients with sex addiction frequently expressed intense feelings of shame and guilt. A book titled *Shame, Guilt, and Alcoholism: Treatment Issues in Clinical Practice* integrated current psychological research with insights in the emotional realities of substance abuse and asserted alcohol addiction often led to destructive shame and guilt (Potter-Efron, 2002), so this did not appear to be a phenomenon that was unique to recovering nurse addicts.

Feelings of guilt and shame do not always resolve once the drug abuse stops. Feelings of shame and guilt begin with the abandonment of personal values as drug abuse begins and then continues on after drug use stops. It appeared that the forgiving of one's self was a difficult thing to do, even after the drug use had stopped, and recovery from the embarrassment or shame was definitely not immediate. The effects of drug abuse on a nurse impact how they feel about themselves, and they worry about what others think of them. They worry about not living up to what they should have been, and they often seem to blame themselves even after drug abuse has stopped. Tamara made the following comment about still feeling shame in recovery:

As a nurse in recovery, because I live in such a small town, I'm very embarrassed. I'm actually very humiliated especially when I run into somebody that knows that I used. It's humiliating. I mean I've been clean for 6 years and I still try to kick my ass for doing it.



In a dissertation by M. Lee Leppanen (2010) on nurses who were addicted, a study was presented on why nurses chose not to seek help for addiction. In this study, the author stated one of the main reasons nurses did not seek help for addiction was because of feelings of shame and guilt about their illness and drug-seeking behaviors and/or fear of losing their jobs or nursing licenses. Dr. Leppanen's findings supported both Theme 1 and Theme 2 in the dissertation being presented here on lived experience of nurse addicts in recovery. Fear, guilt, and shame were all inherent and significant realities in nurse addiction. When speaking about his experience as a recovering addict in the study at hand, Al stated:

It kind of made me mad at first because people; so I had guilt and shame over it. Knowing that I was a nurse and I was a professional and I was using and I guess in a sense professionalism as a nurse, you're not supposed to drink and use out of control, so I had a lot of guilt and shame as I was using but I guess after a while it just went away. But then it always creeps back up. But once you learned how to deal with it, making amends to yourself, to your boss, and strive to do better. So I guess as I was drinking and using I had guilt and shame over it, but I don't have guilt and shame now because I'm not drinking and using and I'm determined not to drink and use again.

When speaking about working around a nurse manager after being identified as a nurse addict in recovery, Valerie remembered:

My hiring manager knew so I always felt a little embarrassed around her. I always felt kind of ashamed because she's the one who really knows what's going on. And she's not a talky person so I don't know what she's thinking. She seems fine with it but there's always a twinge of embarrassment there. But then the fear of what if people find out how will they feel. Will they be ok with it? Should I just tell people and get it out there in the open so I don't have to wonder what they think? . . . most people have had a negative experience so they're going to have a negative view and I'm aware of that. I realize that even though I'm surrounded by people in meetings that are supportive and helpful and optimistic, I know that most of the world doesn't feel that way about addicts. I know that even though in the healthcare field we should be more educated and compassionate about addiction, in reality I don't see it outside of a treatment setting.

Valerie commented further about this shame in a different part of the interview as well.

When asked what the overall experience of being a nurse was like, she said:

Horrible physically, mentally, socially horrible. You feel very isolated. I didn't even know who to talk to about my problem. I didn't know anybody else in recovery. A lot of people that get into drugs have a culture of drugs. They have friends that they use with and that's how it starts; a party atmosphere. We don't usually have that with nurses; usually it's a very private thing. We don't have that. There is no peer and we don't dare. Who do we talk to? . . . we're going to get in trouble, and we're going to let people down because they hold us so high. I mean, I was the go-to person in my unit for all the problem solving. I was the one the doctors called when they had a difficult case when they wanted somebody highly skilled.

In a paper aimed at exploring the existential aspects of living with addiction, Wiklund (2008) described a study she conducted and took as its point of departure the patient's perspective. Guilt was identified as one of the themes in this study presented as challenges of conflict that must be met by people recovering from addiction. This study did not focus on nurses specifically but identified several challenges for addicts. Along with responsibility-guilt, other challenges or conflicts that must be met by recovering addicts were meaning-meaninglessness, connectedness-loneliness, life-death, control-chaos, and freedom-adjustment (Wiklund, 2008). The researcher wanted to help nurses deal with addicted people better by understanding these challenges--putting nurses on the other side of the addiction than the nurses who were studied who were recovering from addiction themselves. She felt addressing the challenges addicts faced would facilitate nurses' interaction with addicted individuals. She encouraged nurses to include motivational aspects when dealing with addicts, instead of just focusing on problems.

Whether nurses or not, addicted individuals seemed to experience significant feelings of shame and guilt both while using the substances as well as after use had stopped. Unique dimensions came with being a nurse who was addicted, though, as these

nurses had to deal with the ethical implications of taking medications from work or from patients. They also dealt with shame in realizing they compromised their professional role and that they often had compromised relationships of trust--both with employers and sometimes patients, as well as dealing with their families and legal entities. Shame and guilt undeniably often accompanied nurses who were addicted.

### **Theme 3. Poor Coping: Addicted Nurses Report Having Underdeveloped Coping Skills**

Part of the original purpose of this research study was to find out whether or not nurses in recovery consider themselves to have been at risk for addiction just by virtue of being a nurse. Risk perceptions discovered in general is discussed at length in Theme 5 and also in the discussion section of this paper; however, an unanticipated theme emerged from a response to this question by one of the participants. When Al was asked whether he thought people were at risk for addiction by virtue of being nurses, he said:

I don't think they [are], no. It becomes for me, it all depends on how you are able to cope. Coping mechanisms and your genetics. I don't think being a nurse puts you at higher risk. But I guess if you are always being put in places of stressful situation if you haven't learned those coping mechanisms I can see how. . .

Later in his interview, when asked how he felt the subject of nurse addiction could most effectively be taught in nursing education, Al said:

[By] learning how to deal with their own behavior. That's the best way. If you're stressed and you're going crazy you have to let people in on that. You have to say hey I'm stressed and going crazy. You have to share these thoughts that are going on in your head and take action. Learn how to apply the nursing process to yourself. I mean we apply it all the time to our clients; we have to turn around and assess ourselves. What's my diagnosis? I'm stressed, I want to kill some people and I want this to go away now. It's very simple to turn around and use the same nursing process because it's almost the same way as a 12 step program. You learn how to do it appropriately, diagnose yourself and go see a psychiatrist or a psychologist and say I have these thoughts and I need to share this with somebody and I don't let it build up inside of my head. So I guess in a sense of learning how

to cope with nursing better. Because it's not really the bottle--the drug isn't what makes us go crazy; it's the thinking and our behavior. So learning how to deal with our emotional aspect of ourselves.

We usually don't deal with the actual issue [any stressor] beforehand. We mostly deal with it afterwards, that's the sad part. I think it goes down to it's a very individual basis and if you don't learn how to--that's the thing--it's very individual on how you feel and how you react to certain things. Some people will always react the same way no matter what. So I guess going back to learning how to deal with our behaviors and our stressors. That's what it comes down to. Learning how to be in my own skin, accept that I'm angry, accept that I'm frustrated and it's ok to be frustrated.

Learn how to cope, and coping with yourself is the biggest key. . . because drinking and using is just the tip of our disease. We have to go back to where it's festering, because it's guilt and shame that I can't handle anymore or if it's because of my childhood or because of the high stress at work or if it is because of the pills while I'm at work, all you got to do is go talk about it to somebody and they'll help you deal with it.

Al's very insightful response to the best way nursing students need to learn about addiction by looking at the root problems underneath addiction has proven to be very profound indeed. After thoroughly studying Al's interview, the researcher went back over the other transcripts again to see whether or not ineffective coping was something that any of the other nurses had mentioned. In fact, none of them had mentioned it in those words, but all had described their addictive behaviors that had occurred as a result of ineffective coping! Later on in the interviewing process, Melissa did mention coping specifically. The topic of poor coping skills came up for her when she was asked whether she thought anything could have been done to prevent her from becoming addicted:

It would have had to go back even farther; I would have had to have just known better coping mechanisms in life and just learned how to be honest despite any consequences. Because I always learned how to lie to avoid consequences and that's what using is. We just keep lying to avoid the consequences of admitting that we're using. I developed poor coping skills early on as a child. And like I said, my dad [a recovering alcoholic] and I have a lot of similarities. . . not that I blame him, but I developed many of my poor coping skills because I was afraid of him. So we learned to lie or hide or pretend that things didn't happen just to avoid

problems. In fact we were even instructed to do that by my mom. We were told ‘don’t tell dad because it would cause trouble’ or ‘does he have to know we did this?’ or ‘don’t ever say this’, but never facing realities. . . never just being honest. . . so I developed the qualities of an addict from early on. . .

But I also need to be accountable, once I became an adult I should have done what I could to develop coping skills on my own and I didn’t. I just kept hiding behind life so that I could. . . there were choices that I should have made; lifestyle choices like maybe my marriage or to get out of situations that I wasn’t happy in instead of continuing on with them and not being happy.

Regarding problems and stressors with her husband, Melissa continued on about her poor coping methods:

I found myself early on having to change the way I did things to avoid trouble. . . I guess similar to when I was a child. Just kind of, you know, I found myself having to change my own beliefs so I didn’t cause trouble with his. I guess the first I ever actually took something inappropriately for the wrong reasons was when I was maybe 25 or 26. He and I were going to attempt to have a grown up important conversation about our relationship and the thought of even having that crucial talk with him made me uncomfortable and so I, for the first time ever, took Percocet because I remembered in the past when I had taken one once for a hernia repair, although it made me really sick, it made me really talkative and it made me feel more relaxed. So I took it thinking it was again, going to make me more open to talking with him.

While Melissa and Al are the only two that mentioned coping by name, all of the other 12 participants referred to their drug use taking place as a result of poor coping. Therefore, all 14 of the participants struggled with ineffective coping, which either led to or contributed to their substance use. Several viewpoints on the ontology and epistemology of the concept of *coping* existed in the literature for nursing as well as in other disciplines. Coping strategies have been conceptualized by one group of scientists as “. . . mediators of emotional reactions” (Elfstrom, Kreuter, Persson, & Sullivan, 2002, p. 23). Coping was further defined by these researchers as “conscious efforts to manage a perceived discrepancy (i.e., stress)” (p. 24). A different group of researchers defined coping as “an essential element in being resilient in the face of physical disability and

stress” (Gillespie, Chaboyer, & Wallis, 2007, p. 130). Coping emphasized the significance of temporal and environmental factors and the way these factors interacted with each other to influence adjustment and recovery (Holaday & McPhearson, 1997). Effective coping has been identified as an action that mitigates the effects of potent psychological and social risk factors (Gillespie et al., 2007).

One concept opposite of coping has been referred to as avoidance. Fear has been referred to as the root of avoidance (Bednar & Peterson, 1990) and, as it has already been established in the discussion of Theme 1 of this paper, fear existed as a significant part of the experience of addiction for nurses. By this reasoning, it became apparent that fear, avoidance, and poor coping have been inter-related. Refusing to face personal conflicts because of fear or any other reason had led people to actions of avoidance, such as denial, distortion of self-image, and rationalization (Bednar & Peterson, 1990).

Coping has often required candid and forthright facing up to things that often cause fear in individuals. Coping, whether effectively or not, has caused people to look at themselves and be honest, with the willingness and the strength to acknowledge the things that may be wrong in themselves (Bednar & Peterson, 1990). Effective coping often has required that imperfections in the self were openly and candidly acknowledged, at least to one’s self, in order for them to be dealt with. Naturally, when addicts feel the fear or the shame discussed in earlier themes, a natural reaction has been further avoidance of discomfort by avoiding stressors altogether. People who have been able to cope effectively have not hidden from painful things in life but instead have recognized them and take responsibility for them. For them, coping has become the path of insight, reality testing, honesty, personal growth, and development (Bednar & Peterson, 1990). It

has allowed individuals to face and overcome problems in spite of the pain they create. A willingness to cope with difficult situations has been a key characteristic of emotionally healthy people. This healthy coping quite often has not taken place in the lives of people who were addicted, and this study on nurse addiction was no different. Time after time, when these addicts were asked to describe how their addictions began, stressful experiences or difficult situations almost always precluded the initiation of the substance abuse. They did not know how to effectively cope. The nurses in this study often exhibited poor coping skills. Mike, the nurse who was a nursing professor at the time of the interview, stated:

I think, for me, there was a certain, I guess, life experiences that were taking place--but I was in graduate school and it was the last year of graduate school where there was high stress and high expectations. I had also at that time accepted an administrative position for an oral surgery group practice where my role as an administrator wasn't clearly defined. . . it was a highly lucrative position, at the same time, high stress. So on top of that was when my wife had filed for divorce, and so at that point in my career and in my personal life was when for me the addiction became something that I fell back into and held on to for some time to be able to get through that. I was trying to escape from--I don't think I was emotionally prepared for a divorce, so divorce and knowing that I was going to work, completely consumed in my mind with what my now ex-wife was doing at the time. For example, I could monitor and see the text messages and the phone calls that she was making to the person that she was cheating on me with at the time and that obsession of needing to know where she was at, and seeing what she was doing was one factor that I was dealing with.

Mike was not the only nurse dealing with marital issues when the drug addiction took hold. In fact, marital (or relationship with a significant other) discord and the attempt to escape that discord was apparent in the interviews of Melissa, Tamara, Linda, and Ashlee. Ashlee made the following comment:

You know, your relationships change if you get involved in unhealthy relationships, things like that that contribute to it. I don't know at the time, I could see definitely why people definitely look to something else to help them that they feel like that's all they have to do. So at the time when I started definitely could

see why I'd be at risk. For me I was in a very horrible controlled abusive relationship so and by the time I think I finally came to the point. . . you know you try to do everything for your kids, you try to be a perfectionist, you go on like your whole life's perfect. It's kind of like fake; you act like your personal life's fine and your careers fine and everything's a-ok, but at the time pretty much I just wanted to die. That's how bad my life had gotten and I was in a relationship where I knew something was wrong, I knew I needed counseling, I knew I needed anti-depressants, I needed something for anxiety, I knew I was there but I was unable to get those things because of the relationship I was in and I wasn't allowed to go to the doctor and that type of stuff so I was getting to the point where I was so anxious. In addition to working night shift you don't get sleep, you're tired, you get stressed when you don't get sleep and it gets worse and worse.

Linda stated her drug use was also partly a result of a stressful and failing marriage:

[The doctor] gave me my first prescription of Lortab and I remember using it--using it like it was supposed to be used--not abused, and when it was gone I remember calling him and asking if I could have another one. And then the cycle began. The more I started to use it--my marriage was sort of falling apart and I began to use it more for numbing the pain of my marriage. . . and still now I was a double edged sword, I was numbing the pain of my injury and it was working for my failing marriage as well.

Tamara talked a lot about how her husband continuously cut her down for being

overweight. She started the methamphetamine use as a direct result of that situation:

Well, I call it my mid-life crisis, is really what I call it. I was getting ready to turn 30 and I was freaking out. . . And I was married at the time. My husband was always telling me that I was fat and ugly, and had pretty much told me that my whole married life. I had a girlfriend who was overweight, and I knew that she had been using meth. . . she kind of made it look glamorous like this wonderful thing, and she had lost a lot of weight and I had tried weight watchers, diet pills, I mean you name I'd done it and I couldn't drop any weight and so I thought what the hell I'll try it out.

At that point, Tamara was not necessarily coping poorly--she was just trying to lose

weight. However, the process progressed and the drugs did become a poor coping

mechanism for her:

I think there were quite a few factors into why I started using. One, I definitely think was the weight loss. Two. . . I freaked out over being 30, I thought, oh my God, I'm so old because my whole life I thought anybody over 30 was so old. . .



So it kind of started off as that and then it just kind of took off. . . I was down, I was wearing size 11 in pants where I had been size 24, I felt sexy, I had energy, that's the best I felt in 20 years. And it sucks that it happened to be when it was drug induced. . . Oh I thought I was super woman. I could do it all. I was super nurse, super mom, super wife. The big problem that I went through a lot prior to addiction was that I was so exhausted all the time to the point where on my days off all I would do is sleep. So when I started using and all of a sudden I had energy, I could play with my kid, I could go and do several visits a day with my job and actually visit with the patients, it made me a little more talkative. Yeah, I thought I was superwoman. I mean I look back now and think what a fool I was, I mean, how could anybody not know. . . because I can see it now and I can see the behavior changes. But at the time I didn't.

Literature related to the concept of coping existed from the viewpoints of many disciplines. In order to support this third theme, a comprehensive literature search was done on coping in general and poor coping as it related to addiction. First, in an article by Cederlund, Thoren-Jonsson, and Dahlin (2010), some coping strategies used in performing daily occupations 3 months after a severe or major hand injury were studied. The discipline doing the research and reporting the findings was Occupational Therapy. In the study, "coping" was broken into two categories: "problem-solving" and "emotional-solving." These two types of strategies were used to support patients early in rehabilitation after a severe or major hand injury. Coping was used in the survey as a broad term for how the patients were able to deal with situations they were faced with after these severe hand injuries. The researchers encouraged social and family support in the rehabilitation process. Even though this was a medical rehabilitation that was studied in this article, lessons learned in this study were very relevant to rehabilitation from drug and alcohol addiction as well. Like the patients who had undergone hand surgery, recovering addicts needed to have a strong social and family support in the recovery process. They also needed to be taught problem- and emotional-solving strategies to support them in their rehabilitation. Another word used in conjunction with coping in this

article was stress--which was part of the theme being presented in this dissertation. These recovering addicts often did not cope with stress in a healthy way. In the study by Cederlund et al. (2010), several themes and sub-themes were given related to stress, including changing performance of daily occupations, actively processing trauma experience, changing occupational patterns, receiving assistance, using emotional strategies, and keeping up a social network. Coping strategies that were used a few weeks after various injuries in this study emphasized the importance of early identification of how patients could reduce their stressful situations. Coping strategies were explored in order to help reduce these stressful situations. All of these techniques for coping effectively could be applied to addiction recovery or education.

In an older study by Ceslowitz (1989), the researcher wanted to study the relationship between use of coping strategies and burnout among 150 randomly selected staff nurses from four different hospitals. According to this author, factors related to burnout were having unrealistic expectations and low self-esteem, having been critical of self, having been overcommitted, authoritarian, having lacked a support system and or having needed to control others. Examples of environmental factors were work overload, high patient acuity levels, role conflict, lack of authority to complete responsibilities, inadequacies in salaries and in head nurse support, and a lack of control over working hours and conditions . The theoretical framework which guided this study was the stress and coping theory of Lazarus and his colleague (Lazarus & Folkman, 1984). In this study, nurses with lower burnout scores used coping strategies of planful problem solving, positive reappraisal, seeking social support and self-controlling coping. Problem-focused coping included efforts directed towards the individual such as initiating changes

in motivation, levels of aspiration, involvement of ego, or levels of knowledge (Lazarus & Folkman, 1984). Nurses with higher burnout scores used the strategies of escape/avoidance, self-controlling, and confronting. These findings supported research conducted among non-nurse populations which found that coping strategies were related to indices of health. Coping was used in relationship to “burnout” and “stress reduction” in this article. Principles associated with stress and burnout that were studied included planful problem solving, positive reappraisal, seeking social support, self-controlling, confronting, accepting responsibility, distancing, and escape/avoidance.

Nurse burnout was one consideration with the population of nurses who become addicted when it came to ineffective coping. Tamara mentioned in the quote above that, “The big problem that I went through a lot prior to addiction was that I was so exhausted all the time to the point where on my days off all I would do is sleep.” Lacey mentioned she used drugs in an effort to cope with a job she was not enjoying anymore:

And when my husband started having chronic medical problems, and I really didn't like my job anymore; I did initially for a long time. And there was a lot of financial stress and stress with juggling my husband's medical problems, and still going to work, and still taking care of my little one. It was my way of not feeling those frustrations and stresses and I started using it more for that than I was actually using it for the pain. . . especially when you get to a point in your life that you're experiencing severe stress or chronic medical problems or not liking your job. I think those things definitely played into when I started using, for me.

Those study participants that did not mention poor coping related to a relationship specifically all had other instances of poor coping resulting in drug or alcohol use or abuse--whether the situations involved poor coping with depression or anxiety, poor coping with health problems in themselves or others. When asked if anything could have prevented his addiction to opiates, Ben answered:

I guess it's all about yourself. If I would have tried to seek channels to help with my anxiety and stuff like that and not just try to look for a means to cover up the fact that I had a predilection to being addicted.

Ashlee indicated the fact that nurses have a stressful profession and that nurses as a whole need to learn better coping mechanisms:

Ashlee: Yeah the stress, but I guess better coping mechanisms. I don't think nurses take the time to sit around and think hey I have these things going on, I think it's just so go go go go go. You don't relax or take time to think about yourself. I mean we teach nutrition, but we really suck at it. That's what they always say, or we get people that say nurses are the worst patients. We get prescribed medication, we tell people how to do it and how it's done right, but I think that when it comes to it we're the worst patients; we don't take care of ourselves.

Many other studies were found in the literature related to coping--with everything from coping with mental illness to coping with the effects of Hurricane Katrina (Langeland, Wahl, Kristoffersen, & Hanestad, 2007; Olejarski & Garnett, 2010). A nursing theory which closely related to the concept of coping was Sister Callista Roy's Adaptation theory. Concepts from Roy's model included focal stimulus, contextual stimuli, coping mechanisms, and self-concept (Levesque, Ricard, Ducharme, Duquette & Boin, 1998). Focal stimulus was an event that confronted a person directly and became the focus of attention for that person. This person then expended energy to deal with it in order to maintain or restore adaptation. Coping mechanisms, according to Roy, were a "cognator sub-system" which included information processing and judgment, which encompassed such activities as decision-making and problem solving (Levesque et al., 1998, p. 32).

However coping has been defined or continues to be defined, nurses who have become addicted to substances usually do not do it effectively. They experienced times of increased stress--like death, divorce, poor health, or other things, and did not know how

to effectively cope. They often turned to substances in an effort to escape whatever stressful situation was weighing down on them. Like Al said:

Drinking and using is just the tip of our disease. We have to go back to where it's festering, because it's guilt and shame that I can't handle anymore. . . or if it's because of my childhood. . . or because of the high stress at work.

Instead of teaching nursing students everything they could ever know about nurse drug addiction, perhaps teaching them effective coping skills would be more effective in helping them avoid addiction as nurses. If they had been taught how to cope, perhaps they would never have to resort to the poor coping skills of avoidance and substance abuse.

#### **Theme 4. Control: Addicted Nurses Feel an Increased Need to Control Their Environments**

A very common and well-known fact about addicts and alcoholics has always been that they often experience some form of denial. The term “denial” has often referred to the process by which addicts pretend (or actually believe) they have not have an addiction when, in fact, they really did. People in denial did not think their behavior was problematic when, in fact, it was. In a study by Peretti-Watel et al. (2007), nicotine smokers were studied in an effort to measure denial in risk perception. The researchers found that, among current smokers, 44% considered smoking might cause cancer, but only for those who smoked more than they did themselves. An additional 20% considered that the cancer risk would become high only for those who had smoked longer than they had themselves. Those who considered they smoked too few cigarettes to be at risk were less likely to report personal fear of cancer related to smoking. Denial was a powerful thing. Denial--both in their own risk perceptions of addiction and in their actual reality of being addicts/alcoholics--was strong in this study on nurse addicts, but one aspect of that

denial really stood out. That aspect of denial which had emerged as the fourth theme was a false sense of control--which in turn contributed to an overall state of denial in these nurses.

So what was this false sense of control? All 14 nurses referred at some point to how their substance use started small or occurred infrequently in the beginning. Of the 14 nurses, 11 of them directly commented on how they could control their use in the beginning, or quit whenever they wanted to, so they did not feel they were addicted. The other three did not directly say they felt they were in control, but statements were made which inferred that conclusion. Dan made the following comment which illustrated this point:

We use to drink and do other drugs and, but I thought I was smart enough to be able to control it. . . So I put down alcohol for a long time and thought I can do that and then I started doing cocaine and started partying and one month I spent the rent on coke and I said you know, this is no good. So I actually gave a couple grams away. It was Christmas time and I said here you go; I'm not doing this anymore. And I didn't touch it again. So in my mind I thought I can put this down anytime I want. I just hadn't come across the thing that was really going to grab me. And that's when pain pills did that.

The nurses in this study often felt they could stop their use of substances at any time should the need arise. Then somewhere along the way, they lost that control. At the time the control was lost, they did not realize it and begin trying to control their drug use in an effort to convince themselves that they were still okay. This false sense of being able to control everything around them was really just a form of denial. Ironically, when they were most out of control, they fought the hardest to control everything they could. They attempted to control their substance use--amounts, times of the day they would use, types of drugs they would and would not use, and so forth. Some of that false sense of control came because of their education and training as nurses--they felt they were immune to

addiction since they knew everything about the medications they were using and knew when it was needed and when it was not. Tamara stated:

I'm a nurse, I know how to do it and not get caught and I'll control it and I'm not going to use on days that I work and I'm not going to use while I'm working, and I'm not going to get addicted because I'm smart. I'm a college girl. . . And within a year and a half I was shooting up a hundred dollars a day. Initially when I first started using I didn't use while I was working. I waited till I was off work or on my days off because I was smart and a college student. . . I'm going to control this. So I would do it on pay days, on days off, and then it just kind of progressed from there. And at the time I didn't see it as a problem. If I look back at it I can see how my work was impaired. I can see where like I would stay away from the office because I had the same boss for 14 years. She knew me like the back of her hand and I knew she would know, so I wouldn't go in; I'd go in after hours and do paperwork.

Terry commented that she started wanting to take all of the extra shifts and, when she worked; she offered to take the hardest patients because they would be the ones who needed the most drugs. The need to control the situation and the drug used led many of the nurses studied to excessive working and taking on of extra shifts in order to have the access they needed to the drugs. Craig expressed similar feelings:

I would think about my next shift or maybe I could take a shift for somebody just to have the opportunity to use something. But negative physical side effects of not using between periods of when I did use--I didn't have any of those things. I wasn't necessarily worried about what would happen if I stopped. It was a point in time when I realized that if I didn't stop then, I probably wouldn't be able to stop ever and that really scared me because I didn't want to keep living like that. It was a real wakeup call when I realized that. . . that's the point in time when I realized that I was actually getting to that point where I'm really out of control.

Valerie also commented on this feeling of being in control. She said having been around the drugs and having felt a superior sense of control over them probably contributed to her abuse of drugs:

We know how they work, we know how the dosaging works, so we can use safely. It's a dangerous mix of knowledge thinking we had power of it and we can use safely and not knowing we are at risk for it because that wasn't discussed in nursing school. It was very briefly mentioned. They very slightly skimmed over it

one day I remember but it wasn't anything we delved into. Just access and familiarity with drugs. Knowing what pills worked for what and what you can take to fix this problem and counteract the bad effects of this drug so that even the negative effects of the drugs you we're able to minimize like nausea. Being able to learn to inject easily, there's no learning curve there. That right there will put you right at risk.

Melissa, the nurse whose drug abuse started with a prescription for Ambien from a physician working with her on the labor and delivery unit, took pride in the fact that, when she started her drug abuse, she was able to keep that first bottle of Ambien in her purse for about a year. She reported taking the pills only "periodically." Then she started realizing she felt "normal" with the drugs, so she would only take them when she wanted to feel uninhibited and normal. She attempted to control her situation by doing whatever she felt she needed to do to feel well. Ambien eventually became too expensive, so she switched to pain pills. Her drug use eventually escalated to the point where she needed to work more often in order to have more access and control over how much she could use. She also reported working extra shifts and being everyone's "favorite nurse." Melissa made the following comments:

I had myself convinced that I was still being a great nurse and being a great resource for all of the nurses that. . . I was overseeing that day when I was charging. I felt like I was functioning, like my dad did. I felt like I was a high functioning addict. My kids were still getting to school. But when I look back at it, my house actually wasn't. It was in disarray and I was falling asleep at the office. But at the time I had myself convinced that I was somehow managing to do it all and that nobody was suffering any consequences from it. . . Well I felt, I always wanted to quit [using] and every day I had intentions of quitting the next day. I would think I can do it after this; I'm going to use this next bottle of pills and take myself off of this. So in my mind I wanted to quit and I always would tell myself this will be the one, this will be the bottle that helps me get off of all this, I'll just taper myself down and be done. So I obviously felt like I knew I did something wrong, but when I was in the deepest part of my addiction I was happiest when I had the drugs and then everything else was great. So as long as I had what I needed and I had things to use, I was happy with everything else too.



Valerie commented further about the way her addiction was “controlled” for a while and how it started small and eventually escalated:

I very clearly remember the first day I took something. I had a whole cabinet full of drugs leftover from all those surgeries that I had had before; I just had all this,  $\frac{3}{4}$  of a bottle leftover of every drug they make. And I remember coming home after one of those 18 hour shifts that your whole body hurts, your mind hurts, everything hurts and I took half of a Percocet 5. I reached into the cabinet to grab an Advil and I saw those and thought huh you know you’ve been giving drugs all day and see how like you said see how well it wipes out everything. I’ll just take a half of this and it so justified with how bad I hurt. Self-medicating, self-medicating, it didn’t occur to me at the time. And just how wonderful it worked and how it just wiped out every ache and pain, I felt great, my husband didn’t seem like such a jerk all of a sudden and wow this is awesome. And a little red flag goes off in my head. . . oooh that’s pretty dangerous; I better not do that again--ever again. . . or at least not very often. I should have flushed them all right then because I had a perfect supply right there to get myself primed. . . denial the whole time thinking it’s not that big of a deal, one pill, I mean you see addicts and they fly through a prescription in two days and at this rate it will take me 2 months so that’s not a big deal. And I have all these drugs in the cupboard so I can stop whenever I have tons that will last me years. All these weird things that we justify, but then it spiraled out of control really quick to where I was considering diverting from work.

Dan made the comment, “I think that when I first realized I was starting to have a problem, I thought I could handle it. . . and thought it was ok.” Similarly, Ashlee said, “Yeah, I’ll just do it and I’ll be able to quit and I won’t do it anymore. . . and I’ll get out of my relationship and stuff. . . and it just kind of never happens.” Lacey commented at one point in her interview about being an addict in control:

My perception was very black and white. It was a weakness of the mind or even though my brother had been an addict I still had a very jaded view of people that used drugs. It was just something that people had control over whether they continued to choose to do these things.

After quitting her use of opiates and later beginning to abuse benzodiazepines, Lacey said, “I kind of felt like I was in recovery from the opiates, but I could use these and they still did the same thing for me. . . but they weren’t what I wasn’t supposed to be

using.” Terry commented about trying to change the unit which she worked on in an effort to control her drug use:

Right toward the end just before I got caught I was starting to move away from working as much directly with the pain pills in the outpatient recovery and talking to my boss about moving more into PACU where you don’t do the pain pills. You never do the pain pills in there, you always do the IV. So that might have been a dangerous move, but I was trying to move out from the pills because I wasn’t into the IV stuff at all. I never did any needle stuff, it was just the pills. So I kind of, I was working on it and then I get caught and that was it. But I’d actually approached my boss and said I want to do more hours in the PACU and take some of my hours. So I was trying, I mean I never really actually tried to stop, but that was my thinking and I doubt it would have happened. I’m sure I would have moved on to the other [IV]. I knew it was just a matter of time so it’s a good thing I got caught. . . But I hid it so well I think. That’s what everybody tells me, I had no idea. But I didn’t use it at work, I think that helped. I wasn’t out of it or anything at work. I would just go home and take a handful of them and party all night long, because I didn’t work. I only worked every other day so I would sleep until like 3:00 in the afternoon the next day.

Even in recovery, Linda believed her addiction to opiates was under control:

I’ve never been one to take someone else’s medicine and I can take it and be fine with it and not even. . . If I had 2 Lortab in my hands I wouldn’t be thinking ‘I wish I could take these.’ I give my medicine to my patients and that’s the way it is. Mine is under control and that’s the way it is.

This theme of needing to control their use (and everything else around them at times) was a pervasive thread that went through these nurses’ recollections of their experiences. It was an aspect of denial that really had not been considered by the researcher before this study was done, so once again the literature was searched to see if any evidence existed about this phenomenon with nurses or any other group of addicts. As far back as 1959, in his paper on human motivation, R.W. White submitted the idea that the need to control the environment was central to human beings. Burger and Cooper (1979) came later and argued that individuals differed in their need for control. They contended that “people’s general level of control motivation is posited to interact with

situational variables to account for behavior differences” (p. 383). The desire or need for control has clearly been manifested in relation to nursing. Researchers deRijk, LeBlanc, Schaufeli, and deJonge (1998) did a study on burnout in ICU nurses and found that active coping showed only a slight correlation with a person’s need for control, which indicated they were more than likely dealing with more than one different personality variable. Active coping was directly related to dealing with job stressors such as high demands, where that was not the case for need to control. What this finding suggested ultimately was that one’s need to control and the actual amount of control in the job was more strongly related to job motivation and satisfaction than to burnout or other stress-related outcomes (deRijk et al., 1998).

It was difficult to say how this would relate to nurses who were actively addicted and working at the same time. What it did suggest was that active coping people did not feel that need to control--so if addicted nurses had that need to control, they probably were not actively coping well--which was what was suggested already in Theme 3.

A more recent study looked at the need to control found in people who were engaged in “excessive exercise”--which was called “exercise addiction” by some and as a “compulsion by others (Johnston, Reilly, & Kremer, 2011, p. 237). Excessive exercise has often been regarded as a secondary symptom of eating disorders, which were commonly accepted as disorders that were addictive or compulsive in nature. In this study, excessive exercise co-occurred with disturbed eating for some participants but not for others. These behaviors often seemed to result from common concerns of participants about the “need to control the body” (p. 237). Controlling the body through exercise was generally perceived by participants as a “good” thing, or at least as “preferable to other

compulsions and addictions” (p. 237). Views of eating as a way of controlling the body were more mixed. Some reported types of diets were considered healthy, while others were regarded as being abnormal, unhealthy, not under control, and extreme. Some participants reported a method of controlling the body was concealment of their eating behaviors. Because eating disorders may be very closely linked to addictive behavior, this study did support the theme of nurse addicts needing to control everything around them in an effort to compensate for what they felt was out of control in their lives.

Another study which looked at need for control was also looking at eating disorders. This study showed that people suffering from non-specific anorexia nervosa were found to have a more negative emotional profile and need to control than all of the other eating disorders studied (Pascual, Etxebarria, & Cruz, 2011). The need to control was definitely a factor exhibited with the compulsive behaviors of people with anorexia nervosa.

Control-related cognitions have often been implicated in discussions of Obsessive Compulsive Disorder (OCD), but research on the topic had never really been done until Moulding and Kyrios (2007) decided to empirically investigate the relationship between control-constructs and OCD symptoms. In their study, it was found that higher levels of “desire to control” and lower levels of “sense of control” were associated with higher levels of OCD-type behaviors or beliefs. In the study, it was shown that the desire for control was significantly positively related to OCD, as well as perfectionism and intolerance of uncertainty. All of these findings could be argued as being present in the active addict’s perceptions of her/her world. This was significant because, as the OCD study stated, “. . . the higher effect of loss of perceived control on symptoms suggests that

it may be particularly important to address factors impacting on an individual's sense of control," because if they were not addressed, their healthy sense of control could be further decreased (Moulding & Kyrios, 2007, p.769). What this was saying was that, once a person was engaging in an unhealthy desire to control, if they were not able to check themselves and experience a healthy sense of control, that desire to control may actually increase, and then a vicious cycle is underway. This type of cycle was clearly evident in the lives of the nurse addicts who felt this compulsion to control everything they could control in their environments, when really they were losing that healthy sense of control more and more.

As far as the need to control in the nurse addict population, no research could be located addressing this issue. One article back in 1991 did look at control beliefs in substance abusers in general, but it was not specific to nurses. Carlisle-Frank (1991) identified four domains related to control in a person's life: (a) control over institutional factors, (b) control over personal achievement/goal attainment, (c) control over interpersonal relationships, and (d) control over personal health habits. She suggested that the need to control in addicts must be addressed from these four different domains and not just look at as the big picture of "need to control." A book was published in 1986 about the need for control that heroin users exhibited. The author even called this need to control a "central problem in substance abuse" (Des Jarlais, 1986, p. 37), yet current literature on the idea was very hard to come by. Also in the 1980s, a study was presented which talked about the loss of control and subsequent effort of addicts to gain it back. They seemed to assume there was a need for control but did not articulate it as such (Stephens & Marlatt, 1987). No recent studies could be identified that looked specifically

at addicts and their need to control their environment. Several other articles were found which were written in the 1970s, 1980s, and 1990s on this subject, but no contemporary recent research could be found.

**Theme 5. A Core Problem Inherent in Nurses  
Who are Addicted is a Belief that Addiction  
Would Never Happen to Them**

Risk has been defined as a “. . . measure of the probability and severity of adverse effects” (Aven, 2010, p. 623). Risk, therefore, has presented itself as a situation or event where something of human value (including humans themselves) has been at stake and where the outcome was uncertain (Aven, 2010). Outcomes, usually negative when related to risk, were also uncertain and varied in severity. One of the purposes of the study at hand on nurse addiction was to find out how recovering nurses perceived their own risk for addiction. A clear finding in all of the interviews was the pre-addiction belief of these nurses that becoming addicted would never happen to them--whether they became addicted before becoming nurses or after becoming nurses. A few of the participants made mention of the fact that they did not decide one day that “I want to be an addict so I guess I will just go ahead and start using drugs.” All mentioned most people, whether nurses or not, probably did not think they would become addicts. In the group of 14 nurses studied, there were really 2 sub-groups when it came to addict types. One sub-group (four participants) either abused drugs/alcohol before becoming nurses or their addictions were not related to nursing at all (i.e., used street drugs or alcohol outside of the nursing setting).

The second sub-group (10 of the participants) became addicted after becoming nurses--most of them *several years* after becoming nurses. The four pre-nursing

users/addicts (Al, Annie, Ben, and Beth) varied in their perceptions of risk. Al and Ben (the two men pre-nursing users) seemed to have a little bit more sense of knowing they were at risk, while Beth and Annie (the two female pre-users) never gave much thought to becoming addicts. It was interesting to note that both of the pre-nursing female addicts, Beth and Annie, were addicted to alcohol as their main substance of choice. Tamara did not start using substances until after she was a nurse, but her addiction was to the street drug methamphetamine, so her addiction was a little bit different in relationship to nursing. Out of the 10 post-nursing users, all but 1 denied the possibility of being at risk before they actually became addicted. Mike was the only 1 of the 10 post-nursing users who recognized he may have a risk for addiction. It was interesting to note that, of the 14 total participants, only 3 perceived some level of being at risk for addiction, and all 3 of those participants were male. A future research study might look into differences between female and male nurse risk perceptions. One study did show males were more likely to engage in risky behavior related to substance use, like driving under the influence or missing class or work because of substance use (Baldwin et al., 2009), so gender differences existed which related to perceptions of risk and addiction. All of the nine females in this study denied having any thought of being at risk for addiction. Whether participants used before or after becoming nurses, 11 of them never considered themselves to be at risk for addiction.

Addiction has affected both young and old, those with a history of drug use and those without any drug history, those with education and knowledge about the risks of working with these drugs, and those without that type of education. Addiction has affected many nurses, yet most have denied the possibility it would ever happen to them.

When the nurses in this study were asked the simple question, “How did you perceive your risk for addiction was before you started using,” the following initial responses were given:

Annie (pre-nursing user/addict): I really didn’t. I didn’t know anything about it.

Ashlee: Oh never at all. I would have never ever ever thought I would ever to anything like that.

Al (pre-nursing user/addict): I knew there was definitely risk, how big of a risk I had no clue. I guess as much of a risk as 14 year old would know.

Ben: I always knew that if I started pills I wouldn’t stop pills. I knew I had the personality that would go crazy with pills if I started getting them.

Beth (pre-nursing user/addict): Low to none. No risk.

Craig: I never thought I was at risk.

Dan: For actual addiction, no. I mean, I knew I liked to party. . . but I thought I was smart enough to be able to control it.

Lacey: I actually didn’t believe that it was an issue for me or a risk for me.

Linda: I didn’t have any thought of abuse at all.

Melissa: Not at all.

Mike: Yeah I did. I was always conscious of having such access to narcotic medications and stuff.

Tamara (pre-nursing user/addict): Not really before I started using, but the minute I shot it up I knew I was hooked.

Terry: I didn’t’ see any risk for addiction.

Valerie: Very low because I had seen firsthand what it did to people.

Six out of the 14 participants stated they had learned about nurse drug addiction in nursing school, yet most of the participants did not feel they were at risk for addiction. If they did not feel they were at risk for addiction when they were learning about it in



nursing school, the chances were good they did not internalize what they were learning, nor take the education seriously or personally. The researcher in this study submitted, if this was the case with these participants, it may likely be the case that most nursing students (especially those who do not abuse drugs or alcohol in school) probably would not consider themselves to be at risk either. Therefore, this concept could very well be a core problem which has undermined why the message of nurse addiction in nursing school has been largely ineffective in the past. Students most likely have not been internalizing it because they probably have not considered themselves to be at risk—but neither did these recovering nurse addicts. Melissa expounded on her perceived absence of risk here:

[At risk?] Not at all. In fact I always have been more of the opposite extreme. I had my children natural, all but one without an epidural. I was against medication when I had surgery. . . even though I was a nurse and administered medications as needed; when it came to myself I preferred more natural alternatives to everything. When I had surgery in the past I used ice packs and avoided the narcotics. . . I was the kind of person who didn't even take home prescriptions after surgery or after child birth. I wasn't a drinker even when I turned 21. My husband wanted to go and hang out for fun at a bar because I was old enough, but I still never went to bars, never! I was just really against that kind of lifestyle for myself. So not at all would I have considered myself at risk to become an addict.

Interestingly, Melissa admitted her father and grandfather were both alcoholics, but she never considered herself to be at risk. After realizing this, the researcher went back and reviewed the other transcripts again and discovered that out of the 11 nurses who never considered themselves to be at risk for addiction, 8 of them commented on having a strong family history of addiction or alcoholism! It was baffling to comprehend how these nurses, with their education about addiction and their knowledge of strong genetic predispositions for addiction, could truly not perceive themselves to be at risk—but they did not. Concerning her perception of risk, Valerie stated:

Before I got here [in recovery], we used to make fun of addicts. Everybody would joke about that, ‘frequent flyers’ as it were, and “I can’t believe they said this,” or “that was so stupid”. . . “why would you do that”-- it made no sense to a sane person. And I just thought there was no way that I could ever fall into something like that. I thought that I was educated enough that that would protect me from the danger of it.

This comment from her was followed up with a question about whether or not she had a family history of addiction, and she stated:

I didn’t think so at the time. I found out now that I’ve been very open with my dad about all this that there’s a lot of addiction in the family that I didn’t know about, because that’s just the dirty secret that we don’t talk about. You hear that someone died in the family, but you don’t hear that it’s because they were drunk and that happened or I didn’t know that back story. So I found that it’s quite rampant on one side of my family. I had one cousin that died an overdose, but I thought, oh a cousin, that’s not a direct link. So I didn’t think I had a family history. I didn’t know until it was a non-taboo topic that we could talk about.

In a study by deAbarca and Pillon (2008), nursing students’ perceptions regarding predicting factors of drug use were studied. When talking about risk factors for addiction, certain personal and social circumstances have been identified which may cause a person to start consuming addictive substances. In the study about nursing students’ risk perceptions, all of the study participants were females. In this study, some of the risk factors identified for addiction were sexual violence, family dissociation, victimization to violent crimes (muggings, kidnappings, and homicide), and diseases such as HIV. It was worrisome to the researchers to see that 21% of the participants saw drugs as simply another kind of medication. This perception was considered to be a risk factor in the ability of helping others as nurses and in the prevention of drug use and abuse (deAbarca & Pillon, 2008). In general, students in this study considered people who drank alcohol were more at risk for using drugs.

No research could be found which addressed risk perceptions of nurse addicts in recovery specifically. Many studies looked at risk perceptions in people who had never been addicted, but nobody seemed to be studying risk perceptions of people who already were addicted. Knowing this information from people who had been addicted was relevant and important, though, because understanding the perceptions of people who do become addicted may help prevent addiction in other people with the same perceptions who had not become addicted yet. Most people who have become addicts probably never thought they would become addicts or alcoholics before ever trying substances that had been identified as addicting. This was definitely the case in the majority of the recovering nurse addict study participants. Here are just a few more statements to emphasize this finding:

Annie: I didn't understand that I was addicted or I was an alcoholic until everything finally fell apart while I was working at a busy hospital in Las Vegas. No, I didn't know anything about it. I just, that was just, you know. I didn't know anything about AA; I didn't know anything about any of that.

Craig: I never thought I was at risk. There was some family history of substance abuse particularly alcohol with my biological father. My mother had a nicotine addiction till I was about 8 years old before she quit. I never really thought about that and what the possible, I never thought about those being a risk factor for myself.

Lacey: I actually didn't believe that it was an issue for me or a risk for me. Like any stupid young kid it seemed to be something that happened to other people; people that were weak, people that had problems; that's how I perceived it.

Terry: I didn't see any risk for addiction. My dad's always drank beer but never more than like 1 and never if he had to drive or anything like that. And I really don't have a family recollection to it that I am aware of. I don't know anybody that's an addict.

Betty: Low to none. No risk: My father was an alcoholic, but when I went out to eat or go out for drinks I could leave a glass on the counter that was half full or whatever.

Linda: Me at risk? Absolutely not, no, In fact when I had my first baby they gave Percodan back then and I remember when I took it, she was a very large baby and I took it as I was supposed to and never took it for a high or, I always took it as the way it was prescribed. And in fact I went back for my follow up appointment and I remember this specifically, my doctor said how is your pain? And I said from what I can remember it's ok, I still have pain. And he said would you like another prescription of Percodan. And I remember thinking at that time that it was, it really did make me feel good and so it was at that moment that I said "as much as I like the feeling of it, I don't want another prescription for it." So it was that time and that was in 1986 that I realized that it could, not that I was at risk for it, but that I could say no to it and just be fine and never have it again.

Ashlee responded, "Oh never at all. I would have never ever ever thought I would ever do anything like that. It was like an out of body experience really, looking back."

These are just a handful of the expressions by participants who commented about not thinking they were at risk for addiction. In addition to being asked about whether they thought they were at risk for addiction, the participants were all asked about whether or not they felt they were at risk for addiction simply by virtue of being a nurse.

Interestingly, the ones who became addicted as nurses felt nursing did put them at risk for addiction, while those who became addicted outside of nursing felt that just being a nurse did not place them at risk for addiction. This topic is discussed in more depth later on, as it is separate from Theme 5. As far as the perception of not being at risk for addiction which most of these study participants had, the researcher felt the very presence of an attitude that "it will never happen to me" actually puts people at greater risk for addiction. This finding was significant and needs to be included when educating nursing students about nurse addiction.

## **Discussion**

### **Lived Experience of Nurse Addicts**

The five themes identified in this research study represented in large part the lived experience of nurses who were addicted. Current and historical research has been included with the discussion of those themes which compared the results in this nurse population with other groups of addicts or alcoholics. Lived experience studies have been done on alcohol-dependent women (Thurang & Tops, 2012), men of Alcoholics Anonymous (Zakrzewski & Hector, 2004), addicts who experienced vulnerability in childhood (Valtonen, Padmore, Sogren, & Rock, 2009), and homeless women (Nyamathi, Stein, Dixon, Longshore, & Galaif, 2003) but not on nurses in recovery. Understanding the lived experiences of nurses who have experienced addiction has needed to occur for a long time. To sum up her experiences, Valerie made the following remark about the experience of addiction:

Its hell while you're going through it and coming out from the other side, I'm so glad that I've gone through it. It's made me a better person and a better nurse. But I still wish that I never had to deal with this. I hate the fact that it's always going to be there. It's not something that I can conquer and move on. It's been very broadening. I've learned a lot about myself and others. So overall it's been good.

The following few paragraphs are other findings noted in the study. They did not present as themes but were significant enough to be included in the discussion of the results. These ideas emerged as a result of what was discovered in the process of developing and understanding the themes already presented.

### **Perception of Risk, Access to Drugs**

In the discussion of Theme 5, a close look was made at the idea that the nurses in this study often did not perceive themselves to be at risk for addiction. The researcher felt

this added component, though related to risk perception, needed a separate discussion. After the participants were asked about whether or not they perceived themselves to be at risk for addiction, they were then asked whether or not they felt people in general who became nurses were more at risk for addiction just by virtue of being nurses. Some literature has suggested that the risk for addiction was an “occupational risk” for nurses (Hastings & Burn, 2007, p. 78). Whether the rate of addiction among nurses is greater than the rate of addiction among the general population is unknown, many nurses may be vulnerable to addiction because of work-related stress or easy access to narcotic medications. Trinkoff and Storr (1998) found that emergency department nurses were 3.5 times as likely to use cocaine or marijuana as nurses in other specialties. Nurses have reported a higher rate of a family history of alcoholism than other groups of healthcare workers (Kenna & Wood, 2005). Of the 14 nurses interviewed in this study, 7 of them felt like being a nurse placed them (and placed other nurses) directly at greater risk for addiction. The other seven of the nurses felt being nurses did not have anything to do with becoming addicted, however, upon further questioning four of these seven nurses admitted that having greater access to drugs did put them at greater risk. Only 3 of the 14 nurses did not believe nursing placed people at risk for addiction. They gave some very interesting responses, some of which are included in this report. It should be noted that all seven of the nurses who felt they were at risk by virtue of being a nurse became addicted themselves as nurses and not before. Here are responses of the seven nurses who felt the profession of nursing posed a risk for addiction:

Craig: Absolutely. Nurses by default are exposed to medications whether controlled substances, narcotics or whatnot its part of the job and as such I believe it creates a higher risk for relapse for those who have had addictions or is recovering from an addiction. That risk is definitely there and it's real and it's

something that has to be on the forefront of every nurse's mind when they're in recovery. I believe nurses are at a higher risk of substance abuse just by virtue of the profession.

Terry: Yes. . . Because you of the access that you have. You see how well medication works for people so you kind of have that too. You know how drugs work. Because of access, for sure, and knowledge. I think that's the biggest thing is knowing how medications work and how safely to take them. Yeah I think it's for sure a big risk, I don't care who you are.

Lacey: Yes, you know when I started at the jail we were placed on a heavy rotation for drug testing for that very reason. And I think that was the first time it really occurred to me that this was a possibility. Just by virtue of accessibility. It had never really occurred to me before that. I'd done a lot of psych nursing, I didn't do things with a lot of access to narcotics, psyche nursing was my passion and I really had never thought of it before.

Ashlee: Looking back when I first became a nurse I would say no . . . well I know nursing definitely makes it easier. I think it can. . . the stress of the job. I think you look at medication differently when you're a nurse. I think you know a little bit more than the general population about medications and things like that.

Valerie: Yeah. In retrospect, yeah. Before I was an addict I would have said that was a safeguard against being an addict because I didn't know any other nurses that were addicts. I had heard rumors about one that had been fired because of issues, but I didn't know anybody that happened to, so I didn't know how common it was. I thought because of our education and knowledge that it made me less at risk. But now I know.

Melissa: Being a nurse definitely put me in a place where the narcotics were accessible. If I wasn't a nurse I wouldn't have gotten them from anywhere else. Even in the hardest part of my addiction I still never went to a drug dealer or any. . . No matter how bad I felt, no matter how much I wanted it even at those really low points I never allowed myself to get it from anywhere that would cause even more trouble, dealing with people who did drugs never. So I wouldn't have gotten it from anyone else. So definitely thinking about it that way, being in a hospital setting where drugs were accessible and being around physicians where you can just ask for prescriptions and they'd give them to you. . . Huge risk there. Had I not been in a hospital I wouldn't have ever asked for drugs. I don't think I would have ever taken them.

. . . . but I don't blame being a nurse on becoming an addict. I blame being and addict on growing up with poor coping mechanisms. . . but being a nurse and being in a hospital where the drugs were so accessible allowed me to act on them, which I honestly doubt I would have ever done so otherwise. Because I think that even in the hardest parts of addiction, maybe when I had to go a whole day with

nothing and I was suffering and crawling out of my skin--even knowing other people who could get that for you--I still never ever ever would have asked a person to get it for me, or I would have never gone to a drug dealer, just because I knew that would have been a problem in my life. So being in the hospital just gave me that access that I needed.

Melissa was the nurse whose addiction began with Ambien given by a physician working on her nursing unit. She could have easily argued that, if she had not had her position as a nurse, the addiction would not have begun the way it did. After she related her story about Ambien, the researcher asked her whether or not she felt her addiction began because of her access to narcotics and her position as a nurse, and she said:

Absolutely, because I was the type of person who followed the rules. I don't know that I would have ever had anything to have used had he not just really given it. I never would have tried Ambien, I never to this day probably would have taken Ambien in my whole life had he not introduced it to us.

Dan had a similar story, where he acquired his drugs from the physicians he worked with in an operating room. His use began with legitimate headaches and pain, but his easy access to these doctors made getting refills really easy:

Because I was working in the OR and I had all these anesthesiologists that were happy to write me a prescription and said here you go. By then I knew I had a problem because my thought process was do I have enough for tomorrow every day.

Dan then made some very interesting observations. When asked directly if he felt being a nurse placed a person at risk for addiction, he responded:

I think if you're an addict it does. No, I think if you're an addict you are more, *but also I think addicts tend to be drawn more to this work.* We are codependent by nature and we like to help people and it's also part of our little mind games we play with helping somebody else is that we deserve the break. I think a lot of nurses are very dysfunctional and addicts are dysfunctional. We're very compulsive people. I mean, I know a lot of people that don't use chemicals but they're just as much of an addict with other things as I was with meth. I mean look at how many obese nurses there are. Food is one the things.



Dan's points were interesting indeed. Is he correct about nurses being "codependent by nature" and that "addicts are drawn more to this work [of nursing]"? If that is the case, does being a nurse place people at risk for addiction, or people with addictive personalities become nurses, thus placing them in a risky situation? Is there truth to the idea that nurse personality traits lend themselves to addiction? This is something that needs to be studied further. If research supported the premise that the personality traits that attract people to the profession of nursing also placed them at risk for developing addictions, that knowledge could change the way nurse educators approached the topic of nurse drug addiction.

Only three of the participants in the study were firm in their beliefs that being a nurse did not pose any greater risk for addiction than any other profession. Tamara was one of those that felt this way, but her circumstances of using were a little different than the other nurses interviewed. Tamara used methamphetamine outside of the nursing setting, so her perceptions may possibly be affected by her experience:

I don't think it really matters what your occupation is or what you choose to do. For me myself, I would have used meth whether I was an attorney or a McDonald's worker or a nurse, it wouldn't have mattered.

Beth used only alcohol before becoming a nurse, and then while she was at work she just worked with infants, so she felt exposure to narcotics was not an issue and did not increase her risk for addiction:

Betty: I don't think so because working with kids and babies, my whole nursing career, it's not like I give out narcotics and had exposure. If I did they were such minute amount that I hadn't even considered trying any on myself.

*(Researcher: In general do you think that going into nursing places somebody at risk?)*

Betty: I think in general if they have a family history or genetics in their background then I think you're predisposition to falling into that mind-thought and, how quickly just a switch can go off, and you find yourself enjoying the feelings of euphoria or being relaxed. So I think more so the family history.

*(Researcher: So if a person was going to become addicted as a nurse they probably would have become addicted anyway?)*

Betty: I know I would have. It wouldn't have mattered what career I had. It was just one day I tried harder alcohol and liked the feeling I got. So I, to me it didn't matter what career I was in.

Linda also felt people were not at greater risk for addiction by virtue of being nurses:

I feel that just because you're in nursing doesn't make you more at risk because you are accessible to Pyxis [medication dispenser] and pain medicine. Many people feel that being in the medical profession that they can't be around that stuff because they know they will take it. For me it wasn't that way.

Linda had a little bit different perception about risk and access than most of the others.

She felt some people used having access as an excuse for becoming addicted, and she felt that was a cop-out:

Like I said, [the idea that] 'just being a nurse makes you more at risk for being an addict'--that sort of thing makes me angry because I think that is people's way of justifying why they got to be an addict in the first place. . . because they were around it. And I just think it's how you are as a person. . .

Responses to the question about nursing as a risk for addiction were varied according to individual circumstances but, on the whole, agreed that having increased access to medications posed a risk to nurses--especially if they were more inclined to addictive behavior and would have eventually become addicted anyway. It was significant that all of the nurses who became addicted after becoming nurses believed their profession placed them at risk. Those that were addicted to opiates all acknowledged that having access to narcotics as nurses posed a risk for them. It could be concluded that, at least for people who were not addicted before becoming nurses, gaining the easy

access to narcotics presented a risk factor for nurses. The nurses who became addicted to opiates after becoming nurses all believed the access to opiates in the workplace pushed them over into addiction when they may not have become addicted otherwise. It was impossible to know whether that was actually the case or not but, with the nurses who informed in this study, an association could be made between their risk perception for addiction and the access they had to drugs as a result of being nurses. In order to understand this aspect of risk more conclusively, further research on this topic definitely needs to be done.

Whether or not nurses are at greater risk for addiction by virtue of being nurses may not be answerable at this point, but one finding about risk in this study was: most nurses did not consider themselves to be at risk for addiction before it happened. This was where the experience of these nurses may become extremely beneficial to nursing students. Nursing students have probably felt they would never be the nurse that would use or abuse narcotics. Perhaps if they realized that most nurse addicts also felt that way at one time, they would think twice about taking their sobriety and risk for granted.

### **Is There Anything that Might Prevent Nurse Addiction?**

Near the end of their interviews, all of the participants were asked if they felt anything would have prevented the addictions from taking hold in their lives. They were asked to consider whether anything could prevent addiction in nurses in the future. As mentioned in the presentation of Theme 3, A1 stated having solid coping mechanisms in place was the only way he could see this being prevented. He said people need to “. . . learn to deal with our acute stressors. . . my drug addiction doesn’t have anything to do with my drugs; it all has to deal with my thinking and my behavior.”

Lacey felt more focus in nursing school on nurse addiction may have been helpful in preventing her addiction. She felt “education is key because narcotics are so much more available than they use to be and it’s so easy to fall into these things.” She stated nursing students need to know that, just because they do not use drugs early in their lives, does not mean they never will. Addiction can happen several years down the road. She said, “Because I had been a nurse for probably 17 years before [getting addicted]. I kind of felt like I was impervious to it and I obviously wasn’t.” Ashlee shared a similar thought about how different stages in life brought different risks and problems:

Right, like you may not be at risk now, but there could come a day or situation where you are at risk. So really you are. Just because you aren’t today doesn’t mean you won’t be. . . or they didn’t have risk factors when they were a nurse but 10 years down the road they are. . . I didn’t [think I was] at the time, but apparently I [was] because when I was really under stress. . . look what happened.

In addition to the comments above, Ashlee felt there needed to be more access to some kind of therapy or somebody to talk to should nurses become overly stressed or started feeling the need to escape life’s circumstances. She said, if she had had somebody to talk to about things like how to get out of her abusive marriage, she may not have felt she had to escape and isolate herself through narcotics. She also suggested testing nurses for risk. She said, “I wonder if they could do some type of test on personality of people that had issues or situations [so] they knew what to look for.”

Linda felt if her physician had said “no” when she kept asking for more narcotics, she may have avoided becoming addicted. Craig felt the hospitals should have employed measures related to drug abuse that were actually enforced. He said:

There are other areas, and I’m talking about tracking narcotics once they leave the machine that dispenses the medication to the nurse for the nurse to take to the patient to give to the patient, there’s a lack of accountability or maintaining a secure way of getting that from where it’s dispensed to where it needs to go to the

patient and then disposing of any leftover medication. Most of the time. . . in fact I'd be willing to say all of the time. . . those medications usually end up in the nurses scrub top pocket to be wasted later. Tracking that and accounting for all that becomes a mess and its very, in my situation, it made it very easy to divert and to divert for quite some time without having anybody suspicious of what was going on. . . Institutional and departmental protocols, some of them weren't followed and in other areas there's just not enough in place to ensure that or to minimize the risk of nurses having multiple narcotics for multiple patients on their person at one time.

Some of the participants felt there was nothing that would have prevented them from becoming addicted. Beth said:

I think because I'm stubborn I would have fell into the addiction regardless. I'm the type that if you tell me I can't do something I will anyway. And therefore it makes me very selfish, so I don't think there's anything that would have prevented me.

Beth's drug of choice was alcohol. Annie, whose drug of choice was also alcohol, felt nothing would have prevented her addiction. She said:

No I think that when I got pregnant I was doomed. I really didn't fit in anywhere and these people that I started hanging around with. They didn't care that I got pregnant at 15. They didn't care, you know; I didn't have anything to prove to them. They weren't like watching me or talking behind my back and stuff like that. So I just think that I was pretty much doomed. . . I remember the first time I was taught even how to take it from a facility by another nurse when I had a headache. I got taught by another nurse.

Annie did agree partly with Ashlee when she said:

I think that if it were more open a lot more people would come forward. And they can get the help they need when it first starts. . . they didn't have to be afraid of the reprimand that they would get. . . so I just think it needs to be more open.

Most of the other participants agreed nothing would have been helpful in preventing their addictions. They stated if someone was going to become addicted, they were going to become addicted--no matter what their profession was and what other people told them in an effort to prevent it. Like Lacey, though, the researcher believed it was worth the effort to try to prevent it, if possible, by educating people better about the

realities and risks of nurse addiction. It was the belief of the researcher that the way this subject was taught in nursing schools needed to drastically change. Based on the results of this study and the insights of these informants who had actually experienced addiction, it may be that nursing education has been lacking in effectiveness in the current and former methods of teaching about nurse addiction.

### **Nurse Addiction in Nurse Education**

As mentioned earlier, 6 of the 14 participants in this study stated they received some type of formal education about nurse addiction in nursing school. Eight (57%) of them did not remember learning anything about it at all in school. Of the six that reported learning about it, five said what they were presented was ineffective or useless. Overall, the subject seemed to be missing from educational programs, and if it was there, improvements in how and what was taught might be helpful. Annie gave some suggestions about improving nurse education:

Annette: I think that in the beginning of nursing school you need to be taught, you're going to be around a lot of drugs and if you have any family member that is an alcoholic or an addict, you really need to take a look at this because it's very real. And it can happen so fast. . . I think it should be part of the curriculum. I really do. Like I said, I knew I was using drugs and I knew that I was drinking when I entered nursing school, but it never occurred to me that I was an alcoholic or an addict. . . it just evolved to be that way. And I don't think people really realize. . . how fast it can occur just by getting away with it one time. That one time or you'll figure a way to get it if you need it or if you want it. There's a way. And I think that we need to be aware of those ways, and I think that people should tell the ways that you get it. I mean, the nurse that taught me, I had a headache one day and I'm just used to doing more alcohol. I'm an alcoholic, but I have dabbled in the prescription and the street drugs.

Ben, who had only been a nurse for three months when he was interviewed, stated:

They talked about how big of a problem it was and you know and what nurses do and that type of thing, but they didn't. . . they just said it's a bad bad thing. It wasn't a whole day's worth of lecture, it was just 'don't get caught', 'so many

people get caught taking pills and it ruins their lives', but no nurse education play on it.

Valerie said:

I think the right thing is definitely to have more education out there. I don't think that it's something that we can ignore. I think it would make us better practitioners to have more education ahead of time. . . more able to recognize addiction and treat it and have more compassion.

Back in 1998, the American Association of Colleges of Nursing (AACN) issued a position statement titled "Policy and Guidelines for Prevention and Management of Substance Abuse in the Nursing Education Community." This statement called for reformation in policies in nursing education related to substance use in the profession, but the statement has gone largely unnoticed or ignored. In fact, the researcher did not even find this document until well into her research on the phenomenon of addiction in nursing. It was buried in the literature and only emerged by "accident." It was not found with all of the literature search efforts done in the preparatory stages of this study. The statement reported the initiation of a Substance Abuse Task Force in 1992 that was charged with developing a policy statement to address the problem of substance abuse in the nursing education community (AACN, 1998). At that time, 21 years ago, the AACN's Board of Directors recognized that ". . . nursing education reflects the society in which school of nursing exist and that substance abuse is a universal health problem that affects all segments of society, including students, faculty, and staff in schools of nursing" (para. 2). The general assumptions and principles used by the Task Force in developing this "Policy and Guidelines" were significant and, therefore, shared in this context. They suggested:

- Substance abuse compromises both the educational process and patient care and must be addressed by schools of nursing;
- Academic units in nursing have a commitment to and a unique role in the identification of abuse, intervention, referral for treatment, and monitoring of recovering individuals;
- Addicted persons need help to recognize the consequences of their substance use;
- Addiction is a treatable illness, and rehabilitative and therapeutic approaches are effective in facilitating recovery;
- Individuals with addictive illnesses should receive an opportunity for treatment in lieu of, or before, disciplinary action. (AACN, 1998, para. 6)

The AACN proposed attention should be given to education, identification, intervention, treatment, and re-entry of nurses into practice. They suggested the process should be “clear and simple, with specific mechanisms to ensure confidentiality at all stages of the process. . . . The procedures and requirements should be reviewed periodically to examine current scientific evidence and policy workability” (para. 7). No follow-up to this statement nor new efforts or statements could be identified as being issued after the issuance of this statement by the AACN in 1998.

The AACN seemed to be truly concerned about creating policy and change related to education about substance use in nursing. They submitted the idea that management of substance abuse was *dependent* upon education. They proposed addiction education should have been provided to nursing students, faculty, and staff. Content on nurse addiction needed be included in the nursing curriculum, they said. Education about



substance abuse should have been supplemented with information on the implications and consequences of impairment due to abuse and addiction. They also suggested faculty needed to be sensitive to cultural differences and the needs of today's diverse student populations. The need for formal nursing education on this topic has been identified and suggested, but at least in lives of the nurses interviewed in this study, that need has not been addressed nor met.

When the literature was re-visited after identifying this lack of adequate education in nursing, some other efforts that have been done on the subject were identified. Marcus et al. (1999) reported a study for which a grant was received in order to increase faculty competence, enhanced curricula, and developed a master's subspecialty program in addictions nursing. With increasing faculty competence in substance abuse and changes in curricula came the growing recognition from neighboring hospitals for the need to increase their abilities to meet the health challenges of addiction. While an educational program was created for nursing education, the addiction education was focused on addiction in general and not on addiction within the profession (Marcus et al., 1999). The nursing students did have to identify their own attitudes toward addiction and learned quite a bit of information about addiction, but they did not necessarily become better educated about addiction within their own profession.

Pullen and Green (1997) did address addiction within the profession specifically in nursing education. They suggested that nurses were, in fact, at risk for addiction, and many nurse peers were unable to recognize the signs of chemical dependency and, therefore, unable to effectively intervene. They submitted that, while the profession had taken measures to assist chemically dependent nurses with treatment and rehabilitation,

nursing peers needed to receive further education regarding the recognition of risk factors and behavioral manifestations of chemical dependency. The study by Pullen and Green (1997), as well as the one by Marcus et al. (1999), both took place in the late 1990s--near the same time when the AACN issued their position statement about increasing nurse addiction awareness. It appeared that, during that time period, nursing education realized there was a need for a change and began trying new things to implement change, but the efforts seemed to have subsided in large measure in the last few years. Shortly after those two articles were released, another study was done which set out to explore what kind of alcohol and drug education was being done in schools of nursing. Several different schools of nursing were studied to see which ones were offering drug and alcohol abuse education, but once again, the education they were seeking to find was education related to addicted patients and how nurses perceive and deal with patients that suffer from addiction--no emphasis was placed on educating nurses about addiction amongst themselves and/or their nurse peers (Howard, Walker, Walker, & Suchinsky, 2001). Study after study was found which addressed perceptions of nurses regarding addiction, attitudes of nursing faculty about addiction, attitudes nurses have about addicted peers, and other related ideas--but very few, if any, were looking at how nurse addiction education was being addressed in nursing curricula.

Other types of schools and disciplines have been teaching about addiction prevention for their own students for years. As early as elementary school, young students were educated about addiction and how it manifested itself. Elementary, junior high, and high school age students learned the importance of saying "no" to drugs and what to avoid. They learned how the types of drugs they may be exposed to would affect

them should they choose to use them, as well as how to recognize drug abuse in others. The Center for Disease Control (CDC) has provided guidelines to prevent tobacco use and addiction in school children, and frequently tests the effectiveness of the education that was taking place (McCormick & Tompkins, 1998; Pirskanen, Pietilä, Halonen, & Laukkanen, 2006; “Guidelines for school health programs,” 1994). Clients in addiction recovery treatment centers even learned how to empower themselves against using drugs and alcohol and how to find resources to help them if they should find themselves at risk (Wood, Englander-Golden, & Pillai, 2010). If school children and adolescents, recovering addicts, and college students in many general education settings learned about addiction and how it related to themselves personally, it would make sense for nursing students to learn about it relative to their own risks and not just relative to the patients they would be taking care of. If nursing students only learned about addiction as it related to people they would be taking care of, the problem of nurse addiction would continue to creep up on unsuspecting nurses as it has done in many of the participants in this study.

### **Recovering Nurse Addicts as Peer Teachers**

Peer support was a major factor for recovering addicts in getting healthy and in overcoming their addictions. Though not identified as one of the “themes” of this study related to lived experience of nurses who were addicted, a very significant and unexpected finding emerged from these interviews related to how recovering nurses viewed the power of peer addict support. The finding came about primarily through a question asked in the interviews relating to what the interviewees felt would be the most effective way to teach about nurse addiction in nursing school. What they said was so powerful, and enough of them said it, that it really cannot be overlooked. Without any

leading questions or coaching from the researcher, 10 out of the 14 participants said the thing they felt would be most effective in teaching this subject to nursing students would be to have a nurse or nurses that had been through addiction come and talk to the students about it. Peer education was their answer--and was something that could not be found anywhere in nursing education literature. A few of the informants commented that probably nothing would have prevented them from becoming addicted unless they had been able to see an actual nurse who had experienced addiction come and talk about it. The responses were so profound to the researcher that many of them are shared here. Melissa, the nurse who worked as a nurse for several years before becoming addicted, never partied in high school or college, grew up in a religious family, and was a mother of five children said this:

Absolutely the most effective way would be to have nurses like me actually in the classroom. Nurses that are willing to be open about their addiction, which most of us who have gone through addiction recovery are. If we are in truly healthy recovery holding ourselves accountable for what we've done, and being honest about what we've done, then those are the ones that aren't going to be afraid to go in front of a classroom and talk. You know, we're not in hiding because it is what it is. But to see like a nurse like me. . . someone who normally you'd probably look at and never guess, or someone you've talked to and never ever guessed that they have done the things that I have done to support my addiction, I think it would be a real eye opener to show these people that it can happen to anyone.

I think if it's just being taught by nurses from a book who've never actually experienced it, the message may not get across, or may not leave a mark in their mind for a time down the road where they're practicing and maybe thinking about it too. We need to tell them something they're going to remember because it's their lives. I mean, nursing now is a personal thing. It isn't learning how to change a catheter. . . it's not a nursing skill. I mean, you know, there are these people who as a teenage have smoked pot, they've struggled with this, they've struggled with that, they had a rough upbringing around it . . . just kind of the people who you predict will end up in prison or whatever for drugs, not people like me who was the exact opposite. I never ever ever drank or used throughout nursing school or as a child.

These statements by Melissa were so simple, yet so profound--and she was not the only recovering nurse addict who thought so. If everything that had been talked about up to this point was considered, though, what she was saying made a lot of sense. Most nurses did not think they would end up becoming addicted. Most were coping just fine for the stage of life they were in during nursing school but had no idea what it would be like 10 or 15 years down the road when they were getting a divorce or a parent died or a loved one became deathly ill--nursing students were not thinking about that when they were in nursing school--but just maybe if they saw someone like Melissa, who was just like all of them at their age, who was very "normal" and did not look like the stereotypical "drug addict"--maybe that was something they would remember and even internalize. Maybe these students who did not believe addiction would ever happen to them would hear someone like Melissa would say, "I never ever thought I would fall into addiction" and realize that it could happen even if you believed it never could. Maybe being exposed to someone like Melissa, paired with education about coping like several nurses suggested would be just what it would take to make a difference in getting this subject internalized and effective in nursing education. When asked what he thought nursing education needed, Craig, the family nurse practitioner who started abusing opiates as a nurse after an ankle injury, said:

Personally myself I need to feel a connection. I need to see those individuals. I believe devoting at least more than one lecture on the subject is needed, and for myself, having an open panel discussion with recovering nurses or recovering healthcare professionals. But more importantly, nurses as part of the educational process would be the best way to get that information to the students. . . not just something out of a textbook. Mostly because it puts a face to the problem. Personal experiences can be recounted by a nurse in recovery. People relate better to these types of issues if they can actually talk to an individual who's either gone through or is going through recovery. And the ability to ask these types of questions to them, because often times we don't. . . if it comes out of a written

text you can't ask questions. . . if the students can see that nurses who are addicted and in recovery look the same as everybody else, act the same. . . it's nearly impossible to distinguish between a nurse in recovery and a nurse that's not in recovery. I think that would be helpful for the students to realize that it's not something that you can notice. Addiction isn't necessarily something that you immediately see, it's more of the experience of the individual and I think that's where people, especially students--that's what they don't realize--that it's almost an invisible thing initially. You don't know that they're going through it unless they tell you that.

Dan, the man who had been a nurse for 32 years and in recovery for the last 19, made a similar comment:

And have some of us that are in recovery come in and tell our stories about what's going on with this stuff. And we have this saying about being nurses that we should know better so I think there's that shame thing that goes on so that we don't want to go get the help because sometimes we wait too late.

Dan was the one who did do a lot of partying in school with mostly alcohol but started his addiction when he acquired multiple prescriptions from anesthesiologists that he worked with in the operating room. Then there was Valerie--the vibrant labor and delivery nurse who ran a Professional in Recovery (PIR) support group:

I think it would be helpful to have a guest speaker come in who's been through the process and explain what it's like. All of that, having to go through the addiction, and working with that, and then the details of having to deal with the legal system or DOPL. Nobody I've ever been in meetings with ever knew anything about that. And that would be enough to scare a lot of people into getting help on their own. Because they have no idea of how much it will turn your life around. . . But I think it would be very eye opening and very educational for them to have a guest speaker come talk.

Valerie, like Melissa, was very insightful in her answers to this particular question. She continued on from the above statement by recalling a time when some nursing students came to sit in on one of her PIR meetings. She said after the meeting, the two students came over to talk to her, and their interaction is described here:

Their first comment was, 'wow you guys are normal people'. They thought they were going to come in and see a bunch of freaks that look like we just walked out

of the jail or some heavy metal concert or something. I don't know what they thought. So that was eye opening. Yeah. Some of them [addicts] are what you visualize and then some aren't. We really do cut across every section of society. We are well represented in every demographic. I think it would be really good to have addicts talk to students. I've just seen how powerful that is to have people in real life share their personal experiences and how profound of an effect that will have on people. . . that's going to stick with you way more than any lecture or video. It's the reality effect.

Valerie was so passionate about this subject she even referred to a very personal experience from earlier in her life when she had been a real-life peer educator before:

I did this once when I put a baby up for adoption--usually in smaller groups like the 'choices' classes, 'adult roles' classes, and support groups--and we would usually have a teen mom that was parenting, me who had placed for adoption, and then someone who was really pregnant, because it was a good visual effect (laughs). . . it's so huge and eye opening. I've just seen how powerful that is to have people in real life share their personal experiences and how profound of an effect that will have on people. I'll have people who are thinking about having sex, deciding not to, or to use protection. They realize that's reality. . . (laughs). . . condoms, wow, ok. Yeah, dude, you know, birth control. There are people who just found out they are pregnant and come talk to us afterwards. I know there's nothing more powerful than that, I've seen it. So I guess I compare it to that and that was almost 20 years ago.

Just like Melissa said students would remember seeing someone like her come and speak to students in the classroom, Valerie had just said that this type of experience had stuck with her for over 20 years. Ben, who came into nursing already addicted and had only been a nurse for a few months, responded:

Have people like us come in and talk to the class. I mean, that is the only way. Because you are already thrown so much crap at you in nursing school that the stuff that you should know they spend 5 minutes on, and the B.S. that you never use, they kill. And this would fall in the category of. . . if you have someone come in and they're. . . telling their story and they see it, I would think that would be the only thing. Not even a movie I think would do. Just get someone to come and say hi, I ruined my life. You know, I did. I threw a lot of my life away. I didn't just do drug things I did other behaviors associated with addiction that ruined my family. . . You [imagine] an addict and you think the guy with the sign on the corner, or some guy scratching his elbows with shifty eyes. . . he's a drug addict. You don't expect them to be lawyers and all licensed people, I guess that would hit home a

little more if someone comes in a suit or dress or whatever and says yeah this is what I did and this is how it ruined my life.

Lacey similarly responded when asked how this should be taught in nursing school:

I don't think it would have been effective being presented by people that had not been through it. I was somebody that wasn't, it could never happen to me and I may have listened more to someone that it had happened to because I'm sure we all thought in the beginning it could never happen to us. It definitely needs to be presented as a possibility of what can happen in a career with availability. It needs to be put in the curriculum, but I really think it would be more effective with even a movie about someone that had fallen into the trap. Yes. I think that would be helpful. Anybody can say the chances of that one of you is going to become addicted is one 1 in 6 or 7, but everybody always thinks they can play the odds. But to see what they could lose is that much more effective.

Mike actually had the experience in graduate school where he said a speaker came to the classroom that was a recovering addict. This person told his story and the consequences of his addiction professionally. Mike commented on this experience:

The professional side of things was eye opening. He was able to spell out exactly what he had to go through, the types of probation, and what was required of him to be able to eventually return to work as an anesthesiologist. One aspect I loved was that he was able to give a personal insight having been through it to how it affected him personally. I thought that was powerful to receive within a nursing program. I'd never had that experience in all of my education. So for me it brought about an awareness that I needed to be careful having heard what he had to go through.

Terry talked a little bit about the honors project she had completed in her RN to BSN program. She felt the students in the nursing program appreciated seeing the video she had created telling about her experience with being addicted as a nurse:

I think about that all the time especially when I was doing my own project, my video, I was thinking will this really help anybody? It might, because I was never actually walked through the process, It wasn't even until I did my video until I actually saw the process. Just to sit and think [as a student] if I saw that video. . . I might [have gone], 'hey I think I'm seeing a pattern here' a lot sooner than I did. Because I didn't see a pattern [in myself] really until it was over with.



When Terry was asked what she thought would be the best way to teach nurse addiction in nursing school, she said:

Discuss it. Just bring it up and have people come in and talk about it or do videos like I did. . . They just have to hear it again I think over and over again. . . I think having people that have had the experience come and share their 'from when they started to when they got caught', story--I think that if somebody can see themselves in that. I think a lot of people could relate to my story.

*(Researcher): Why do you think that could be more meaningful than just hearing a lecture about it?)*

Terry: Because you're hearing it from somebody who has no idea what it's like and you're just being lectured to rather than hearing a story. A real personal experience, I think works a lot better than someone just telling you. . . somebody that's really lived through it--I'm going to remember and listen to them a lot more than somebody else who's just saying 'this is what you've got to do but I've never done it'.

Beth also suggested having recovering nurse addicts come speak to the nursing students as a more effective way to teach this subject:

If they can even have guest speakers or people who have, like me, I'd love to go and talk to a class and let them know how it all began and how it is a disease. And I think just hearing it from other people in person, not just a book or from a lecturer who isn't an addict or alcoholic, but from real people who are in the throes of it or have come out of it, and have a pretty normal life now in their recovery. I think coming from somebody I could relate better. So I think just going into these classrooms. . . yeah, not just from a book. I don't think that would cut it.

Linda similarly suggested, "The only thing I can really think of is to have people that have been addicted or are addicted and still practicing as addicts to be incorporated in the curriculum."

As one result of the previously discussed feelings of guilt and shame that accompany addiction, nurse addicts in recovery often felt the hope and desire to help other nurses avoid the pitfalls and chains of drug addiction. They felt a great need to give something back. They wanted something good to come from their mistakes. Several of

the nurses interviewed mentioned that they hoped this study would help other people. Several of them offered to come talk to nursing students if something like that ever became a part of the nursing curriculum. They expressed a sincere desire to have their experiences help others avoid making the same mistakes. They wanted to talk about their experiences. All of the participants said they were glad to have the opportunity to share their experiences if it would help someone else or help “get the word out” about nurse addiction.

Because this recommendation for peer educators by the participants was so prevalent throughout the interviews, the researcher again turned to the literature to see whether this type of education was already taking place or not. No evidence of this happening in nursing education could be found, even though evidence of peer education related to addiction had been shown to be extremely effective in other environments. Treatment centers for addiction have been using the “peer principle” to aid in treating addiction for years (Riessman, 1998). That was one reason the nurses in recovery have felt that support in recovery from other recovering addicts--this was where they felt they were best understood, and it was where they found hope and strength in the success of others. This type of peer support was documented in a classic magazine article titled *These Drug Addicts Cure One Another* (Ellison, 1954; see Figure 4). Even back in the 50s, the benefit of peer mentoring was recognized. In the article, the experience of a man named “Dan” who attended this Narcotics Anonymous (NA) meeting is described:

After a month of sullen silence, he began attending the group meetings, which were a new feature at the hospital since his last trip. ‘I still wouldn’t talk’, he reports, ‘but I did some listening. I was impressed by what Houston had to say. Harry came back one time and told us his story. For the first time, I began to pray. I was only praying that I would die, but at least it was prayer (Ellison, 1954, p. 48).

Hearing the story of someone who was succeeding in recovery gave Dan hope. The article showed a picture of participants of a NA group sitting at a table in the McBurney Y.M.C.A. in New York. The picture is included here as Figure 4.



*Figure 4.* Photo of a Narcotics Anonymous (NA) Meeting in 1954. (Ellison, 1954). Photograph © SEPS. Used with permission from Curtis Licensing. All Rights Reserved.

The literature had numerous other studies related to peer mentoring in addiction recovery (White, 2010; Whitten, 2005; Wood et al., 2010), but after several different efforts to find other research, no evidence of using peer mentors for a preventative teaching standpoint could be found. When the researcher was about ready to give up, a half-page newspaper article was found that was printed in the *New York Times* in 2002 that reported a group of medical students at Cornell University who had been educated about addiction by actual recovering addicts. The medical students admitted they felt very insecure about dealing with addicted patients because they had very little experience with them. One student said, “I thought the only people who got addicted were those who

were wealthy with nothing to do or the urban poor” (Villarosa, 2002, p. F6). The medical students actually took a field trip to Phoenix House, a drug treatment center in Queens, New York, and took part in an informal but intense session in which the students and some of the residents engaged in a free-flowing discussion. After hearing the story of one of the treatment center residents, a medical student stated the experience had helped her see those addicted to drugs as real people. “What I heard were people who were using drugs to make the suffering go away, to get lost in the world of drugs,” she said. “This experience will stick with me for a long time” (Villarosa, 2002, p. F6).

This newspaper article was the only bit of literature that could be found in which those learning about addiction from recovering addicts were not addicts themselves. The experience was very powerful and made an impression on the medical students--much more so than learning about it from a textbook or a lecture. This idea was the premise for having recovering nurse addicts come and teach non-addicted nursing students about the reality of nurse drug addiction. Nurse addicts in recovery themselves identified this as the way they felt nursing education could change and cause this content to be more effectively understood by nursing students getting ready to enter the workforce.

### **Overall Finding: Nurses in Recovery Feel Misunderstood and Judged, and Just Want to be Accepted**

Nurses recovering from substance addiction experienced a wide range of emotions, feelings, consequences, and repercussions. They experienced a significant amount of fear, guilt, and shame in their lives--both during and after their active substance use. They often did not have effective coping skills. They lost their healthy sense of control and often try to compensate by trying to control everything they can in their environments. Nurses who were addicted usually did not plan to become addicted

and, in fact, did not perceive themselves to be at risk at all for addiction, even if they had strong family histories of the disease. Addiction was defined as a chronic, relapsing brain disease that was characterized by compulsive drug or alcohol seeking and use, despite harmful consequences. It was considered a brain disease because the substances actually change the brain--they change its structure and how it works (NIDA, 2007). With all of these experiences, feelings, and facts in mind, it was easy to see how nurses recovering from addiction sometimes felt overwhelmed in the process of recovery. In early recovery, they were dealing with the physiological and psychological adjustments that came when the substance was no longer being used. They often experienced depression and anxiety early in recovery. They had a variety of physiological accommodations being made, usually accompanied by the same stressful outside circumstances that led them to use in the first place. They were trying to deal with the problems that they attempted to escape before, while at the same time suffered mental and physical changes. Many recovering addicts felt a lot of self-condemnation and worry about the wreckage their addictions had left behind. Most felt an acute sense of guilt and shame as they tried to rebuild their lives. Addicts were extremely hard on themselves and really felt they needed support and encouragement from those around them.

The recovering nurses in this study did feel a lot of guilt, shame, and self-condemnation, but they often did not feel the needed support and encouragement from others in these difficult times. The recollections of their experiences in recovery were threaded with feelings of being misunderstood, judged, and demoralized. They frequently expressed a desire to have non-addicts understand the “disease” and treat them as people with other diseases would be treated. Al was able to verbalize this feeling well:

I think it [would be] a little bit easier if [instead of] just ‘oh you’re an alcoholic’, or ‘you’re a drug addict’, [others] realized this is an actual disease. We’re not going to shove people out. It wouldn’t make sense if we shoved people out because they’re an alcoholic and drug addict and they’re stealing things. Let’s get them the appropriate help, just like someone that has diabetes, we need to treat them the same. You’re not going to be like oh I ate a whole box of donuts, my blood sugar is 5000, let’s educate them on the carb count. The same thing--if someone goes out and relapses we don’t want to push them out and shove them away. We have to be like, ok, this is part of the process, but why did you drink and use? Where are these stumbling blocks that you obviously didn’t have [tools for] in your tool belt? So I guess we have to learn how to do that better because a lot of people don’t see; a lot of our clients don’t see it as a disease, they just see it as a psychiatric disorder; they choose it in a sense.

Ironically, Al was not the only one that compared the disease of addiction to diabetes.

Two other nurses made that same comparison, with expressions of wanting to be understood and treated more compassionately:

Craig: What I’ve gone through is the same or similar to anything anybody else would go through as far as a personal crisis, whether it’s an addiction of a sort or any other type of a disease. . . because that’s exactly what it is. . . a disease. It is treatable and it’s a lifelong condition. And you put it up against diabetes or something else, and they have similar things. As long as the person or patient is compliant with the treatment plan they are fine; you don’t need to be afraid of them or think of them in a negative way because you wouldn’t think of your grandparent who has diabetes in a negative way. They are an individual and they are a person just like anyone else, and they need to be treated as such.

Annie: Just be nice, you know, you don’t have to talk behind their backs, you don’t have to go to your manager or whatever. They’re just people that are sick. It’s just like diabetes or whatever. They’ve got to a point where they need that stuff and they’re not bad people, they just need help and kindness and a helping hand. If you know somebody using or you kind of got proof they are, rather than running to your manager, offer a helping hand. Say ‘look I haven’t said anything to anybody but I’ve noticed these few things. I’m an addict myself; alcoholic myself and I’d like to help if you want my help’.

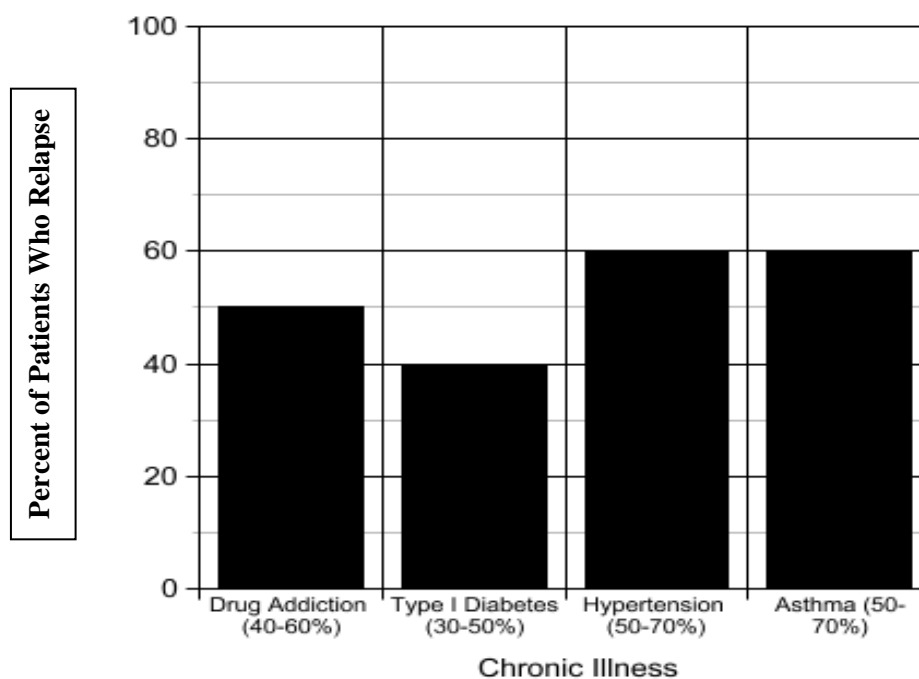
It was interesting that addiction as a disease was often compared to diabetes. In fact, in treatment settings where addicts were being treated and taught about the disease model of addiction, they were often instructed to view their own addictions as a “disease like diabetes,” in order to help them better understand the nature of disease processes. Like

Craig said, if a person had chosen not to regulate and control their diabetes by what they did and did not eat, they may experience negative outcomes because of their disease.

People with diabetes have to be vigilant in making sure they stay on top of their blood glucose levels because, if they choose not to, they could experience some of the more serious effects of uncontrolled diabetes. They could lose their eyesight or get severe sores in their feet, or a number of other consequences for not controlling their diabetes.

Addiction should be viewed in a similar way. It should be viewed as a progressive disease that, if not held in check, could cause severe repercussions.

In “Drugs, Brains and Behavior: The Science of Addiction,” the National Institute on Drug Abuse (NIDA) presented a graphic that compared relapse rates between drug addiction and other chronic illnesses. This graphic was re-created, and is presented in this document as Figure 5.



*Figure 5: Comparison of Relapse Rates Between Drug Addiction and Other Chronic Illnesses (NIDA, 2007).*

Relapse rates for drug-addicted patients have been compared with those suffering from other chronic diseases like diabetes, hypertension, and asthma, as the figure portrays. Relapse was common and similar across all of these different medical illnesses (as is adherence to medication). Thus, they suggested drug addiction should be treated like any other chronic illness, with relapse serving as an indication for renewed or altered intervention (McLellan, Lewis, O'Brien, & Kleber, 2000; NIDA, 2007). Further, NIDA asked the question, "Does relapse to drug abuse mean treatment has failed?" They followed up the question with this answer:

No. The chronic nature of the disease means that relapsing to drug abuse is not only possible, but likely. Relapse rates (i.e., how often symptoms recur) for drug addiction are similar to those for other well-characterized chronic medical illnesses such as diabetes, hypertension, and asthma, which also have both physiological and behavioral components. Treatment of chronic diseases involves



changing deeply imbedded behaviors, and relapse does not mean treatment failure. For the addicted patient, lapses back to drug abuse indicate that treatment needs to be reinstated or adjusted, or that alternate treatment is needed (NIDA, 2007, p. 26).

Addiction was not the only disease that required both physical and behavioral modifications, like the quote above described. If a person chose to relapse on drugs, it was like a diabetic choosing to “eat a whole box of doughnuts” (like Al said). However, diabetics who make the poor choice to eat a whole box of doughnuts usually were not thrown out and frowned upon for a poor set of morals--like the addict who made poor choices and suffered the consequences of his or her unmanaged disease.

With all of this information being taught to the recovering nurses, it was no surprise they often felt misunderstood when everyone outside of recovery rooms was treating them like they had something wrong with them. In reality, most recovering nurse addicts were doing the best they could to rebuild their lives, and they just yearn for acceptance instead of judgment. Most nurses were actually very intelligent and skilled and want to be seen and accepted for the good things they could do and not only be labeled as “addicts.”

Ben: I don't know if it's just nurse addiction, but it's kind of depressing that the wealth of knowledge and experience that are in the meeting rooms of all these nurses that [are] branded as almost worthless because they were addicts--but their abilities and their skills are not diminished by the fact that they had an addiction problem. And that's the kind of pervasive thing that is still going on. Like ok, you were an addict, well that takes the fact that you were a 20 year special LD nurse or something like that away because you took a couple pills or you had a problem. It doesn't.

Lacey and Valerie were still trying to get jobs as nurses but had a difficult time because of their experiences with addiction:

Lacey: It's been far more difficult to get a job than it had been before. I think there's definite stigma attached to it. So I get frustrated. It's very difficult for me

to go to a work place that has narcotics and avoid them. It's definitely been an added stressor on my career and I've left more than one job because of that.

Valerie: We're going to let people down because they hold us so high. I mean I was the go-to person in my unit for all the problem solving. I was the one the doctors called when they had a difficult case when they wanted somebody highly skilled. Let's call and see when Valerie's scheduled--we'll do that when she's there. As that person I wasn't going to be the 'idiot' who, because we went back to the way we view addicts--they're stupid; they got themselves into this and they're stupid. So I felt stupid, I felt isolated, very berating to myself. I very much berated myself. . . But most people have had a negative experience [with addicts] so they're going to have a negative view and I'm aware of that. I realize that even though I'm surrounded by people in meetings that are supportive and helpful and optimistic, I know that most of the world doesn't feel that way about addicts. I know that even though in the healthcare field we should be more educated and compassionate about addiction, in reality I don't see it outside of a treatment setting.

Many of the interviews done in this study had an underlying tone of sadness or remorse portrayed by the informants. The nurses were not sad they had addictions--or even sad about being caught--they seemed sad about being "that nurse" who was no longer respected and often judged. Annie encouraged others who may struggle with addiction:

If you go tell on yourself first then they don't have to investigate you and make you feel like a criminal. You're just sick; you've done stuff that you normally would not ever do. You're a good human being. That doesn't mean you're not caring, you're just sick. And you can get help without them taking away your license. You know, if you just be open and honest they will help you. If you don't think 'oh my god'-- if you can just be open and honest with people.

In 2002, Join Together, a project of Boston University School of Public Health, met as a national policy panel to address the issue of discrimination against people seeking treatment or recovery from substance abuse (Leis & Rosenbloom, 2009). It turned out their fears were well founded. They discovered 25% of people in recovery reported they had been denied the opportunity for a job or promotion or had trouble getting insurance, and 4 in 10 said they experienced shame or embarrassment because they were in recovery. Apparently nurses were not the only recovering addicts who had

difficulty being accepted by others. This article stated that, even for individuals who received treatment and stopped using substances, the road to acceptance as functioning members of the community remains fraught with difficulty (Leis & Rosenbloom, 2009). They were frequently confronted with the stigma of addiction and faced discrimination from many sources--from their own families to the federal government. Recommendations for change were proposed by the authors in an effort to help recovering addicts re-enter society and contribute in positive ways. Results of the recommendations were not included in the article.

### **Summation of Analysis**

Fourteen nurse addicts in recovery were interviewed in this qualitative study in an effort to better understand their lived experience as addicts in recovery. Risk perceptions were also investigated, as well as ideas about the subject of nurse addiction being taught in nursing education. Nurses were also asked if they felt anything could have prevented their addictions and if they could recommend a more effective way of educating nursing students about nurse addiction.

As a result of the analysis of the data acquired in this study, five themes were identified. Those themes were: (a) Fear is a significant part of the experience of being a nurse who is addicted; (b) Shame and guilt are felt by nurses who are addicted; (c) Poor coping: Addicted nurses report having underdeveloped coping skills; (d) Control: Nurses feel an increased need to control their environments (e) A core problem inherent in nurses who are addicted is a belief that addiction would never happen to them.

Each of the five themes were discussed in detail and supported by several statements taken from the interviews with the study participants. The five themes

encapsulated the overall experience nurses who had been addicted have had, as well as a close look at the risk perceptions nurse addicts had related to their own risk for addiction. After themes were described, an in-depth discussion of implications took the findings discussed in the themes and then applied them to nursing and nursing education. The nurses discussed whether or not they felt being nurses placed them at risk for addiction. Seven nurses, all of whom did not become addicts until after they became nurses, stated they did feel they had been at risk for addiction just by virtue of being a nurse. Four nurses stated they did not think being a nurse necessarily placed people at risk for addiction more than any other occupation, but they did think the increased access to narcotics could become a risk factor for people who might already be prone to addiction. The other three nurses felt being a nurse did not place them or other nurses at risk for addiction.

Some historical considerations of nurse addiction education in nursing schools were examined, followed by some recommendations for change in the teaching of this subject. A significant finding related to how addicts felt the subject could be more effectively taught was discussed. Ten out of the 14 nurses suggested having peer mentors--actual recovering nurse addicts--come and talk to nursing students about nurse addiction. No research could be found to support this finding, so the recommendations of the addicts in recovery were interesting and intriguing indeed. These recovering nurses were eager to get the word out to nursing students in an effort to prevent others from becoming addicted.

## **CHAPTER V**

### **CONCLUSIONS AND RECOMMENDATIONS**

#### **Conclusions**

Substance abuse and addiction have posed and continue to pose serious concerns for the nursing profession. Nurses who have lived the nightmare of addiction have a keen insight into this phenomenon. These nurses often experience fear, shame, and guilt after emerging from addiction. The informants of this study reported that they did not have good coping skills, and they often tried to manipulate their environments in an attempt to compensate for the loss of healthy control and healthy coping. Nurse addicts often attempted to control the amount of drugs they use, the shifts they work, and everything else they could manage to influence control over. Their substance use was progressive in nature. Nurses who had become addicted to drugs rarely imagined finding themselves in that situation. Most of the nurses in this study never thought they would ever become addicted. They often had stereotypes of drug addicts in their minds and never associated themselves with those stereotypes. Most nurses did admit there was an occupational risk involved with being a nurse because of the access it provided to narcotics and the perception that they could control their abuse of drugs or alcohol.

A good deal of public attention has been devoted to the issue of nurse substance use. Since the 1950s, nursing schools have been encouraged to include some formal

content on addiction and/or alcoholism in their nursing curricula (Hyman, 2004).

Currently, pedagogy to help nursing faculty and students meet current societal and professional demands and standards related to substance abuse has been implemented in nursing programs worldwide (Hyman, 2004). While the exact number of chemically dependent nurses in the United States has remained unknown, the fact has existed that there are nurses affected currently by substance abuse problems to the extent that job performance could be impaired. Left unchecked, substance abuse could exert profound effects on public safety and patient care. Many impaired nurses were not identified until patient safety was already compromised (Clark & Farnsworth, 2006). Because these issues have been so serious, substance abuse and dependency have been health and safety issues that have needed to be addressed within nursing education.

Recovering nurse addicts who interviewed in this study thought they were not adequately educated about nurse addiction while in nursing school. A significant number of them perceive the best way to have the subject taught in nursing school would be to have recovering nurse addicts come and talk to nursing students about their experiences. They believed nurses who had experienced this problem and were successfully recovering from addiction would be an invaluable teaching tool in bringing the severity of this problem to the attention of nursing students. Nursing students have learned about addiction in general but not always about nurse addiction. Something different has needed to be done in order to help nursing students see the seriousness and reality of the abuse of drugs and alcohol in the profession. Having recovering nurse addicts come teach nursing students about nurse addiction may help students internalize the reality of the risk

of addiction. Nursing students could also benefit from learning about coping techniques so that using substances would not even have to become an issue.

The experience of recovery from addiction often included feelings of being misunderstood and judged by others. The nurses in this study expressed a desire to be accepted by others--their families, friends, colleagues, and professional associates. Sadly, the stigmatizing attitude of nurses and other mental health professionals has also been shown to effect treatment recruitment and retention (Lovi & Barr, 2009). Additionally, stigma limited access to resources, thus contributing to the problem of people with dependency not receiving the treatment they need. Some nurses were eventually able to overcome some of these negative feelings and find hope in their futures. Fortunately, Beth was one recovering nurse who had been able to transcend beyond what others thought and was finding joy in her new life as a recovering nurse. She expressed her hope in the following way:

It feels really good and it's amazing to me, I was just thinking the other day even after 4 years, I'll have 4 years January 15<sup>th</sup> of sobriety. Even after 4 years I didn't think I could think more clearly, you know I thought maybe after a few months your mind clears up and now I see that I'm a smarter person, I make good decisions and I'm thinking 'gee it took years to get your brain back to where you were or even better than you use to be.' I feel smarter, more confident, my coworkers like me, I like to joke around, and I have good friends that know my whole story and I feel really good. My boss is very supportive, she knows everything. She sends my evaluations into DOPL every 3 months and she can see and she hears through other people that I'm doing a good job and I have good judgment.

I'm just happy and confident and I love my life and my job. . . Right now it's wonderful to say you've come through and that you've gotten a lot of what you lost in your life back. That there is hope, when I thought there was none for me. I didn't see my life without it [alcohol], how could I live day to day without it. I never want to go through that hell again. I lost everything; kids, family, license, job. I was working at Kimberly Clark when I lost my nursing license, stacking diapers for \$9 an hour. I was working at a golf course flipping burgers for \$6.50 an hour and maybe get \$10 in tips on a good day. And once you've experienced

that then it even motivates you even more to work harder to get back your nursing license where you have the insurance and the ability to support your kids and do things in order to enjoy life. To live a normal life.

Dan, who had more time in recovery than all of the other nurses, has had more time to deal with the repercussions of his addiction. He said:

I think if anything my recovery has made me a better nurse. I've had the opportunity to share with other people and help in their recoveries and like I said, I've talked to my internist about the whole thing and every year I go in and the first thing he asks me is, 'Are you doing meetings'? Not 'how's your blood pressure' and all these things, but 'are you still doing meetings'. And I think it's been. . . by me staying there. . . I felt really guilty for a long time about letting my team down and the docs I work with because they're all friends. I was able to show that I can do that, and show I can do a good job of it. And I think God's put me there for a reason because every time I turn around somebody--whether they've got somebody in their family that needs help or them themselves--I've given more of those big books at my work than I have at most meetings I go to. That also showed me that there's a lot of people with addiction problems in the healthcare field.

Melissa expressed optimism in dealing with her addiction, despite what others might think:

I guess the ones that maybe grew up with addiction problems, drugs problems or alcohol problems, maybe kind of see it as a hopeless disease, a lost cause that they've been battling with their whole life. But I've lived 34 years of my life drug free and so I don't see addiction as a lost cause or a hopeless disease. I see it as something that is unfortunate that we're all at risk for but it's also something that there's not a cure for, but there's treatment for it and we don't have to suffer with it ever again if we choose not to.

While dealing with addiction and recovery in nursing, these nurses illustrated the fact that there was hope after addiction and, with perseverance and effort, nurses addicted could continue to grow, progress, and feel whole again.

### **Significance of the Study**

Nursing schools have been challenged to integrate substance abuse and addiction content into both their undergraduate and graduate curricula (Hagemaster et al., 1994).



Some people have even suggested that, for some nurses, substance abuse began while attending nursing school (Coleman et al., 1997). Governing nursing education bodies have issued challenges to address the issue more thoroughly (AACN, 1998). All of these efforts to improve education on this topic could not be done without special attention being given to understanding the experiences and perceptions nurses struggling with addiction have. Nurses who have lived the experience were able to share their knowledge and unique perspectives in a way that nobody else could. That was why this study was significant. No qualitative research studying nurse addicts could be found in the literature and, without the knowledge of this phenomenon, further progress in education and prevention of nurse addiction would be very difficult. No literature could be found addressing the lived experience of nurse addicts specifically, yet educators had a charge to teach this vital information to students.

Another significant result of this study was that insight on the phenomenon of nurse addiction was now available to help nurses, educators, and students understand the realistic experience of addiction from the perspective of those who have lived this experience. This perspective could aid educators in elucidating the experience of nurse addicts and imparting this information to students. Understanding the lived experience of nurses who were addicted may help students identify their own risk factors for addiction before entering the workforce. They may have more awareness of what it would be like to be a nurse and have access to drugs and the difficulties this may present.

### **Limitations**

One potential limitation of this study was the sample size of 14 subjects. While appropriate for qualitative inquiry since data saturation was reached, it was still

considered a smaller sample size relatively speaking, which may not fully be representative of the larger population of nurse addicts. Using a smaller sample size could make generalization to the larger population more difficult. It also caused a potential limit to generalizability with demographic or cultural differences between the sample and the population of nurse addicts. There was only one Hispanic participant and all of the others were Caucasian in this study. No other nationalities were involved. While this demographic was representative to the population of nurses in Utah, it was not representative to the distribution of nationality types in other parts of the nation. However, addiction has been a human phenomenon that has existed throughout the years, and the processes involved have been only in part determined by the socio-economic, cultural, or political contexts. The phenomenon was most likely characterized by many universal processes and characteristics that largely transcend the specific geographic, cultural, or socioeconomic context.

Another potential limitation was the varying backgrounds of the subjects who were interviewed. Generalizability to all nurse addicts was difficult when not all of the study participants had the same variables involved--i.e., drug of choice, whether or not they were addicted before becoming nurses, and whether they used drugs from work or not.

A potential limitation may be that the participants were all recruited from the same place (DOPL or the Board of Nursing) or referred by other study participants. Anyone recruited by DOPL was currently in their probationary program, which would indicate they were newer in recovery. Ideally it would have been good to find nurse

addicts in all stages of recovery. This study was very weighted to the side of having nurses that were new in recovery.

### **Recommendations for Further Research**

Recently, pedagogy to help nursing faculty and students meet current societal and professional demands and standards related to substance abuse has been implemented in many nursing programs (Hyman, 2004), but more needs to be done. More qualitative research on this topic would be especially useful, so nurses, nurse educators, and students would have a more accurate understanding of the phenomenon of nurse addiction. Since this was a unique study, it needs to be replicated to provide credibility and trustworthiness to its findings. It was the only study like it, so it needs further verification. Also, a similar study outside of the State of Utah would be a good complementary study to see how other areas of the United States compare to the state studied here. It may be interesting and useful if in future research nurse addicts could be studied in treatment centers or in other recovery-related settings. Further, some mixed methods may be useful related to this topic. The researcher would recommend having nursing students assess their own risk of becoming addicted as nurses by employing quantitative methods of study. Then, they could be exposed to the stories and education by recovering nurse addicts discovered as a potential educational intervention in this study.

Another area in which more research should be pursued is related to the idea that a certain personality type has been drawn to the profession of nursing, and this personality type has often possessed characteristics similar to those of addicts (as Dan suggested). It would be interesting to do some personality testing on nurses to see if this

claim actually has some merit, and if it does have merit, education about nurse addiction might need to take a totally different course.

Another consideration discovered in this study that might merit further research would be the inquiry into gender differences and their related perceptions and experiences related to addiction. The males in this study tended to be more adamant about not being at risk for addiction by virtue of being a nurse than the females were. The men tended to use drugs before becoming nurses, while the majority of the females did not become addicted until after they became nurses. It would be interesting to see if other variables exist which would indicate risk for male versus female nurses.

Finally, it may be beneficial to separate “nurse addicts” into more specific study groups in order to get more generalizable data. For instance, have a study only for nurses who used opiates from work, or have a study of nurses who did not become addicted until after becoming nurses or vice versa. Consider whether or not variables such as these are significant or predictive of high risk for addiction among nurses.

### **Summary**

Substance abuse and addiction are serious concerns for the nursing profession. Nurses who have lived the nightmare of addiction have a keen insight into this phenomenon. Nurse addicts’ lives are often filled with fear, guilt, and shame. Most nurses do not consider themselves to be at risk for addiction, even with the presence of a strong family history of alcoholism or addiction. Nurse addicts felt they did not receive adequate education about their own risks for becoming addicted while they were in nursing school. They recommended having recovering nurse addicts come and teach nursing students about nurse drug addiction.

The knowledge and experience nurse addicts had and were willing to share could be very beneficial to nurses, nurse educators, and nursing students. It is no longer sufficient to just provide information about substance abuse. Understanding why nurses misuse substances and how they experience the different stages of addiction and recovery humanizes the experience, which may ultimately prevent other nurses from demonizing their colleagues who have this medical illness (Dunn, 2005). It could also help nurses realize their own risks for becoming addicted to drugs or alcohol, and this awareness may help nurses recognize what is happening early in the journey down the road to addiction and encourage entering treatment.

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**APPENDIX A**  
**IRB APPROVAL LETTER**

UNIVERSITY of  
NORTHERN COLORADO



*Institutional Review Board*

DATE: December 14, 2012

TO: Karen Burton, MS, PhD(c)

FROM: University of Northern Colorado (UNCO) IRB

PROJECT TITLE: [390518-3] What is the Lived Experience of Nurses who are Addicted, and How do They Perceive Their Risk for Addiction?

SUBMISSION TYPE: Amendment/Modification

ACTION: APPROVED

APPROVAL DATE: December 14, 2012

EXPIRATION DATE: December 14, 2013

REVIEW TYPE: Expedited Review

Thank you for your submission of Amendment/Modification materials for this project. The University of Northern Colorado (UNCO) IRB has APPROVED your submission. All research must be conducted in accordance with this approved submission.

This submission has received Expedited Review based on applicable federal regulations.

Please remember that informed consent is a process beginning with a description of the project and insurance of participant understanding. Informed consent must continue throughout the project via a dialogue between the researcher and research participant. Federal regulations require that each participant receives a copy of the consent document.

Please note that any revision to previously approved materials must be approved by this committee prior to initiation. Please use the appropriate revision forms for this procedure.

All UNANTICIPATED PROBLEMS involving risks to subjects or others and SERIOUS and UNEXPECTED adverse events must be reported promptly to this office.

All NON-COMPLIANCE issues or COMPLAINTS regarding this project must be reported promptly to this office.

Based on the risks, this project requires continuing review by this committee on an annual basis. Please use the appropriate forms for this procedure. Your documentation for continuing review must be received with sufficient time for review and continued approval before the expiration date of December 14, 2013.

Please note that all research records must be retained for a minimum of three years after the completion of the project.

If you have any questions, please contact Sherry May at 970-351-1910 or [Sherry.May@unco.edu](mailto:Sherry.May@unco.edu). Please include your project title and reference number in all correspondence with this committee.

- 1 -

Generated by UNCO IRB

**APPENDIX B**

**LETTER FROM STATE OF UTAH DEPARTMENT OF**

**COMMERCE AGREEING TO HELP RECRUIT**



State of Utah  
Department of Commerce

Division of Occupational and Professional Licensing

GARY R. HERBERT  
Governor

FRANCINE A. GIANI  
Executive Director

MARK B. STEINAGEL  
Division Director

August 1, 2012

To the Institutional Review Board at UNC (and whomever else this may concern):

This letter is written in support of the research proposal being submitted by Karen Burton in the PhD in Nursing Education program at UNC. Karen has asked for our aid in recruiting subjects for her qualitative study on nurse addiction. We are happy to assist her in this endeavor. We have agreed to distribute her query requesting study participants among the nurse addicts we work with. A flier with a short description of her study and Karen's contact information will be distributed by us to nurse addicts involved in the Utah Recovery Assistance Program (URAP) and/or other disciplinary programs in the State of Utah's Department of Occupational and Professional Licensing (DOPL).

We assure you strict confidentiality with our clients will be adhered to. We will not give any names or other information about individuals to Karen directly. Rather, we will offer Karen's contact information to our clients and give them the opportunity to contact her and participate in the study voluntarily if they should so desire. There will be no incentives nor penalties associated with participation in the study in association with their contracts with us. Participation will be completely separate and independent of our programs, and we will not know one way or the other whether or not they choose to participate in the study.

We have worked closely with Karen over the last six years in other endeavors, and support her wholeheartedly in her efforts to study and shed light upon this unique population.

Sincerely,

Debbie Harry  
URAP COORINATOR

801-530-6718

**APPENDIX C**  
**RECRUITMENT FLIER**

**NEEDED:**  
**Participants for a Study on Nurse  
Addiction**

I am doing a study on the phenomenon of nurse addiction for my dissertation. It entails a 45-60 minute interview with recovering nurse addicts. I will come to you, or if you would prefer we can do it over the phone. Interviews will be in October-November 2012. No names or identifying information will be used or even known by me. Strict confidentiality will be enforced.

Please help me get the word out about nurse addiction by participating! With results of the study I hope to create an educational program about nurse addiction for nursing schools, and your insights are invaluable!

**Contact: Karen at 801-589-5459 OR**  
**[burt0108@bears.unco.edu](mailto:burt0108@bears.unco.edu)**



**APPENDIX D**

**PARTICIPANT DEMOGRAPHIC FORM**



**Project Title:** What is the Lived Experience of Nurses Who Are Addicted, and How Do They Perceive Their Risk Was for Addiction?

**Researcher:** Karen Lee Burton, PhD(c), MS, RN, CNE

**Phone:** 801-589-5459

**E-mail:** burt0108@bears.unco.edu

Participant Demographics:

1. How old are you?
2. Gender(circle one): Male Female
3. Race/Ethnicity: Caucasian African American Native American  
Latino/Hispanic Other
4. What unit(s) in the hospital or other facility were you working in when you were actively using drugs/alcohol?
5. How long have you been a nurse (*list all nursing licenses*)?
6. Were you educated about *nurse* drug addiction while you were in nursing school?  
(Yes or No)
7. How long have you been in recovery?
8. What was your drug(s) of choice?
9. How long had you practiced as a nurse *before* you started using?
10. Did you use drugs and/or alcohol while you were in nursing school?
11. How long (i.e. months or years) did you use drugs and/or alcohol while in your active addiction?

**APPENDIX E**  
**INTERVIEW GUIDE**

## INTERVIEW GUIDE

### WHAT IS THE LIVED EXPERIENCE OF NURSES WHO ARE ADDICTED, AND HOW DO THEY PERCEIVE THEIR RISK WAS FOR ADDICTION?

Interview Questions (for guiding purposes only--other questions may be asked as they become implicated)

#### **Interview Questions:**

1. Tell me about yourself and how you became involved in nursing.
2. How did you perceive your risk for addiction was before you started using?
3. Now that you are on the other side of addiction, do you feel you were at risk for addiction by virtue of being a nurse? Explain.
4. What happened when you started using the substances that ended you ended up getting addicted to?
5. How did it feel to be a nurse who is addicted *while* you were using?
6. How does it feel to be a nurse who is addicted *now that you have quit* using?
7. Do you think anything might have been helpful in preventing you from falling into addiction? If so, what? If not, why not?
8. What would be the most effective way to get this topic discussed and understood in nursing school?
9. Is there anything else you would like me to know about your experience as a nurse addict?

**APPENDIX F**  
**CONSENT FORM**



CONSENT FORM FOR HUMAN PARTICIPANTS IN RESEARCH  
UNIVERSITY OF NORTHERN COLORADO

Project Title: What is the Lived Experience of Nurses Who Are Addicted, and How do They Perceive Their Risk for Addiction?

Researcher: Karen Lee Burton, PhD(c), MS, RN, CNE  
801-589-5459  
burt0108@bears.unco.edu

Research advisor: Lory Clukey, PhD, PsyD, RN, CNS, Dissertation Chair  
Gunter Hall 3130, School of Nursing, College of Natural and Health Sciences, University of Northern Colorado, Greeley, CO, 80639  
(970) 351-2648  
lory.clukey@unco.edu

*Purpose and Description:* The purpose of this study is to investigate, explore, understand, and describe the lived experiences of nurses who are addicted to drugs and/or alcohol. Risk perception related to being nurses will also be explored. A phenomenological method will be used. Nurses in recovery from drug addiction will be interviewed. Their experiences will be analyzed and described. Addiction in this study refers to chemical dependency--specifically to narcotic drugs. It is hoped that by gaining insights from this study, other nurses and nurse educators will have a better understanding of what it is like to be a nurse addict, in order to better assist and teach other nurses in the profession.

*Rationale:* Substance abuse among nurses has existed for at least 150 years. Intoxication on the job existed even during the mid-19<sup>th</sup> century when Florence Nightingale began her work. Research suggests that one in six to seven nurses will experience a problem with drugs and/or alcohol over the course of his or her career. Nurses often use prescription drugs more often than the general public, and are more likely to access drugs at their places of employment. For each nurse who admits to having a substance abuse problem, many other impaired nurses remain unidentified and continue to practice as nurses. Patterns of drug use among nurses are unique. Chemical dependency can undermine a nurse's physical, psychological, social, and professional functioning, and needs to be addressed from a prevention and health promotion standpoint as early as nursing school.

*The Study:* I am researching what it is like to be a nurse who is addicted to drugs and/or alcohol. As a participant in this research, you will be interviewed by me and asked about your experiences and thoughts related to nurse drug addiction and recovery, as well as

risk perceptions for addiction. I will schedule this interview with each participant individually.

*Risks:* Risks to you are minimal. You may feel anxious or frustrated answering the questions about drug addiction, but I am trying to minimize these feelings by keeping your information confidential. The benefits to you include the opportunity to reflect upon your experiences as a nurse addict, and help other nurses and nursing students gain an understanding of what it is like to experience the life of an addicted nurse. Hopefully, your reflections and insights will be helpful in helping other nurses identify their feelings about the reality of nurse addiction.

Participation is voluntary. You may decide not to participate in this study and if you begin participation you may still decide to stop and withdraw at any time. Your decision will be respected. Having read the above and having had an opportunity to ask any questions, please participate in the interview if you would like to participate in this research. By completing the interview, you will give me permission for your participation. You may keep this form for future reference. If you have any concerns about your selection or treatment as a research participant, please contact the Office of Sponsored Programs, Kepner Hall, University of Northern Colorado Greeley, CO 80639; 970-351-2161.

**APPENDIX G**  
**REFERRAL SOURCES FOR PARTICIPANTS**



## Referral Sources for Participants



### COUNSELORS AND/OR PROVIDERS

Tracy Anderson, LCSW  
Clinical Director  
Alpine Center for Personal Growth  
Email: admissions@alpinecenters.com  
5689 South Redwood Road  
Salt Lake City, UT 84123  
Phone: 801-268-1715  
Fax: 801-268-1783

Tony Martinez, LSAC  
(Licensed Substance Abuse Counselor),  
Alcohol and Chemical Abuse Treatment  
Center (A.C.T.)  
Ogden Regional Medical Center  
801-479-2250  
**A.C.T. HELP line: 800-215-2250**

Eric McCarty, IOP Coordinator, Chaplain  
Life Works Intensive Outpatient Substance  
Abuse Program  
Lakeview Hospital  
630 Medical Dr., Bountiful, Utah  
801-299-2443

Julie Krause, APRN, MSN  
Adult Psychiatric Nurse Practitioner  
425 E 5350 S Suite 280  
Ogden, UT 84405  
(801) 475-0712

### PROFESSIONALS IN RECOVERY (PIR) MEETINGS IN UTAH:

**Taylorsville**  
Wasatch Canyon Hospital  
5770 S 1500 W  
Contact: Stuart – (801) 435-752-5681  
Mondays - 7:00 p.m.

### PIR Meetings Continued:

**Midvale**  
Highland Ridge Hospital  
175 W 7200 S  
Contact: Stuart - (801) 486-1920  
Sundays - 9:00 a.m. to 10:00 a.m.

**Salt Lake City**  
Mountain America C.U.  
Cornerstone Counseling  
660 S 200 E  
Contact Joan - (801) 209-4705  
Thursday - 6:00 p.m.

**Provo**  
UVRMC  
Northwest Plaza 2nd Floor (*Not in the  
hospital*)  
1230 N 5th W, Class Room 2  
Contact: Marsha - (801) 426-4966 or  
Lillian - (801) 787-9742  
Thursdays - 7:00 p.m.

**St. George**  
INSTACARE  
577 S River Rd  
Contact: Linda - (435) 634-9226 or  
Sandy - (435) 313-3681  
Tuesdays - 5:30 p.m.

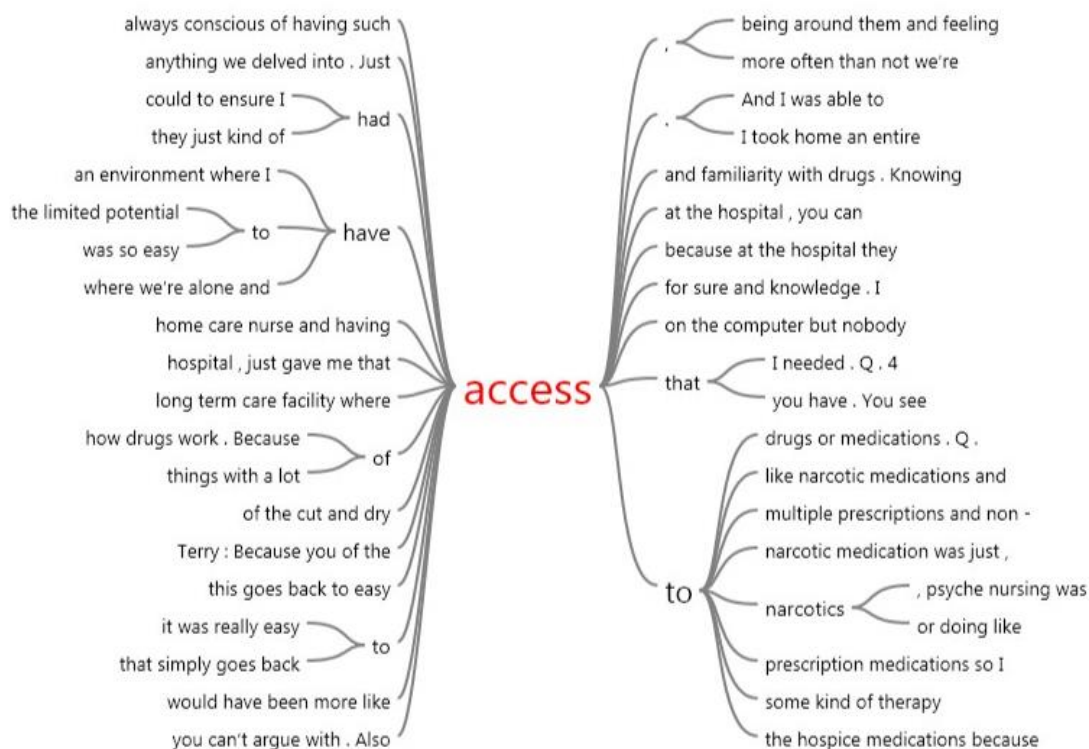
### PROFESSIONALS IN RECOVERY FACILITATED GROUP (FEE)

**Ogden**  
McKay Dee Hospital  
Contact: Nancy Carter - (801) 390-6262 or  
(801) 621-5820  
Wednesday - 6:00 p.m.

**APPENDIX H**  
**NVIVO® QUERY GRAPHICS**

## NVIVO® QUERY GRAPHICS

## “Access” text search query:



## “Recovering” text search query:



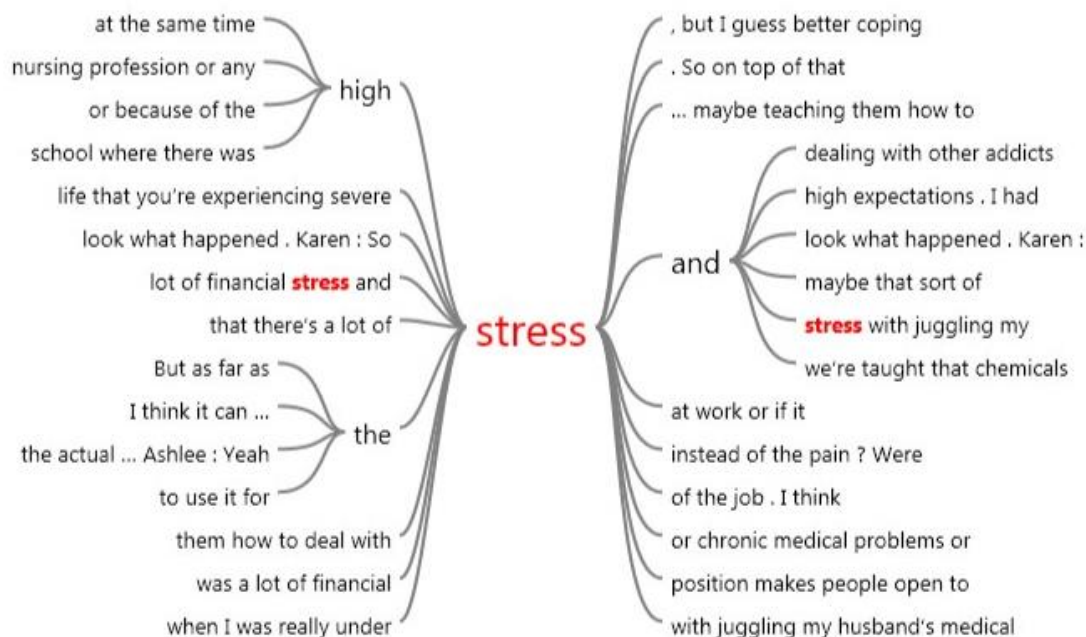
### “Fear” text search query:



### “Guilt” text search query:



“Stress” text search query:



“Shame” text search query:

