

December 2015

The Lived Experience of Registered Nurses with Substance Use Disorder who complete an Alternative to Discipline Program through a state board of nursing

Susan Melanie Ervin
University of Nevada, Las Vegas

Follow this and additional works at: <https://digitalscholarship.unlv.edu/thesesdissertations>



Part of the [Nursing Commons](#)

Repository Citation

Ervin, Susan Melanie, "The Lived Experience of Registered Nurses with Substance Use Disorder who complete an Alternative to Discipline Program through a state board of nursing" (2015). *UNLV Theses, Dissertations, Professional Papers, and Capstones*. 2534.
<http://dx.doi.org/10.34917/8220102>

This Dissertation is protected by copyright and/or related rights. It has been brought to you by Digital Scholarship@UNLV with permission from the rights-holder(s). You are free to use this Dissertation in any way that is permitted by the copyright and related rights legislation that applies to your use. For other uses you need to obtain permission from the rights-holder(s) directly, unless additional rights are indicated by a Creative Commons license in the record and/or on the work itself.

This Dissertation has been accepted for inclusion in UNLV Theses, Dissertations, Professional Papers, and Capstones by an authorized administrator of Digital Scholarship@UNLV. For more information, please contact digitalscholarship@unlv.edu.

THE LIVED EXPERIENCE OF REGISTERED NURSES WITH SUBSTANCE USE
DISORDER WHO COMPLETE AN ALTERNATIVE TO DISCIPLINE
PROGRAM THROUGH A STATE BOARD OF NURSING

By

Susan Melanie Ervin

Bachelor of Science in Nursing
University of Utah
1974

Master of Science in Nursing
University of Utah
1980

A dissertation proposal submitted in partial fulfillment
of the requirements for

Doctor of Philosophy -Nursing

School of Nursing
Division of Health Sciences
The Graduate College

University of Nevada, Las Vegas
December 2015

Copyright by Susan Melanie Ervin 2016
All Rights Reserved



Dissertation Approval

The Graduate College
The University of Nevada, Las Vegas

October 19, 2015

This dissertation prepared by

Susan Ervin

entitled

The Lived Experience of Registered Nurses with Substance Use Disorder Who Complete
an Alternative to Discipline Program through a State Board of Nursing

is approved in partial fulfillment of the requirements for the degree of

Doctor of Philosophy – Nursing
School of Nursing

Lori Candela, Ed.D.
Examination Committee Chair

Kathryn Hausbeck Korgan, Ph.D.
Graduate College Interim Dean

Carolyn Yucha, Ph.D.
Examination Committee Member

Michele Clark, Ph.D.
Examination Committee Member

LeAnn Putney, Ph.D.
Graduate College Faculty Representative

ABSTRACT

The Lived Experience of Registered Nurses with Substance Use Disorder who Completed an Alternative to Discipline Program Through a State Board of Nursing

by

Susan Melanie Ervin

Dr. Lori Candela, Examination Committee Chair
Associate Professor, School of Nursing
University of Nevada, Las Vegas

Substance use disorder, defined as the misuse of drugs and/or alcohol, is a major health problem in the United States. Health care providers, including nurses, are at risk for this disorder. Risk factors for substance use disorder (SUD) in nurses include social factors such as family history of the disorder and biological factors such as genetic predisposition. Specific risk factors for nurses include easy access to controlled substances (such as opiates), stressful work environments, the belief that substance use assists with coping and a lack of education related to SUD.

Substance use disorder in nurses is a significant issue because of the potential for impaired practice and patient endangerment. In the 1970s, state boards of nursing developed disciplinary programs for nurses with SUD that protected patients through the removal of nurses from practice. These programs, primarily punitive in nature, provided little advocacy or treatment for nurses and, as a result, nurses hid or denied the disorder, and moved from job to job becoming sicker and sicker in their substance use disorder and further endangering patients. In 1984, the American Nurses' Association recommended state boards of nursing develop alternative to discipline programs that provided treatment and monitoring of nurses with substance use disorder. The purpose of these programs was to remove nurses from practice

during the acute phase of the disorder, provide treatment and then allow the nurse to return to practice in a structured, monitored environment.

Research related to nurses with SUD has addressed characteristics of those nurses, types of substances abused, and area of specialty. It has also addressed characteristics of completers and non-completers of alternative to discipline programs (ADPs), the impact of the programs on stress and life-burden, and the self-integration that occurs during the program. There is a paucity of literature however that addresses the actual lived experience of nurses who complete an ADP.

The purpose of this phenomenological inquiry was to describe, interpret, and gain a deeper understanding of the experience registered nurses have in an alternative to discipline program. Van Manen's six research activities of interpretive phenomenology guided this inquiry. Colaizzi's seven step method of data analysis operationalizes van Manen's activities and was used for analyzing the research data. The question guiding this study was: What is the meaning and significance of the lived experiences of registered nurses with substance use disorder who completed an alternative to discipline program through a state board of nursing?

Three registered nurses participated in this research. The findings of the research resulted in five main themes and four subthemes that provide a rich description of these nurses' experiences. Findings were validated through participant review and provided the essence of completing an alternative to discipline program- *A Transformative Journey*.

Understanding the meaning and significance of completing an ADP has implications for both nursing practice and nursing education. Implications for nursing practice include provision of a voice for those nurses who complete ADPs, information for state boards of nursing to enhance ADPs for increased success, and creation of a practice culture that supports the professional responsibility of nurses to intervene with colleagues who have SUD. Implications

for nursing education include increased curricular content related to risk factors for SUD that are specific to nurses, the recognition of SUD in students and in graduates, and professional responsibilities in recognizing, and intervening with colleagues and students with SUD.

ACKNOWLEDGEMENTS

I would like to acknowledge and personally thank those who facilitated the completion of this research. My success in this endeavor would not have been possible without support of family, friends, and mentors.

I would like to thank the members of my dissertation committee. Dr. Lori Candela who provided strong guidance through the recruitment, data collection and data analysis of this research. Thank you for the encouragement and for the countless hours you spent reading my work. Thank you Dr. LeAnn Putney for helping me distill categories into themes and finally into the essence of the lived experience of the nurses who participated in this research. Thank you Dr. Michelle Clark for your insight and thank Dean Carolyn Yucha for your willingness to join my committee midstream in this project. I would also like to remember Dr. Tish Smyer; her support for nurses encouraged me to pursue this research. She was a strong advocate for nurses and will be truly missed.

I would like to thank the Nu Iota Chapter of Sigma Theta Tau and the Smernoff funds whose research scholarships offset some of the financial burden of this study. I am proud to be part of Sigma Theta Tau and deeply appreciative that Dr. Noah Smernoff valued and supported nursing research.

Many thanks to all my friends and colleagues who supported me through this endeavor. I would especially like to thank Kelly, who started with me in 2011 and continues to offer encouragement and share this experience. To Cathy, my “office neighbor”, who has acted as muse, proofreader, and cheerleader please know that words can never express how much your support meant through this process. Thank you Patsy for every time you said, “I know you can

do this”. And finally, Becky, thank you for being you; I will always cherish your friendship and kindness.

Thanks to the three awesome young men I am privileged to call my sons, Vincent, Christopher and Steve. Your never ending support and your sacrifice of mom-time over the past four years kept me going. And thanks to my parents, John and Zena, who taught me the importance of education and kept telling me I could do anything I set my mind to.

TABLE OF CONTENTS

ABSTRACT.....	iii
ACKNOWLEDGEMENTS.....	vi
CHAPTER I INTRODUCTION.....	1
Background and Significance.....	1
Definitions related to Substance Use Disorder and Monitoring Programs.....	2
Problem Statement.....	4
Purpose of the Study.....	4
Research Question.....	5
Chapter Summary.....	5
CHAPTER II LITERATURE REVIEW.....	6
Theories of Substance Use Disorder.....	6
Stigma and Substance Use Disorder.....	8
Women and Substance Use Disorder.....	10
Health Care Professionals and Substance Use Disorder.....	11
Nurses and Substance Use Disorder.....	13
Chapter Summary.....	28
CHAPTER III METHOD OF INQUIRY: GENERAL.....	30
Historical Foundations of Phenomenology.....	30
Max van Manen’s Approach to Researching Lived Experience.....	32
Phenomenological Activities Related to this Study.....	33
Research Plan.....	37
Ensuring Trustworthiness.....	39
Chapter Summary.....	41
CHAPTER IV METHOD OF INQUIRY: APPLIED.....	42
Participant Recruitment and Selection.....	42
Gaining Access.....	43
Privacy and Confidentiality.....	44
Informed Consent.....	45
Data Generation and Analysis Procedures.....	45
Ensuring Trustworthiness.....	47
Strengths and Limitations.....	49
Chapter Summary.....	51
CHAPTER V FINDINGS.....	52
Data Collection.....	53
Data Analysis.....	54
Essences, Themes and Subthemes.....	57
Chapter Summary.....	68

CHAPTER VI DISCUSSION AND INTERPRETATION.....	70
Findings as They Relate to the Current Literature.....	70
Implications for Nursing.....	83
Limitations	91
Recommendations for Further Research.....	93
Chapter Summary.....	95
Conclusions.....	96
APPENDICES.....	97
Appendix A: Review of Literature Related to Substance Use Disorder.....	97
Appendix B: IRB Approval.....	104
Appendix C: Original Recruitment Flyer.....	105
Appendix D: Modified Recruitment Flyer.....	106
Appendix E: Informed Consent.....	107
Appendix F: Confidentiality Agreement.....	109
Appendix G: Interview Questions.....	110
Appendix H: Demographic Data Form.....	111
Appendix I: Participant Profiles.....	113
REFERENCES.....	114
CURRICULUM VITAE.....	123

CHAPTER 1

INTRODUCTION

Background and Significance

Substance use disorder (SUD), defined as the misuse of drugs and/or alcohol, is a major health problem in the United States. It is estimated that between 6-8% of the population aged 12 and older have SUD (Substance Abuse and Mental Health Services Administration [SAMHSA], 2011) and may seek assistance from health care providers. Health care providers themselves, including nurses, are at risk for SUD. Nurses experience many of the same risks as the general public, that is, social factors such as family history, psychiatric factors such as anxiety and depression, and biological factors such as genetic predisposition or neurotransmitter deficits (Darbro & Malliarakis, 2012; National Council of State Boards of Nursing [NCSBN], 2011). Nurses have additional risk factors which include easy accessibility to controlled substances (such as opiates), stressful work environments, a belief that substance use assists with coping, and a lack of education related to substance use disorder (Darbro & Malliarakis, 2012; NCSBN, 2011).

Substance use disorder in nurses is a significant issue because of the potential for impaired practice and patient endangerment. In the 1970s, state boards of nursing began to address SUD and developed programs that protected patients through the removal of affected nurses from practice. These programs were primarily disciplinary and punitive in nature; there was little attempt to advocate or provide treatment for nurses (Fletcher, 2001). As a result, nurses hid or denied their disorder and moved from job to job further endangering themselves and their patients (Darbro, 2005).

In 1984, the American Nurses' Association (ANA) recommended that state boards of nursing develop alternative to discipline programs (ADPs) that provided treatment, rehabilitation and monitoring of nurses with substance use disorder. These alternative programs support early identification of nurses with substance use disorder, removal of the nurse from practice during the active phase of the disorder, and monitoring of the nurse's practice for a designated period of time following treatment and recovery. By 2009, 43 states offered ADPs in addition to disciplinary programs (Bowen, Taylor, Marcus-Aiyeku, & Krause-Parello, 2012).

Definitions related to Substance Use Disorder and Monitoring Programs

There are many definitions related to substance use disorder, recovery and monitoring programs found in the literature. For the purpose of this study, the following definitions are offered:

Substance use disorder (SUD): the misuse of drugs and/or alcohol that can range from abuse to dependency to addiction (NCSBN, 2011). This term has been substituted for the term "impairment" because a nurse with SUD does not always demonstrate impaired practice. In addition, the term "impairment" has been used in the nursing literature to refer to nursing practice that is affected by psychiatric diagnoses (Grover & Floyd, 1998), a phenomenon not addressed in this study. Finally, substance use disorder represents the most current and accepted terminology (American Psychiatric Association, 2000).

Nurse: literature that addresses substance use disorder in nurses includes both Registered Nurses (RNs) and Licensed Practical/Vocational Nurses (LPN/LVN). This study focuses on RNs; hence the term nurse is defined as an RN.

Impaired nursing practice: the “inability of a nurse to perform the essential functions of his or her practice with reasonable skill or safety because of chemical dependency on drugs or alcohol” (Dunn, 2005, p. 574).

Recovery: the process of a nurse’s acknowledgment and acceptance of having a substance use disorder, abstinence from mind-altering substances, and a return to mental, physical and emotional well-being (NCSBN, 2011; Crowley & Morgan, 2014).

Disciplinary monitoring programs: programs administered by state boards of nursing that are designed to protect the public by removing nurses with substance use disorder from the workplace (Monroe, Pearson, & Kenaga, 2008).

Alternative to discipline programs (ADPs): programs administered by state boards of nursing, or contracted entities, that protect the public and facilitate treatment for a nurse with SUD. An ADP has three components: 1) the nurse self-reports substance use disorder to the state board of nursing, 2) the nurse temporarily surrenders a license until recovery is established, and 3) the nurse enters into a nonpublic monitoring agreement which includes working under a conditional license (limited narcotic privileges and work hours), participation in recovery groups, and periodic drug testing (Nevada State Board of Nursing website, n.d.).

Alternative to discipline programs are labeled differently throughout the literature. They may be termed “diversion programs” (Darbro, 2005, 2009; Hughes, Smith, & Howard, 1998), “professional recovery programs” (Bowen et al., 2012; Fletcher, 2001), or “alternative program for chemically dependent nurses” (Nevada State Board of Nursing website, n.d.). For the purposes of clarity and consistency in this study, the term alternative to discipline program will be used.

Nonpublic: all information received or generated by a nurse's participation in an alternative to discipline program remains privileged and confidential and participation in the alternative program is not disclosed to the public but is known by the board of nursing and can be required to be shared with employers, treatment providers and other state boards of nursing (NCSBN, 2011).

Problem Statement

Public opinion views nurses as the most compassionate, understanding and trusted of all health care professionals. Nurses, however, often fail to extend that compassion and understanding to one another. Nurses may view colleagues with SUD as moral failures with defective characters. They have difficulty confronting a colleague whose practice is impaired because of moral judgement, a lack of knowledge about SUD and assistance programs (such as ADPs), and the perception that supervisors are intervening with these colleagues. The nurse with substance use disorder experiences significant shame and guilt; they may also be unaware of how and where to seek assistance (Heise, 2003; Hughes et al., 1998). These views and experiences contribute to stigmatizing, punitive environments and concealment of substance use disorder because of potential loss of license, income and respect. In order to provide knowledge of ADPs, erase stigmatizing attitudes and build empathy for nurses with SUD, a deeper understanding of nurses' actual experiences of completing an alternative to discipline program is needed.

Purpose of the Study

Literature related to nurses participating in ADPs has described the programs (Bettinardi-Angres, Pickett, & Patrick, 2012; Fletcher, 2001), developed a description of nurses who

participate in the programs (Clark & Farnsworth, 2006), and compared experiences of nurses who completed ADPs with those who have not (Darbro, 2005). The literature has also addressed stress, coping and adaptation in nurses participating in ADPs (Bowen et al., 2012; Brown & Smith, 2003). A major gap in research related to nurses in ADPs is the lived experience of the nurse who completes an alternative to discipline program. A deeper understanding of this experience may give nurses with SUD a voice related to their experience, contribute to a supportive, nurturing practice environment, and support development of nursing curricula that address the concern of SUD in nurses. The purpose of this study therefore, is to describe, interpret and gain a deeper understanding of the experience of registered nurses with substance use disorder who complete an alternative to discipline program that is administered by a state board of nursing.

Research Question

The main question used to guide this study was: What is the meaning and significance of the lived experience of a registered nurse with SUD who completed an alternative to discipline program through a state board of nursing?

Chapter Summary

This chapter offered an introduction to substance use disorder, the impact of that disorder on nursing, and how state boards of nursing have addressed the concerns about patient safety that arise when nurses practice while impaired. Operational definitions related to substance use disorder, the purpose of this study and the research question were delineated. Chapter II will provide a discussion and analysis of the literature that is relevant to this study.

CHAPTER II

LITERATURE REVIEW

A search for literature related to substance use disorder, SUD in nurses and state board of nursing programs for nurses with substance use disorder began with a review of the literature in Academic Search Premier, CINAHL, ProQuest and PubMed. The plethora of literature that resulted from that search (Appendix A) is organized as follows: 1) theories of substance use disorder, 2) stigma and substance use disorder, 3) women and substance use disorder, 4) health care professionals and substance use disorder, 5) nurses and substance use disorder, and 6) the experience of nurses in ADPs.

Theories of Substance Use Disorder

Attempts to explain the development of substance use disorder have resulted in theories that address multiple antecedents to the disorder. Through a review of literature West (2001) delineated five interrelated groups of theories that explain substance use disorder.

The first group of theories explains SUD in relation to biological, social, or psychological processes or some combination of these processes (West, 2001). These theories address phenomena such as deficits in neurochemistry that may be present in persons with substance use disorder. Neurotransmitters, for example, such as dopamine facilitate communication to the reward center of the brain; this area of the brain is responsible for remembering positive experiences such as pain relief and pleasure. These neurotransmitters may be depleted in the brain of the person with SUD, hence outside substances are sought to facilitate communication to the reward center (Bettinardi-Angres & Angres, 2010).

A second group of theories addresses why particular stimuli (such as drugs and/or alcohol) have a tendency to become the focus of substance use disorder. Those stimuli that provide pleasure, relief or excitement on a consistent basis may be a focus for the person with SUD (West, 2001). Freud, for example, viewed substance use disorder as a person's pursuit of relief from depression; he also hypothesized substance use as substitution of gratification of oral and genital needs (Naegle, 1988). More recently, Miller (2000) used this type of theory to explain why persons with SUD continue to seek access to the substance; continued access to the substance of choice provides relief from unpleasant withdrawal symptoms.

A third group of theories looks at individual susceptibility to substance use disorder. Theories related to genetic susceptibility are a major part of this group (West, 2001). There is a percentage of the population that is hypothesized to have a genetic predisposition to SUD and studies of twins and half-siblings have been used to control for environmental influences for the disorder. Identification of genetic markers has also been used in an attempt to determine genetic influences on the disorder (Naegle, 1988). Genetic predisposition alone, however, is rarely sufficient to precipitate substance use disorder. The influence of psychological (history of physical or sexual abuse, for example) and social (substance use by peers and family) phenomena interact with any genetic predisposition (Bettinardi-Angres & Angres, 2010).

Theories that explore environmental and social conditions that contribute to the development of substance use disorder are the fourth group that West (2001) delineates. Situations that lead to a need for the effects of a substance or situations in which those effects take on greater significance may promote substance use disorder. Environmental conditions such as inadequate support at work, burnout and work overload have all been identified as

situations that may promote SUD in nurses (West, 2002; NCSBN, 2011). Social conditions such as changes in socioeconomic status or being immersed in a substance use/abuse culture may also promote SUD (West, 2001).

The final group of theories delineated by West (2001) focuses on recovery and relapse. Approaches such as cognitive-social learning, stages of change, and models of coping are addressed in these theories. Recovery approaches delineated by ADPs may be based on some of these theories. Stages of changes, for example, may be addressed in the individual counseling nurses are required to seek in ADPs. Models of coping and new coping strategies are learned in weekly nurse support groups that are also required for nurses in ADPs.

Stigma and Substance Use Disorder

The phenomenon of stigma was originally developed by Erving Goffman (as cited in Storti, 2002) and defined as a “powerful discrediting and social label that radically changes the way individuals view themselves and are viewed as persons” (p. 14). There are two groups of stigmatized individuals: persons whose stigmatizing attributes are immediately apparent to others (physical changes for example) and those whose attributes are less apparent but are at risk of being disclosed in social situations. The person with substance use disorder fits into this second group. The person with substance use disorder possesses the attribute of uncontrolled substance use that is not readily apparent but may be disclosed through social or professional situations.

When related to substance use disorder, stigma may be defined as negative perceptions of substances (drugs or alcohol) that are abused and the persons who abuse those substances (Libby, 2009). Stigma has been strongly associated with the loss of control over substance use

that persons with SUD develop. That loss of control is seen as indulgent, a manifestation of weak will, and moral failure (Dunn, 2005). Women are especially impacted by the stigma of substance use disorder; they experience greater social stigma than men. They also experience intense shame and guilt and often have less support for treatment from family and friends (Darbro & Malliarakis, 2012). The shame, guilt and lack of support further contributes to stigmatization which, in turn, makes women remain silent and delay seeking treatment.

The stigma experienced by nurses with substance use disorder is profound. American society, in general, views nurses as nurturers, trusted individuals and angels of mercy (Dunn, 2005). A nurse with a substance use disorder is a major contradiction to that view. Nurses with SUD fear being discovered because of the potential loss of license and employment. Brewer and Nelms (1998) found that nurses were actually denied employment because they were stigmatized as being “impaired” even though they had been in recovery for several years.

Nurses also fear being stigmatized as a weak person and a bad nurse if colleagues discover they have SUD (Brewer & Nelms, 1998). Lillibridge, Cox and Cross (2002) found that nurses were afraid of losing employment and their identity as a nurse if it was discovered they had SUD. These fears were major reasons why nurses did not acknowledge their SUD or seek help (Lillibridge et al, 2002).

Nurses have also seen the stigmatizing manner in which their colleagues treat patients with SUD. Patients with substance use disorder may be seen as responsible for the disorder and not really sick; as a result, they are treated in a callous and hostile manner (Lovi & Barr, 2009). Darbro (2005) found that the stigmatizing treatment of patients was a prevailing reason for nurses with SUD to conceal their problem from colleagues.

Women and Substance Use Disorder

Historically, substance use disorder has been viewed primarily as a problem for men. Women however have been at risk for SUD throughout history. Until the late nineteenth century, for example, women were prescribed cocaine, opiates and hypnotics on a consistent basis for everything from “female disorders” to fidgetiness (Kandall, 2010). Knowledge about the impact of substance use disorder on women was lacking until the 1990s when women began to be included in research related to the disorder. Women make up 91.1% of registered nurses so it is important to have an understanding of how they are affected by substance use disorder (Darbro & Malliarakis, 2012).

Men are more likely to develop substance use disorder, but women tend to develop the disorder more quickly and experience a phenomenon termed “telescoping” (Kay, Taylor, Barthwell, Wichelecki, & Leopold, 2010). Telescoping means that women develop substance use disorder and the physiological consequences of the disorder more quickly. They have higher rates of premature deaths, cirrhosis and cardiac disease than men with substance use disorder (Kay et al., 2010). Biological factors contribute to women’s increased vulnerability to the complications of substance use disorder. They have a greater percentage of body fat for example; body fat retains alcohol which increases exposure of internal organs to the drugs or alcohol (Zilberman, Tavares, Blume, & El-Guebaly, 2002).

Women with substance use disorder also tend to have more psychiatric comorbidities and social challenges than men with SUD. They are more likely to be prescribed, and use, tranquilizers and pain-killers. They are also more likely to report symptoms such as anxiety and depression and have increased rates of suicidal ideation (Zilberman et al., 2002). They generally

have less family support, more frequent unemployment rates and are twice as likely to have a partner with substance use disorder (Zilberman et al., 2002).

Health Care Professionals and Substance Use Disorder

It is estimated that approximately 6-8% of the U.S. population aged 12 or older have substance use disorder (SAMHSA, 2011). The prevalence of SUD among health care professionals is similar to that of the general population but patterns of use tend to vary. Physicians and nurses, for example, tend to use prescription drugs more frequently and have greater access to drugs in the workplace (Shaw, McGovern, Angres, & Rawal, 2004). Research related to substance use disorder among health care professionals addresses substances used, treatment referral, and return to work patterns.

Kenna and Wood (2004) looked at alcohol use in four groups of healthcare professionals: dentists, nurses, pharmacists and physicians. Participants completed a self-report survey on patterns of alcohol use, monthly drinking, heavy episodic drinking, alcohol-related dysfunction and social or professional influence of drinking. Dentists used significantly more alcohol than pharmacists and physicians. A greater percentage of nurses reported that alcohol use had impacted social relationships and led to the provision of less than optimal patient care. Nurses also tended to worry more about their drinking and contemplate suicide because of their drinking. This research obtained a representative sample of healthcare professionals (178 dentists, 188 nurses, 186 pharmacists, 196 physicians) yet is limited in generalizability because the sample was drawn from only one state. The response rate for the study was robust (68%) but about 31% of the original sample did not respond. This also limits generalizability because the alcohol use histories of those who did not respond could have been different than those who did.

Gossop et al (2001) reported substances used and reasons for referral among 62 healthcare professionals. Among these professionals 21 (46%) were physicians and 18 (39%) were nurses; the remainder were paramedical staff. A majority of the participants used alcohol and those who used drugs primarily used injectable opiates or anesthesia agents. Seventy-two percent were polysubstance users. Only 9% of this sample self-referred for treatment. The majority (41%) were referred by an employer for poor work performance or absenteeism. Disciplinary action or threats of disciplinary action were also frequent reasons for referral (30%). Comparisons between physicians and nurses in relation to referral to treatment were not delineated in this research. Only half the participants enrolled in this study completed treatment and there was no statistically significant difference between physicians and nurses in treatment completion ($\chi^2 = 0.00$; $p = 0.98$). This study had a very small sample which limits generalizability. In addition, no information was provided as to reasons healthcare professionals left treatment.

Shaw, McGovern, Angres, and Rawal (2004) compared substance use, referral to treatment and return to work patterns in physicians and nurses who received treatment for substance use disorder. Of the 73 physicians that participated, 70% used one substance (alcohol or opiates) and the remaining 30% used a combination of substances, most frequently prescription opiates and alcohol. Of the 17 nurses that participated, 82% used opiates, a number that was statistically significantly higher than the number of physicians who used opiates ($\chi^2 = 7.77$, $p < 0.01$). Nurses tended to use one substance (opiates) more than the physicians. Physicians and nurses also differed significantly in referral to treatment. Nurses were more likely to be referred by employers while physicians were more likely to be referred by state

physician's assistance programs ($\chi^2 = 44.57, p < 0.001$). Post-treatment, nurses returned to work more quickly, more of them worked full-time, and more reported ongoing symptoms of depression and anxiety. In addition, nurses received more frequent and severe professional sanctions than physicians. This study had a small sample size which limits generalizability, however Shaw et al (2004) assert that the differences in return to work and sanctions support development of treatment programs that address the specific needs of nurses.

Research related to health care professionals and SUD addresses differences among professionals in relation to use, treatment and return to work. A majority of physicians, for example, use alcohol and/or opiates, while nurses use statistically significant more opiates. Neither physicians nor nurses tend to self-report SUD; most are referred to treatment by employers or threatened with disciplinary action if they do not seek treatment. More nurses report that substance impacted social relationships and led to the provision of less than optimal care. In addition, nurses received more frequent and severe professional sanctions than physicians and returned to work more quickly.

Nurses and Substance Use Disorder

The story of Jane Gibson, one of the nurses who accompanied Florence Nightingale to the Crimea may be the earliest documented case of a nurse with substance use disorder. Ms. Gibson was fired from her postwar position in a London hospital because she came to work under the influence of alcohol. Her behavior was viewed as shocking because she had ruined the image of the "Nightingale Nurses" as angels of mercy (Monahan, 2003).

Nursing literature of the late 19th and early 20th centuries noted there were nurses like Ms. Gibson but there was no consistent effort to address the issue. It was not until the 1970s that

the issue of nurses with SUD began to be seriously addressed; by 1978 some type of disciplinary program for nurses with SUD had been developed by boards of nursing in 48 states (Fletcher, 2001). In the 1980s the American Nurses Association (ANA) convened a special task force on substance use disorder and adopted a resolution that encouraged state boards of nursing to offer treatment to nurses before disciplinary action was considered (Fletcher, 2001). Research related to nurses with substance use disorder began in earnest following the ANA resolution and focused on characteristics of nurses with substance use disorder, the recovery process, and the impact of work environment on substance use in nurses. By the late 1990s (and into the 21st century) research addressed risk factors for SUD that were specific to nurses. Nursing education, and the role it has played in preparing nurses to recognize SUD, is threaded throughout the literature.

Early research

Early research that focused on characteristics of nurses with substance use disorder found that these nurses were often described as high achievers and highly respected; a majority of them graduated in the top 1/3 of their class. In addition, a majority earned degrees beyond their basic education and were viewed as expert nurses by their colleagues (Bissell & Jones, 1981).

Hutchinson (1987) used grounded theory to explore the recovery process of nurses with substance use disorder. Through participant observation in a nurse support group and interviews with 20 nurses in recovery from SUD, Hutchinson (1987) developed a theory that viewed the recovery process as a trajectory that moved from self-annihilation to self-integration. Self-annihilation represented the nurse's surrender to substance use disorder; it is at this juncture that internal or external pressure forced the nurse into treatment. Self-integration represented the

process in which the nurses wove their lives back together. It consisted of three stages, surrendering, accepting, and commitment to recovery.

Trinkoff and Storr's (1998a) work discovered that substance use in nurses varied across specialties. They surveyed a stratified sample of 4438 registered nurses and discovered that emergency room and critical care nurses were more likely to use cocaine and oncology nurses and nurse administrators were more likely to engage in binge drinking. Trinkoff and Storr's (1998a) sample did not include nurses who self-reported as having substance use disorder and they caution that the substance use cited by the nurses in this study did not meet criteria for substance use disorder. Trinkoff and Storr (1998b) also looked at work shifts and hours in relation to alcohol use. Using the same sample as the substance use across specialties research, Trinkoff and Storr (1998b) found that nurses who worked night shifts longer than eight hours and nurses who rotated shifts reported higher alcohol use.

Risk factors

Nurses have risk factors for substance use disorder that are similar to the general public. These include family factors such as alcohol and drug use by parents, siblings, and/or spouse, psychiatric factors such as depression, anxiety and low self-esteem and physiologic factors such as predisposition to substance use disorder or deficits in neurotransmitters such as dopamine (Darbro & Malliarakis, 2012; West, 2002). There are however risk factors that are considered unique to nurses and these include: 1) easy access to controlled substances, 2) attitudes toward the use of controlled substances, 3) stressful work environment, and 4) a lack of education related to substance use disorder (NCSBN, 2011). Gender may also be a risk factor for nurses because while men represent approximately 6-9% of the nursing workforce, their representation

in both disciplinary and alternative to discipline programs is much higher, 19-38% (Dittman, 2008).

Easy access to controlled substances. Nurses have relatively easy access to controlled substances (narcotics such as morphine, for example) in the workplace and are part of a professional culture that promotes the use of medications for treatment (Dunn, 2005). Trinkoff, Storr and Wall (1999) explored prescription drug misuse among nurses. They defined misuse as taking drugs without a prescription, in greater amounts than prescribed, or for reasons other than prescribed. They found that nurses who reported easier access to controlled substances such as opiates, amphetamines, or tranquilizers had twice the risk of prescription drug misuse than nurses who reported less access to controlled substances. Trinkoff et al (1999) also found that nurses who administered controlled substances daily or who worked in areas with poor workplace controls related to access were also at higher risk for prescription drug misuse

Attitudes toward the use of controlled substances. Clark and Farnsworth (2006) identified five attitudes that can place nurses at risk for substance use disorder. The use of substances as a means of coping with professional and personal stresses is one such attitude. The second attitude is pharmacologic optimism, or placing faith in medications as a primary means of healing. Nurses can also develop a sense of entitlement which is the third attitude identified by Clark and Farnsworth (2006). Nurses may experience physical pain and/or emotional distress but feel the need to continue working. As such, they may feel entitled to use substances in order to decrease the pain and stress. The fourth attitude revolves around perceptions of invulnerability. Because they understand the power of medications, nurses may feel invulnerable to substance use disorder. The final attitude that can contribute to the risk of substance use

disorder is self-diagnosis and self-medication. Nurses often have difficulty seeing themselves as recipients of care, hence they diagnose and treat themselves in order to continue provision of care (Clark & Farnsworth, 2006).

Stressful work environment. Nurses can be employed in incredibly stressful environments and actually report more on-the-job stress than any other health care professional (Darbro & Malliarakis, 2012). Acute and critical care environments can be especially stressful because of the number and acuity of patients. Employment stress can also be related to staffing shortages, rotating shifts and floating to different units (Dunn, 2005). Night shifts longer than eight hours and rotating shifts have been associated with increased substance use in nurses (Trinkoff & Storr, 1998b).

Nursing education and substance use disorder. Lack of education about substance use disorder is not only a risk factor; it contributes to the stigma experienced by nurses with SUD (NCSBN, 2011). The first research directed at the delineation of content related to SUD in schools of nursing was performed by Hoffman and Heinemann (1987) who surveyed 336 schools of nursing (1035 surveys were mailed with a 36% return rate) in 49 of the 50 U.S. states. Respondents included 154 (46%) baccalaureate programs, 126 (38%) associate degree programs, and 56 (17%) diploma programs. All respondents confirmed that substance use disorder was addressed. Didactic content ranged from 1-5 hours, focused on alcohol abuse and emphasized care of the patient with substance use disorder. While considered a seminal study, Hoffman and Heinemann (1987) make no mention of content related to nurses with SUD. There was a low response rate for this study so caution is required in the interpretation and generalizability of its results. Hoffman and Heinemann (1987) however expressed concern that the low number of

content hours related to SUD was disproportionate to the prevalence of substance use disorder in the general population.

Savage, Deyhouse and Marcus (2014) looked at content related to alcohol use, but only in baccalaureate curricula. They did a cross-sectional electronic survey of schools that were members of the American Association of Colleges of Nursing (AACN). Of the final sample (66 baccalaureate programs), only 39 provided information about total content hours related to alcohol. The mean number of hours was 11.3 (SD = 8.3). The majority of content was presented in psychiatric/mental health courses and primarily focused on withdrawal and care of the alcoholic patient. Savage et al (2014) compared their finding to Hoffman and Heinemann (1987) and postulated that “there has been little overall progress” (p. 32) related to the inclusion of content about substance use disorder in nursing curricula. Savage et al (2014) assert that content is still limited in hours, it tends to be restricted to psychiatric/mental health courses, and the focus remains on care as opposed to assessment and education. They express concern that the findings in this study may have serious consequences if nurses lack knowledge and competency to provide care to patients who abuse alcohol. This lack of knowledge could also mean that nurses may be unable to recognize substance use disorder in their colleagues. Limitations to this research included the inability to calculate a response rate, reliability of the electronic survey instrument (which had not been tested for psychometric properties), and a lack of geographical representation. Savage et al (2014) did not include questions related to type of content in baccalaureate programs that addressed SUD in nurses.

Pullen and Green (1997) performed a small-scale needs assessment to support literature that asserts nurses lack the knowledge to recognize substance use disorder in their colleagues and

that most nursing curricula allot minimal time to substance use disorder. They delineated specific content that can be used in academic and institutional settings to assist nurses in recognition of the risk for SUD in themselves and in their colleagues. The content included definitions, scope of the problem, risk factors and manifestations, and resources for prevention and intervention.

Hughes et al (1998) recommend varied approaches with a wide population of nurses to improve knowledge related to substance use disorder. Group discussions, nursing student involvement in campus programs that address risk for SUD, and institutional creation of policies that support treatment are all approaches delineated. Hughes et al (1998) also recommend that nursing administrators (in academic and institutional settings) be more knowledgeable about treatment programs and resources for nurses (and nursing students) who may be at risk for substance use disorder.

In summary, early research related to nurses and SUD focused on characteristics of those nurses, trajectories of nurses with SUD who entered recovery and specialty areas and substance use. Important research focused on risk factors for SUD that are specific to nurses. While nurses have risk factors that are similar to the general public, ones that are specific to nurses include easy access to controlled substances, attitudes of pharmacologic optimism, stressful work environment and a lack of education related to SUD.

Men in nursing and substance use disorder. While being a man in nursing may not be a specific risk factor for substance use disorder, men are overrepresented in monitoring programs for nurses (Darbro & Malliarakis, 2012). Men represent between 6-9% of nurses in the U.S. but their participation in monitoring programs ranges from 19-38% (Dittman, 2008; Freeman-

McGuire, 2010; Hughes et al, 1998). Evangelista and Sims-Giddens (2008) found that men received disproportionately higher rates and more severe discipline from state boards of nursing than women. They were more likely to surrender a professional license or have that license suspended or revoked.

Freeman-McGuire (2010) postulates that a higher rate of substance use disorder in men in nursing may relate to the continued perception that nursing is women's work. Men in nursing, therefore, can be stereotyped as more feminine and less masculine, a stereotype that is potentially stigmatizing. Dittman (2008) found that society's expectations for men to internalize emotions contributed to substance use disorder. When caring for a difficult patient or a patient that experienced a negative outcome, men who are nurses had to seek different outlets for their emotions and drugs and/or alcohol represented one of these outlets. These men also felt nursing was a lonely profession due to lack of a peer group.

The experience of nurses in alternative to discipline programs

Although the need to address the problem of nurses with addictions was recognized as early as the turn of the century, it was not until 1980 that the National Nurses Society on Addictions (NSNA) created a task force to examine the need for professional assistance programs. In the early 1980s, disciplinary programs were in place in a majority of states and many states were investigating implementation of alternative to discipline programs (Heise, 2003). In 1984, the ANA offered support through formal recognition of SUD in nurses and recommendations that treatment for nurses with substance use disorder be implemented rather than disciplinary action (American Nurses' Association [ANA], 1984). At present, programs

administered by state boards of nursing for nurses with SUD include both disciplinary and alternative to discipline.

Disciplinary programs. Disciplinary programs are designed to protect the public from nurses whose practice may be impaired because of substance use disorder. Disciplinary programs involve a complaint against a nurse, formal hearings, and, if the complaint is substantiated, disciplinary action against the nurse's license (Monroe, Pearson & Kenaga, 2008). Most disciplinary programs offer limited support for the nurse in terms of treatment and recovery services; this often results in higher relapse rates and sometimes the death of a nurse. There is also no provision for protecting the privacy of the nurse. The fact that discipline has been instituted against a nurse is made available to the public (Bettinardi-Angres et al., 2012; Monroe et al., 2008). A major challenge to disciplinary programs is the time involved in the complaint process. A nursing license represents a means to make a living hence due process must be followed prior to any suspension or revocation of that license (Bettinardi-Angres et al., 2012). Cases can take up to a year for resolution and the nurse remains in practice continuing to place the public, and his/herself at risk (NCSBN, 2011).

The punitive nature of disciplinary programs can also act as a barrier to treatment. Nurses are reluctant to report themselves because of the fear of loss of license and income and potential arrest (if drugs have been diverted). Nurses are reluctant to report colleagues for the same reason (Lillibridge et al, 2002; Freeman-McGuire, 2010; Bettinardi-Angres & Bologeorges, 2011; Bettinardi-Angres et al, 2012).

Alternative to discipline programs (ADPs). Alternative to discipline programs (ADPs) also seek to protect patients. In addition, they support the nurse through early intervention and

rapid entry into treatment. Self-reporting of substance use disorder by the nurse is a component of ADPs; very few nurses however voluntarily self-report. It may take strong encouragement or threat of disciplinary action on the part of an employer to encourage a nurse to self-report and enter an ADP (Gossop et al, 2001; Shaw et al, 2004). Other components of ADPs include temporary surrender of a nursing license while in the acute phase of treatment and a nonpublic monitoring agreement for a period of five years (Nevada State Board of Nursing website, n.d.). During this five year monitoring period nurses are required to attend twelve step meetings (such as Alcoholics Anonymous [AA] or Narcotics Anonymous [NA]), weekly nurse support groups and undergo random urine testing for the presence of mind-altering drugs (Freeman-McGuire, 2010).

Research that addresses ADPs is both quantitative and qualitative. There is far more quantitative than qualitative research that addresses nurses in ADPs.

Quantitative research. Quantitative research related to nurses in ADPs addresses the description of nurses who participate in ADPs, the impact of discipline and alternative to discipline programs on relapse and retention in the workforce, confidence to resist relapse and stress, coping and adaptation.

Kowalski and Rancourt (1997) and Clark and Farnsworth (2006) developed a profile of nurses who participated in ADPs through retrospective record reviews. Kowalski and Rancourt (1997) found that the majority of nurses (86%) were diploma or associate degree graduates who worked in acute care settings, most frequently on day shift and on medical-surgical units. A majority (37.2%) had been referred to ADPs by employers; only 9.3% self-referred. Many had a family history of substance use disorder (86%) and first used drugs between the ages of 13-19

years of age (72%). Limitations to Kowalski and Rancourt's (1997) work include a convenience sample and lack of a standardized tool for data collection.

Clark and Farnsworth (2006) found that while the majority of nurses enrolled in the ADP were female (81%), the percentage of men enrolled was double the national average of men licensed to practice nursing in the U.S. Educational level was not delineated in this study other than the information that 4% of the participants were Advanced Practice Nurses. Most (40%) worked in acute care settings, either on medical-surgical or critical care areas. Employment among the other participants was distributed among long term care (24%) and mental health settings (3%). Fifteen percent of the nurses were unemployed. Nurses had been referred to the ADP by employers (50%), the Board of Pharmacy (14%), colleagues (6%) and treatment providers (6%). Fourteen percent of the nurses self-referred. There was a family history of substance use disorder (40%) and 61.4% used substances prior to the age of 18 ($x = 16.8$, $SD = 5.3$ years). Limitations to this study include a small sample (207) and limited geographical area (one state).

A longitudinal study (six data collection points in six months) in three U.S. geographic areas was completed by Haack and Yocum (2002) to investigate the impact of discipline and alternative to discipline programs on relapse rates and retention in the nursing workforce. No statistically significant differences in relapse rates were found between participants in the two programs. Nurses in the ADP however had more active licenses, greater employment in nursing and fewer criminal convictions. Generalizability of these data are limited because of self-report bias and the inability to control for differences in disciplinary and alternative to discipline programs among states.

Brown and Smith (2003) surveyed nurses enrolled in an ADP to determine how the burden of life problems related to the confidence to resist relapse. Three-fourths of the nurses in this study reported a lower burden of problems after enrolling in an ADP. Self-reported confidence to resist relapse was high (median 98, 0-100 scale). Limitations to this study included retrospective reports for past problems, concerns about anonymity, and nonresponse bias. Nurses who had been in the ADP for an extended period of time might have different problem recall than those who had been enrolled for a shorter period of time; the majority of nurses in this study however were in the first three years of recovery so likely had similar recall of past problems. Assurances of anonymity were provided in this study but some nurses may still have been reluctant to disclose feelings related to lack of self-confidence or other negative feedback about the ADP. Demographic data were not collected for this study, hence nonresponse bias was unable to be assessed. There was an 85% response rate so generalizability to other nurses in ADPs is good.

In a descriptive, correlational study, Bowen et al (2012) examined the relationship among stress, coping and adaptation in 82 nurses in different stages (between 1-5 years) in an ADP. They used the perceived stress scale, multidimensional scale of perceived social support, and the psychological general well-being index, all instruments that have established reliability and validity. There was a statistically positive relationship between social support and well-being ($p < .05$) and negative relationships between stress and social support and stress and well-being. Limitations to this study include the lack of analysis related to specific support services such as AA and NA. In addition, support related to actual participation in the ADP was not analyzed.

Bowen et al (2012) also did not address supportive measures related to gender which limits generalizability of the study.

Taken together, these studies indicate that the majority of nurses who enter an ADP are female with diplomas or associate degrees; approximately 4% of participants are Advanced Practice Nurses. The percentage of men who are enrolled in ADPs is double the percentage of men who are licensed to practice nursing in the U.S. A majority (40%) work in acute care settings, primarily in medical-surgical or acute care settings. Very few nurses self-refer to ADPs; most are referred by employers, colleagues or treatment providers. As compared to disciplinary programs more nurses in ADPs have active licenses and employment in nursing and they feel fewer life burdens and less stress than prior to entering the ADP.

Qualitative research. Qualitative approaches were seen less frequently in the literature than quantitative approaches to research with nurses in ADPs. Two of the studies actually used mixed methods approaches. Qualitative research addresses stigma, the nurse's experience of being monitored, the experience of ADP completers and non-completers, and men.

Brewer and Nelms (1998) and Freeman-McGuire (2010) looked at the phenomenon of stigma in nurses who were in recovery from substance use disorder. Brewer and Nelms (1998) used a phenomenological approach to investigate the lived experiences of nurses in recovery who had been labeled "impaired". Five themes emerged from data analysis, two of which were negative and three of which were positive. The negative themes included living with a negative label and denial of employment due to being labeled impaired. The positive themes included recovery as a way-of-life, recovering as an identity, and willingness to share one's recovery with professional peers. Brewer and Nelms (1998) had a purposeful sample of three men and 11

women all of whom were in recovery and employed in nursing. They do not, however, state if the participants in this study were in an ADP.

Fogger and McGuiness (2009) used a mixed methods approach to delineate the experience of nurses in both disciplinary and alternative to discipline programs. A survey that included both quantitative (demographic variables, length of treatment programs, time in monitoring program) and qualitative (“If you could propose changes in work restrictions, what would they be?”) questions was mailed to nurses in both programs; there was a 45% response rate. Quantitative results revealed only one significant difference; the length of recovery was longer ($X = 4.4$ years, $z = -2.438$, $p = .015$) in nurses participating in an ADP. Qualitative data indicated that nurses in both groups felt narcotic restrictions and the inability to work overtime added to the burden of being in either type of program. They also struggled with anonymity in the workplace and felt the stigma of being labeled with substance use disorder contributed to the stress of the work environment. In contrast, the majority of nurses in both groups indicated that the structure of the programs contributed to recovery. Data were gathered via self-report and that can limit generalizability; nurses who felt more positive about either program may have been more likely to return the surveys.

Darbro (2005) used a grounded theory approach to compare the experiences of nurses who completed an ADP with those who did not complete the program. Common themes shared by the two groups included medical issues, diversion of drugs from the workplace, stressful work environment, and positive changes in nursing practice (such as being more compassionate, tolerant, and patient). Nurses in both groups listed a pivotal event that led to recovery. These events included being caught at work and the impact of SUD on the nurse’s health and/or family.

Nurses in both groups felt that the culture of mistreatment of addicts, or the stigma those patients experienced, was a prevailing reason for the nurses' own concealment of their problem from their colleagues. Themes among the nurses who completed the ADP were commitment to nursing, affiliation of other recovering nurses and development of a personal plan of recovery. Common themes among non-completers were a lack of commitment to nursing, feelings of alienation from other recovering nurses and negative perceptions of the structure of the ADP.

A phenomenological approach was used by Dittman (2008) to identify characteristics of men in nursing who completed an ADP. Two overarching, interacting themes, person and profession, were identified. The person theme, which examined each participant's journey through SUD, had 3 subthemes. These subthemes included predetermined risk; all the participant's felt that a chaotic childhood environment contributed to their SUD. The other two subthemes under the person theme included sensation-seeking (undertaking risky behaviors regardless of the consequences) and altered values (denial, rationalization and social exclusion). The profession theme described how the nurses related to the profession and survived in the workplace. Six subthemes emerged and included 1) masterminding, which described manipulation of connections to other humans, both personal and professional, 2) professional heteronomy which is the opposite of autonomy; the person's will is determined by something outside of that person, in this instance drugs, 3) getting caught which represents one of the biggest fears nurses with SUD experience, 4) rehabilitation, which included entrance and completion of the ADP as well as reentry to practice, 5) spirituality, or the need to believe in a higher power to assist in day to day life, and 6) the nurse becomes the nursed. This final subtheme represents the profession reaching out to assist the nurse with SUD. From recognition

of the disorder to removal from practice to the post-rehabilitation phase, this subtheme was described as “saving my life and my patients lives” (Dittman, 2008, p. 328). This study was one of the few found that actually addressed SUD in men in nursing.

These studies documented that nurses do indeed experience stigma related to SUD; nurses are labeled “impaired” which is perceived as negative and have been denied employment because of SUD even if they have maintained recovery for a period of time. There are also some commonalities between nurses who complete ADPs and those who do not; both groups acknowledged a pivotal event that preceded entrance into an ADP and conceded that the stigma persons with SUD experience was a reason for not seeking help. Nurses who completed ADPs however had a greater commitment to nursing, stronger affiliation with other nurses in recovery and a personal plan of recovery. One of the few studies that addressed men in ADPs found that these men had chaotic childhoods and altered values and were sensation-seekers. Hypotheses as to why men are overrepresented in ADPs include the stereotype that nursing remains a female domain and that, in U.S. culture men have difficulty expressing feelings.

Chapter Summary

Substance use disorder may be defined as the misuse of drugs and/or alcohol that can range from abuse to dependency to addiction (NCSBN, 2011). Multiple theories address the development of substance use disorder. These theories range from biological (genetic predisposition, deficits in neurotransmitters) to familial (history of SUD in the family) to sociological (immersion in a culture of drinking); it is likely an interaction among multiple phenomena precipitates SUD. No matter the antecedent, substance use disorder is perceived as a stigma; it represents lack of control, moral failure and defective character.

The incidence of substance use disorder among nurses and other health care professionals is similar to the general population (6-8%). Patterns of use vary however and nurses may use more prescription drugs than alcohol. Substance use disorder is a major problem among nurses because of the harm they can do to themselves and their patients. Since the 1970s, state boards of nursing have attempted to recognize and address SUD among nurses. Early programs developed were primarily disciplinary in nature and while they removed the nurse from practice, there was little focus on treatment and or return to work. In the 1980s, state boards of nursing began to develop alternative to discipline programs that removed the nurse from practice, but also provided a structure for treatment and return to work. Research that addresses alternative to discipline programs has described the nurses in these programs, the impact of programs on relapse rates and retention in the workforce, and the relationship among stress, coping and adaptation in nurses with SUD. Research has also addressed the stigma of being labeled with a substance use disorder and compared nurses who have completed ADPs with those who have not. Research that is focused on describing and interpreting the nurse's actual experience in an alternative to discipline program has not been published.

CHAPTER III

METHOD OF INQUIRY: GENERAL

The research method used for this study was phenomenology. Phenomenology is both a philosophy and a research method. As a philosophy, phenomenology asserts that reality consists of phenomena (objects and events) as they are perceived by human consciousness; reality does not exist independently of that consciousness. As a method, phenomenology seeks to explore *Geisteswissenschaften*, human sciences. It describes how people interpret their lives and make meaning of what they experience (Cohen, Kahn, & Steves, 2000). The contemporary phenomenologist, Max van Manen, introduced guidelines for research rooted in phenomenology.

Phenomenology seeks to transform the lived experience into a “textual expression of its essence” (van Manen, 1990, p. 36). It seeks to describe and interpret the meaning of unique human experiences. Nursing, as a discipline, is also concerned with experience as a means of understanding humans as whole beings. Phenomenological nursing research helps gain insight into how persons interpret the meaning of life experiences. This study gained greater insight and understanding into the human experience of participation in an alternative to discipline program. Phenomenology, as a research method, provided the means to gain that insight and understanding. Today’s phenomenology is grounded in the work of phenomenological scholars of the 19th and 20th centuries whose work is reviewed here.

Historical Foundations of Phenomenology

There are three defined periods of philosophical phenomenology discussed in the literature: the early or preparatory phase, the German phase and the French phase.

Preparatory phase

The two most important people in the preparatory phase were Franz Brentano (1838-1917) and Carl Stumpf (1848-1936). Brentano was the first to discuss the concept of “intentionality” or “intentional consciousness”, a concept that influenced Edmund Husserl’s work. Intentionality refers to the fact that consciousness is always conscious of something; intentionality represents the inseparable connection the human mind has to the world (Shaw & Connelly, 2012). Phenomenological philosophers were originally interested in the way the human mind found meaning in the world and the concept of intentionality helped them understand this abstract problem (Shaw & Connelly, 2012). Stumpf was Brentano’s student and his work demonstrated the scientific rigor of phenomenology and focused on clarification of intentionality (Streubert & Carpenter, 2011).

German phase

Edmund Husserl (1859-1938) and Martin Heidegger (1889-1976) represent the two most important philosophers in the German phase of phenomenology. Husserl, considered the founder of philosophical phenomenology, is credited with introducing the study of “lived experiences” or experiences within the “life-world” (*Lebenswelt*). Husserl defines phenomenology as a “descriptive philosophy of the essences” of lived experiences (van Manen, 2014, p. 89). He is known for his concepts of intentionality and phenomenological reduction (bracketing). Intentionality means that all human thinking, feeling and acting is directed toward experiences in the world (van Manen, 2014). Phenomenological reduction (eidetic reduction), or bracketing, involves the researcher consciously stripping away prior knowledge and personal bias so the phenomenon under study can be described in its “pure, universal sense” (Wojnar & Swanson, 2007, p. 173).

Heidegger, a student of Husserl's, moved from description to interpretation and is credited with the development of hermeneutic, or interpretive, phenomenology. He was concerned with the interpretation of the lived experience and believed that humans are interpretive beings capable of finding meaning in their lives (Wojnar & Swanson, 2007). He advocated the concept *dasein*, which loosely translates as humans questioning the meaning of their existence (McConnell-Henry, Chapman & Francis, 2009). Heidegger rejected Husserl's concept of bracketing. He felt that prior understanding, or fore-structure, of a phenomenon was necessary for interpreting and understanding the meaning of that phenomenon.

French phase

Predominant leaders of the French phase were Jean-Paul Sartre (1905-1980) and Maurice Merleau-Ponty (1908-1961). Concepts explored during this phase were embodiment and being-in-the-world. These concepts refer to the belief that all human acts are based on foundations of perception. It is through the consciousness that humans possess that they are aware of their being-in-the-world (Streubert & Carpenter, 2011). Sartre believed that humans' pursuit of meaning in their actions represented their being-in-the-world. Merleau-Ponty placed a particular emphasis on the dialectical relation between subject and object. He and Sartre focused on existential descriptions of everyday experiences.

Max van Manen's Approach to Researching Lived Experience

The contemporary phenomenologist, Max van Manen, is part of the Dutch, or Utrecht, school which combines characteristics of descriptive and interpretive (hermeneutic) phenomenology. Van Manen (1990) suggests there is no description without interpretation; description allows the phenomenon to be revealed and interpretation captures the phenomenon's

essence. The essence is the description of the phenomenon and a good description allows the researcher to understand the nature and significance of the phenomenon in a new and previously unseen way (van Manen, 1990).

Van Manen (2014) delineates two critical interrelated conditions that are necessary for phenomenological research. First, phenomenological research assumes there is an appropriate phenomenological question. Second, there must be experiential narrative upon which thoughtful and mindful reflection can be conducted. An appropriate phenomenological question investigates the essential meaning of human experience (van Manen, 2014). This study, for example, seeks to explore the meaning of the lived experience of nurses with substance use disorder who complete an alternative to discipline program. The essential meaning of that experience for nurses will be investigated through collection of information and reflection on that information.

Van Manen's (2014) second condition for phenomenological research is experiential narrative. Experiential narrative involves concrete, direct descriptions of an experience that promotes thoughtful reflection, description and interpretation (van Manen, 2014). Narratives provided by nurses who participate in this study have the potential to provide rich descriptions of their experience in an ADP and indeed, allow the student investigator to "borrow" their experiences in order to gain greater understanding of them.

Phenomenological Activities Related to this Study

While the phenomenology of Husserl, Heidegger, Sartre and Merleau-Ponty was philosophical in nature, van Manen (1990) developed a methodological approach to phenomenological research. He outlines six interactive activities which include: 1) turning to the

nature of lived experience, 2) investigating experience as we live it, 3) reflecting on essential themes, 4) the art of writing and rewriting, 5) maintaining a strong and oriented relation, and 6) balancing the research context by considering parts and the whole. These activities were used in this study and are explicated here.

Turning to the nature of lived experience

Phenomenological research begins when the researcher strives to derive meaning from some aspect of human existence (van Manen, 1990). This involves “orienting to the phenomenon”, questioning the nature of a lived experience or approaching the experience with interest (van Manen, 1990). This student investigator began to seek meaning of completing an ADP following discussions with nurses who actually lived through the experience. They related stories of reaching the point of surrender with substance use disorder and the role of entering the ADP as part of that surrender. These nurses expressed a wide range of emotions (from anger to gratitude) about the process and requirements of an ADP. Explicating the experiences of these nurses provided new meaning and understanding of the experience of completing an ADP and gave voice to that experience.

Investigating experience as we live it

This activity represents the educational development of the researcher, that is, finding ways to develop deeper understanding of the phenomenon being investigated (van Manen, 1984). Van Manen (1990) delineates three methods of collection to develop deeper understanding. These include interviewing, writing, and observation. For this study, interviews were used to collect data; talking with these nurses created a dialogue and helped develop an understanding of the nurses’ experience in the ADP. The student investigator entered thoughts, observations and

feelings into a reflective journal which represented writing as a means of data collection.

Observation occurred primarily during the interviews; the participants' body language, eye contact, and movements supported the recitation of their experience in the ADP and contributed to the student investigator's understanding of the experience.

Reflecting on essential themes

Reflection is a means of discovering the essence, or understanding, of an experience. Thoughtful, reflective immersion in the participant's experiences help the researcher grasp what it is that renders the experience its special significance (van Manen, 1990). In order to capture the significance of the experience nurses had in an ADP, open-ended questions were used. This allowed the participant to share the nature of the experience and provided rich data for reflection by the student investigator.

Van Manen (1990) offers four interconnected existential "lifeworlds" that pervade the experience of all humans and can act as a guide to reflection: 1) lived space (our physical environment), 2) lived body (corporeal and mental experiences), 3) lived time (our situatedness in and sense of, time passing) and 4) lived human relations (our interaction with others). During data collection, the student investigator attended to references related to these "lifeworlds".

The art of writing and rewriting

Writing is an important component of van Manen's approach. He emphasizes that the phenomenological method consists of the "art of being sensitive to the subtle undertones of language, to the way language speaks when it allows the things themselves to speak" (van Manen, 1990, p. 111). This represents the ability of the researcher to collect stories of the research participants and illuminate the phenomenon being explored through writing those

stories. It is the movement from identification of themes to presentation of a whole picture of the phenomenon. In this study, the student investigator collected stories of nurses who journeyed through an ADP and identified five themes and three subthemes to distill the essence of the experience, *A Transformative Journey*.

Maintaining a strong and oriented relation

Van Manen (1990) emphasizes the need for the researcher to provide the strongest possible interpretation of the phenomenon being explored. To do this, the researcher must be open to the participant's experiences. While van Manen (2014) does not propose the researcher bracket personal knowledge, experiences and biases, the researcher must be aware of these in order to truly hear the meaning of a participant's experience. The student investigator, for example, had knowledge related to state board of nursing programs for substance use disorder; that knowledge, and biases related to that knowledge were recorded in the investigator's reflective journal. Deep reflection was also used to identify, acknowledge, and set aside assumptions and biases that were held related to substance use disorder and nurses with substance use disorder.

Balancing the research context by considering parts and whole

While it is important to have a clear research plan, van Manen (2014) encourages the researcher to periodically step back and look at how parts of the plan actually contribute to the overall study. He suggests several ways to approach the research study. These include a thematic approach which uses themes generated by the participant and researcher to write the study. Other approaches include analytic in which interviews can be rewritten into life stories or anecdotes and existential which involves weaving the researcher's description of the

phenomenon into the four life-world existentials of lived body, lived space, live time and lived human relations (van Manen, 1990). The researcher may use any or all of these at different phases of the study. Throughout this study, the student investigator listened to, and read, transcripts of participants' stories. Colaizzi's (1978) seven step method of data analysis, which operationalizes van Manen's (1990) phenomenological activities, was used to extract significant statements from the stories. These statements were woven into themes that illustrated the nurses' journey through the ADP.

Research Plan

Participant Selection

Purposive sampling was used for this study. This is common in phenomenological research; participants need to have experienced the phenomenon being explored and be able to articulate the meaning of that phenomenon (Streubert & Carpenter, 2011). The purpose of this research was to gain an increased understanding of registered nurses' lived experience in an ADP. This understanding can only be achieved from nurses who have had this experience. Specific criteria and method of purposive sampling will be discussed in the following chapter.

Data Generation Methods

As suggested by van Manen (1990) interviews were used for data generation. Interviews are a means to explore and gather experiential material that can allow the researcher to gain a deeper understanding of a phenomenon. Van Manen (1990) suggests that beginning a question with the phrase such as, "what is it like" to have a certain experience can begin to elicit the meaning of that experience. Participants in this study were asked what it was like to complete an ADP. This began to elucidate the essence of the lived experience for these nurses.

Van Manen (1990) also encourages researchers to elicit stories of the participants' lived experiences. Participants were asked "What was it that made you decide to enter an ADP?" and "Why did you choose the state board of nursing ADP rather than another program?" This initiated a relationship between the student investigator and the participant and assisted in the gathering of data.

Data Analysis Methods

Data analysis in phenomenology preserves the participants' experiences and provides the researcher an opportunity to gain a deeper understanding of the phenomenon being explored. Van Manen's (2014) techniques for isolating thematic statements were used to begin the analysis. These included a holistic reading approach (audiotapes were listened to and verbatim transcriptions were read multiple times to capture the significance of the ADP experience), a selective reading approach (portions of the verbatim transcripts were recorded in a separate document and significant statements were underlined), and a detailed reading approach (significant statements were examined to see what each revealed about the phenomenon) (van Manen, 2014). Colaizzi (1978) developed a method of data analysis that operationalizes van Manen's techniques and this was used. The seven steps of Colaizzi's method are as follows:

- 1) Transcribing and reading the participants' descriptions. Participant narratives were transcribed verbatim by a transcriptionist who signed a confidentiality agreement (Appendix F). The student investigator read the transcripts multiple times to gain an understanding of the participants' description of the ADP experience;

- 2) Extracting phrases or sentences that directly pertain to the phenomenon under investigation; Colaizzi (1978) labels this "extracting significant statements" (p. 59). The student

investigator analyzed the text of the verbatim transcripts line by line, highlighted, underlined and starred significant statements. These statements were then placed in similar groups; these were placed in a separate word document;

3) Creating formulated meanings. Meanings for the significant statements were derived by the student investigator. Those meanings were analyzed and themes were derived;

4) Aggregating formulated meanings into clusters of themes. The researcher organizes the formulated meanings into similar groups or clusters which constitute themes (van Manen, 1990). The student investigator derived five themes and four subthemes from the formulated meanings; these themes were compared with the original participant transcripts for validation. This ensured that content in the transcripts was reflected in the themes and the themes did not propose anything that was not in the original transcripts (Colaizzi, 1978);

5) Developing a description of the experience as articulated by the participants. Themes were synthesized and the meanings attached to those themes were explicated by the student investigator;

6) Identifying the fundamental structure of the phenomenon (Colaizzi, 1978). The fundamental structure is the “essence” of the description of the phenomenon and allows it to be understood in a new and previously unseen way. The “essence” of completing an ADP was described by the student investigator as *A Transformative Journey*.

7) Returning to the participants for validation. The student investigator returned to the participants to validate the “essence” of the phenomenon. Participant feedback supported the essence of completing an ADP and themes that had been derived.

Ensuring Trustworthiness

Trustworthiness and rigor in qualitative research is provided by the accurate representation of study participants' experiences (Streubert & Carpenter, 2011). Guba (1981) identifies four criteria that can be used to ensure trustworthiness of qualitative research. These include credibility, dependability, confirmability, and transferability.

Credibility

Credibility, or truth value, addresses the congruency of study findings with reality; it asks if the researcher accurately described the phenomenon (Shenton, 2004). One way to ensure credibility in qualitative research includes member checking or returning to the participant to see if they find the study findings familiar (Streubert & Carpenter, 2011).

Dependability

Once credibility has been established the researcher may ask, "How dependable are these results?" (Streubert & Carpenter, 2011, p. 49). Dependability may be addressed by ensuring processes in a study such as research design and implementation, data collection, and interpretation are reported in detail. This ensures that a future researcher can repeat the study and provides the reader an opportunity for understanding the research (Shenton, 2004).

Confirmability

Confirmability involves an audit trail, a recording of research activities over time. This illustrates the thought processes that lead to any conclusions reached by a study (Streubert & Carpenter, 2011).

Transferability

Qualitative research does not have, as a goal, generalizability. Nonetheless, the student investigator provided a thick description of the experience participants had in an alternative to

discipline program. Potential users of this study will be able to apply the findings within the context of the study, that is, they can apply these findings to nurses who have completed an ADP.

Chapter Summary

This chapter began with an overview of phenomenology, the research method that was used for this study. Van Manen, a phenomenologist from the Utrecht school, has developed six interactive activities that provided the structure for data collection. A general research plan that includes participant selection, data collection and analysis methods was addressed; Colaizzi's method of phenomenological inquiry was used for data analysis in this study. The importance of trustworthiness in qualitative research and how that can be ensured through criteria identified by Guba was also addressed. The following chapter will provide specific information as to how van Manen and Colaizzi were used in this study and how trustworthiness was ensured.

CHAPTER IV

METHOD OF INQUIRY: APPLIED

This chapter details the study's implementation process. The method of inquiry was interpretive phenomenology and van Manen's (1990) six phenomenological activities were used to direct the study. Colaizzi's (1978) seven steps of analysis were utilized for data interpretation and Guba's (1981) strategies to ensure trustworthiness of data were used to strengthen the study.

Participant Recruitment and Selection

Purposive sampling was used to recruit participants from nurses who completed an alternative to discipline program through a state board of nursing within the last 15 years. This allowed the student investigator to work with participants who had knowledge of, and experience with, ADPs. The goal was to recruit 10 participants in an effort to achieve data saturation; data saturation was achieved with three participants in this research.

The inclusion criteria for this study were: 1) registered nurses (RN) who completed an ADP through a state board of nursing within the last 15 years, 2) RNs who self-reported substance use disorder to the state board of nursing as a requirement for entrance into the ADP, 3) active RN licensure in the state where the study was conducted, and 4) employed at least part-time (50%) in nursing. The criterion of completion of an ADP was consistent with van Manen's (1990) premise that meaningful interpretation requires retrospective reflection after an experience rather than introspection during that experience. The criterion of completion within the last 15 years minimized recollection from the distant past. The criterion of active RN licensure and employment in nursing was related to potential differences in experiences; the nurse not presently licensed or employed in nursing may have had different meanings related to

the ADP. Exclusion criteria for this study therefore were: 1) ongoing participant in an ADP (not yet completed), 2) ongoing participant in, or completion of, a disciplinary program for nurses with substance use disorder, 3) inactive RN license in the state where the study was conducted, and 4) not employed in nursing.

Participants agreed to a face-to-face, audio-taped interview conducted in a setting of their choice. They also agreed to follow-up communication that would be face-to-face, via telephone or email. All participants were initially interviewed in the same setting, a health assessment/skills lab that was located on a satellite campus of the student investigator's university. Follow-up communication was conducted via telephone or email and used to clarify potential errors of the transcription and/or misinterpretation of the student investigator regarding themes. It also allowed participants the opportunity to add additional information about their lived experience.

Gaining Access

Protection of Human Subjects

Approval was obtained from the Institutional Review Board (IRB) of the University of Nevada, Las Vegas (UNLV). Initial approval was obtained in January 2015 (Appendix B). Subsequent approval was obtained in March 2015 for modifications in the flyer and time frame for participants completing the ADP.

Recruitment

Once approval from the IRB was received, a mailing list of all RNs in the state where the study was conducted was obtained from the state board of nursing. A flyer (Appendix C) explaining the purpose of the study, eligibility criteria, and contact information for the student

investigator was sent via U.S. Postal Service to a random selection of 4000 nurses from the list. One participant was recruited from this initial mailing. The student investigator did receive phone calls and emails from nurses who expressed concern that the flyer implied they had been disciplined by the board of nursing. Based on these concerns, the flyer was modified (Appendix D). The modified flyer was approved by the UNLV IRB in March 2015 and a subsequent 17,878 flyers were sent out to RNs in batches of 4000.

Interested participants contacted the student investigator via email (a separate email account was established for this study) or telephone. The student investigator then offered additional information related to the purpose of the study and eligibility criteria. Additional information related to the maintenance of confidentiality, the structure of interviews, the handling of data gathered, and informed consent (Appendix E) was also addressed.

Privacy and Confidentiality

Interviews

Interviews were conducted face-to-face using a digital tape recorder in a private location that was convenient for the participant. The setting had a closed door and only the researcher and participant were present.

Data

All participants in this study had a pseudonym to protect their anonymity and confidentiality. This pseudonym, and only this pseudonym, appeared on demographic data forms, recordings, interview notes, and transcribed materials. Participant contact information and a key to the pseudonyms were kept in a locked cabinet by the student investigator and all electronic information was stored on a password-protected computer. A confidentiality

agreement was signed by the individual transcriptionist who had access to the interview data (Appendix F).

Informed Consent

Informed consent (Appendix E) was obtained prior to interviews with participants and reaffirmed at the beginning of each interview. Participants were informed that participation was voluntary, there would be no repercussions if they chose not to participate or withdraw from the study at any time, and that confidentiality would be maintained throughout the study.

Participants were informed they could refuse to answer any question on the demographic data sheet or any question posed during the interview. Benefits and risks of the study were also explained. Per IRB direction, participants did not sign the informed consent; this provided an extra layer of confidentiality and anonymity for the participants.

Data Generation and Analysis Procedures

Data Generation

Using a guided approach, data for this study were collected through an in-depth interview with each participant. Interviews were conducted at a private location agreeable to the participants to ensure privacy and confidentiality of provided information. Interview questions (Appendix G) were prepared and used. A demographic data sheet (Appendix H) was completed by the participants at the beginning of each interview to identify the characteristics of the participants. All interviews were audio-taped with a digital recorder, transcribed verbatim by a transcriptionist who signed a confidentiality agreement (Appendix F), and reviewed for accuracy by the student investigator. Field notes and journaling were used to reconstruct aspects that were not evident in the transcript of the recording. These aspects included body language,

distractions, dress and demeanor of the informant as well as recording ideas, insights and observations of the researcher. This ongoing reflective commentary formed an “audit trail” for this phenomenological inquiry.

Data analysis

Analysis of data utilized Colaizzi’s (1978) seven step method which operationalizes van Manen’s (1990) six phenomenological activities. These steps were:

Transcribing the participants’ descriptions. The student investigator personally conducted each interview. Following the interview, audiotapes were transcribed verbatim by a transcriptionist who signed a confidentiality statement (Appendix F). The verbatim transcript was read by the student investigator and compared with the audiotapes to ensure accuracy. Following this, the student investigator read the transcripts numerous times to gain an understanding of what the participants said and become familiar with the data. Thoughts, feelings and ideas that arose during the readings were entered into the student investigator’s journal.

Extracting significant statements. The student investigator analyzed each transcript and explicated statements that illustrated the experience of completing an ADP. Statements were underlined, starred and highlighted. Those statements were moved to a separate file and re-read to identify early themes of the participants’ experiences.

Creating formulated meanings. This part of data analysis is identified by van Manen (1990) as the detailed reading approach. The student investigator studied, and reflected on, the words, phrases and sentences of each participants’ narrative for meanings related to the experience of completing an ADP.

Aggregating formulated meanings into theme clusters. Van Manen (1990) posits that the words and phrases that are similar in each participant's narrative constitute a theme. The student investigator organized the formulated meanings derived from participant's transcripts into clusters of themes. These themes were compared with the original transcripts for validation.

Developing a description of the experience as articulated by the participants.

Themes were used to develop a description of the experience of registered nurses who completed an ADP. An in-depth description, in narrative form, that contained all the dimensions of the lived experience of completing an ADP, was explicated.

Identifying the fundamental structure of the phenomenon. This is the essence, or description of, the phenomenon (van Manen, 1990). This was completed in an effort to formulate a comprehensive, in-depth description of the experience of completing an ADP.

Returning to the participant for validation. Colaizzi (1978) states that the researcher must return to the participant to ensure that the structure of the phenomenon truly represents the participant's experience. Participants were contacted and the transcribed interview was distributed to them. Participants were asked to provide any corrections or clarifications, and return those to the student investigator. This provided them the opportunity to add any additional thoughts about their lived experience.

Ensuring Trustworthiness

Rigor of this study was strengthened using Guba's (1981) strategies to enhance the trustworthiness of data. These include credibility, or truth value, dependability, confirmability, and transferability.

Credibility

Credibility represents the confidence the researcher has in the credibility of the findings of a study (Guba, 1981). In this study, van Manen's (1990) well-established method was used, one method of ensuring credibility. In addition, the student investigator returned to the participants in this study and they agreed with the themes and essence that were derived.

Dependability

A written audit trail is a clear demonstration of the decisions the researcher makes during data collection and analysis (Sanders, 2003). All records of locations, times, dates and observations made by the student investigator were included in a written audit trail for this study. The student investigator also ensured participants had access to transcripts of interviews so they could review them and provide any corrections or clarifications.

Confirmability

The written audit trail will contribute to the confirmability of this study. Prior to data collection the student investigator spent time reflecting on attitudes, assumptions and biases related to substance use disorder and nurses with substance use disorder; this reflection continued throughout data collection and data analysis. One such assumption held by the student investigator was that surrendering their license as they entered the ADP would have a negative impact not only on the nurse's employability, but on their emotional state as well. Data from this research indicated this the negative impact on the nurses' emotional state did occur.

During data analysis, the student investigator often returned to the data to ensure the categories, explanations and interpretations reflected the nature of the participants' experience in an ADP.

Transferability

It is the responsibility of the researcher to provide a sufficient in-depth description of study findings so they can be applied or transferred to similar situations (Guba, 1981). This student investigator was responsible for writing a thick description so readers may generalize the findings.

Strengths and Limitations

This study had both strengths and limitations. Strengths of this study included the potential sample, and the actual participants. Limitations of this study included the novice status of the student investigator, recruitment challenges, lack of diversity and lack of generalizability.

All nurses with active licenses in the state where the study was conducted were contacted via flyer for potential inclusion in this study. A total of 21,878 flyers were sent via U.S. mail by the student investigator to these nurses. Participants in the study also represented a strength; they had active licenses, worked full-time in nursing, and had completed an ADP. They represented diversity across specialty areas yet consistency with their experience in an ADP. This gave rise to themes that described the essence of the experience, *A Transformative Journey*.

Limitations to this study included the novice status of the student investigator, recruitment challenges, lack of diversity and lack of generalizability. The student investigator is very novice in phenomenological research. In order to compensate for her novice status, the student investigator informed the dissertation chair about progress of the study frequently, and reviewed data with the dissertation chair and the qualitative expert on the committee.

Recruitment challenges were encountered in this study. An initial recruitment flyer was misunderstood by nurses who expressed concern that they were being targeted for discipline by

the state board of nursing. The flyer was modified and a total of 21,878 flyers were mailed via US Postal Service to nurses in the state where the study was conducted. Even with the modified flyer, a lack of understanding remained about the study. The student investigator was contacted by nurses who had been disciplined by the board of nursing for practice related issues, nurses who were still in the process of completing the ADP, and one nurse who believed the ADP referred to associate degree education. Recruitment may have also been impacted by feelings nurses who completed the ADP had toward that program. If nurses felt their journey through the ADP had been exceptionally negative they may not wish to re-visit the experience. Even if nurses did not perceive the journey as especially negative, they may feel that chapter in their lives was closed and not wish to re-open it. Assurances of anonymity were also provided in this study. Some nurses however, may still have been reluctant to disclose feelings about their experience with SUD or the ADP

This study was completed in one geographical area of the U.S., hence lacked diversity and can only speak to the experiences of nurses who complete an ADP in that geographical area. The structure of ADPs differs throughout the U.S. The program in this study, for example, required a 5 year monitoring contract for participants; other states require a 2-3 year contract. The program in this study had oversight by the state board of nursing. In other states the board of nursing contracts with outside agencies to oversee the ADP. There was also a lack of participant diversity in this study, especially in relation to participation of men. Men represent 6-9% of nurses in the U.S., however they represent between 19-38% of participants in ADPs. Their experience in, and stories about, ADPs may be very different from those of women who

complete the program. Hearing their stories would strengthen knowledge about the lived experience of completing an ADP.

Finally, this study lacks generalizability. While phenomenological research does not aim to generalize, provision of a rich description of a lived experience allows readers to apply findings to similar populations. While data saturation was achieved with three participants in this study, the student investigator wonders if inclusion of more participants would have offered even greater insight into the lived experience of completing an alternative to discipline program.

Chapter Summary

This chapter presented the application of van Manen's (1990) phenomenological approach to the study and discusses how Colaizzi's (1978) method of data analysis was used to discern five themes and three subthemes. These themes and subthemes gave rise to the essence of the lived experience, *A Transformative Journey*, which will be discussed in the next chapter. Strategies to enhance the trustworthiness of the study were explained and strengths and limitations of the study addressed.

CHAPTER V

FINDINGS

The purpose of this phenomenological study was to gain a deeper understanding of the lived experience of registered nurses with substance use disorder (SUD) who completed an alternative to discipline program (ADP) through a state board of nursing. The question that guided this research was: What is the meaning of the lived experience of a registered nurse with SUD who completes an alternative to discipline program through a state board of nursing?

Description of the participants

Participants for this study were recruited via flyers sent to 21,878 nurses who held active licensure in the state where the study was completed. These flyers were mailed in batches of 4000 over a period of approximately six months. Recruitment via the snowball technique was also employed; nurses the student investigator knew, for example, acknowledged receipt of the flyer, indicated they did not fit the criterion (completion of an ADP) but knew nurses who did. The student investigator encouraged these nurses to provide her name, phone number and email to these possible participants. At no time did the student investigator ask for identifying information from anyone. The student researcher had frequent communication with the dissertation chair and the qualitative expert member of the committee as potential participants were recruited. In the end, a total of 3 registered nurses participated in this study; this was acceptable because data saturation was reached. All participants were licensed in the state where the study was completed and all were employed full-time in nursing. Participants were employed in three specialty areas: dialysis, psychiatric mental-health and critical care. All the participants were female and their ages ranged from 39 to 63 years. Two had completed

associate degree programs in nursing as their highest level of education and one had completed a master's degree in nursing. Individual participant profiles are included in Appendix I

Data Collection

Following approval by the IRB at University of Nevada, Las Vegas, a list of registered nurses in the state where the study was conducted was obtained from the board of nursing. Between the months of January 2015 and June 2015, a total of 21, 878 flyers were sent to registered nurses in the state; these flyers were sent in batches of 4000.

Interviews were conducted over approximately a four month time frame between February and May of 2015. Participants were initially interviewed in a mutually agreed upon, private setting that was convenient for the participant. These interviews were conducted in a health assessment/skills lab on a satellite campus of the student investigator's university.

The physical environment of the lab was comfortable for the participants. There were small tables and chairs that allowed the participant and student investigator to sit side by side and share access to the questions asked. The recorder was placed on the table between participant and student investigator. The room was only accessible by key and a sign, "Meeting in Progress: Do Not Disturb" was placed on the outside of the room.

Verbal consent was obtained prior to starting the interview. Written consent was not obtained per the approved IRB as a way of helping to provide extra anonymity and confidentiality for the participants. Verbal consent was reaffirmed as the recording of the interview was begun. The consent form (Appendix E) had been e-mailed to participants at least a week before the interview. Each participant was given the opportunity to again read through the consent form prior to the interview and any last minute questions were answered.

Participants were informed they could decline to answer any of the questions that would be asked during the interview or terminate the interview at any time.

Participants also completed a brief demographic data form (Appendix H) prior to the beginning of the interview. The student investigator explained that participants' answers on the demographic data sheet were voluntary and they could decline to answer any or all of the questions. All of the participants completed the demographic data sheet.

The student investigator built a rapport with each participant prior to the interview with an open dialogue about where they worked and their responsibilities at their place of employment. Prior to beginning the recording, each participant was asked, "Are you ready?" When the participant acknowledged yes, the recorder was turned on and the formal part of the interview began. Prior to ending the interview, the student investigator asked each participant, "Is there anything else you would like to add?" Once the participant acknowledged they did not, the recorder was shut off.

Follow up meetings were conducted between April and September 2015. Communication occurred via email and allowed for clarification of the transcripts and provided participants the opportunity to add additional thoughts they had about their lived experiences. The three participants who started the study all completed it.

Data Analysis

Data analysis was guided by Colaizzi's (1978) seven-step method for phenomenological inquiry. Van Manen's (1990) four existential lifeworlds provided a loose framework to facilitate analysis. These lifeworlds are common to all human experience and include lived space (physical environment), lived body (corporeal and mental experiences), lived time (situatedness in, and

sense of, passing time), and lived relation (our interaction with others). Colaizzi's (1978) steps of data analysis are outlined below.

Transcribe and read participant's descriptions

Participant descriptions, or protocols, were read to acquire a feeling for, and make sense of, what they said (Colaizzi, 1978). All participant interviews were transcribed verbatim by a transcriptionist who signed a confidentiality agreement (Appendix F). While waiting for the verbatim transcripts the student investigator listened to the interview recordings. Thoughts and ideas that occurred while listening to the interviews were written in the student investigator's reflective journal. Once the verbatim transcripts were available, they were read while listening to the recordings to establish accuracy. Recordings were listened to, and transcripts were read, many times to gain a sense of understanding of what the participants were explaining. Thoughts, feelings and ideas continued to be recorded in the student investigator's journal.

Extract significant statements

Colaizzi (1978) recommends that the researcher return to the protocols and extract phrases and statements that directly pertain to the phenomenon being investigated. While transcripts were read, the student investigator underlined, highlighted and starred key words, statements and phrases. Statements and phrases that captured participants' feelings about the ADP, meanings of the lived experience of the ADP, and anecdotes that illustrated those experiences were marked for inclusion in data analysis. Significant statements about the experience, for example, included:

I didn't realize how dependent I was on that random drug screen...that was one of the reasons I stayed sober (Betty Lou)

Formulating meanings

In this step of data analysis, the researcher “leaps from what...subjects say to what they mean” (Colaizzi, 1978, p. 50). This can be precarious because the researcher goes beyond participant statements but must stay with them as well; connection with protocols is maintained.

The student investigator entered the significant statements from the protocols into a Word document, reread that document and made manual notations in the margins about meanings of the statements. For example, based on the significant statement related to dependence on drug screening for sobriety, the student investigator formulated the meaning, “monitoring helps”.

Aggregating formulated meanings into theme clusters

Theme clusters are created by finding commonalities across the protocols (Colaizzi, 1978). During this step, formulated meanings that had been derived from significant statements were reviewed for commonalities among the participants’ experiences and grouped into categories that reflected a unique structure. For example, the meaning of “monitoring helps” became part of a theme cluster labeled, “structure contributes to sobriety” which became the theme “structured sobriety”.

Developing a description of the experience as articulated by the participants

Colaizzi (1978) advocates that the researcher should integrate all the resulting ideas into an exhaustive description of the phenomenon. Through a synthesis of theme clusters and formulated meanings a description of the lived experience of completing an ADP was formed.

Identifying the fundamental structure of the phenomenon

The fundamental structure of the phenomenon refers to the essence of that phenomenon. It is the description of the lived experience and allows the researcher to understand the nature and the significance of the phenomenon in a new and previously unseen way (van Manen, 1990;

Edward & Welch, 2011). The student researcher reviewed significant statements, aggregated meanings and themes with the dissertation chair and the qualitative expert committee member. Five themes were derived from the data and included Leap of Faith, Pain of Surrender, Drowning, Structured Sobriety and Nurse to Nurse. The theme Nurse to Nurse was actually woven across the other four themes. Continued discussion with the committee chair and the qualitative expert, helped the student investigator distill the themes into the fundamental structure, or essence, of the lived experience of completing an ADP. This essence represented the journey the participants traveled as they entered, participated in, and completed the ADP. The essence is, *A Transformative Journey*.

Returning to the participant for validation

Follow-up with participants can validate the essence of the phenomenon. Participants have the opportunity to make any changes that ensure their intended meaning is explicated and they may add additional information that further explicates the essence of the phenomenon (Edward & Welch, 2011). Follow-up in relation to data analysis for this study occurred through email and face-to-face meetings. Two of the participants provided corroboration of the student investigator's findings as evidenced by the following comments:

You have developed some interesting themes. I think this captures the experience I had (Carolyn)

Oh gosh-this sounds so much like me (Betty Lou)

The third participant commented that it was an excellent job and would result in the student investigator obtaining her degree.

Essences, Themes and Subthemes

The student investigator identified themes that reflected the nurse's experience of completing an Alternative to Discipline program. The overall essence of this study was, A *Transformative Journey*. Other themes identified were 1) Leap of Faith, 2) Pain of Surrender, 3) Feelings of Drowning, 4) Structured Sobriety, and 5) Nurse Affiliations. Four subthemes were identified and were: Future Nurses at Risk, Hidden Pain, (part of the theme, Leap of Faith), Tell Me Why (part of theme, Drowning) and Protecting One Another (part of the theme, Nurse to Nurse)

Overall Essence: A *Transformative Journey*

The initial hermeneutic inquiry for this study was: "I am trying to understand the nature of alternative to discipline programs and nurses' involvement in them. From your own lived experience of the program, what was that experience like for you?" Participants consistently described a grueling journey that began with a crisis or intervention at work about their substance use disorder. This crisis or intervention resulted in a decision to enter the alternative to discipline program through the state board of nursing. This decision involved a temporary surrender of the participants' nursing license, treatment for substance use disorder and, upon restoration of their nursing license, agreement to a five (5) year monitoring contract that involved a conditional license (inability to administer narcotics or supervise other nurses and restricted work hours and environment), supervision at work, and monthly drug screening. Looking at the program retrospectively, each participant felt it had positively impacted her professional life.

Their goal was to assist in my completion of a sobriety program so that I could be an effective nurse (Carolyn)

I really am grateful for the seriousness of the [program]. The one thing I held onto in sobriety was I was so proud of my nursing license and even though I thought my

marriage had ended and I didn't care so much about that and I thought my life was going down the tubes the one thing I wanted to hang onto was my nursing license. And I can say I got sober to keep my nursing license (Carolyn)

...over time I started to feel better. I actually reached a point in the program where I actually like myself which is something I had never done before (Chloe)

But as I started going through it I realized it was the best thing that ever happened to me (Betty Lou)

The overall essence, "Transformative Journey", and the themes are depicted in Figure 1.

This model depicts the movement from the theme Leap of Faith to Structured Sobriety all of which are encompassed as part of, *A Transformative Journey*. The relationships among the themes are also depicted in this figure. The theme Nurse to Nurse is woven throughout the journey.

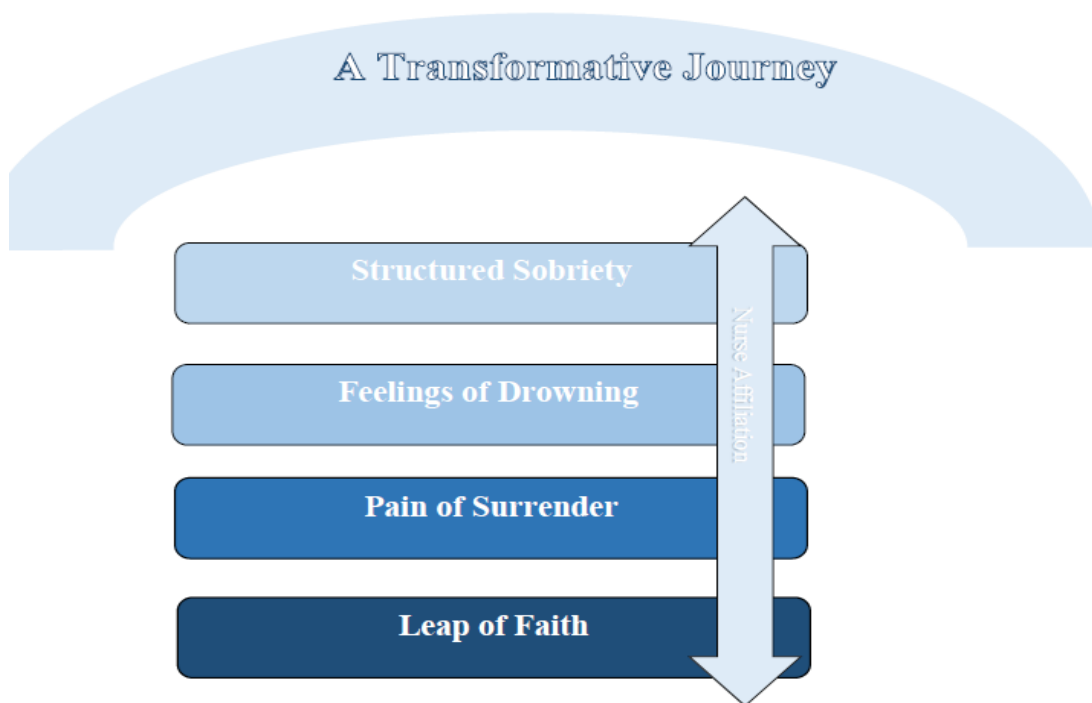


Figure 1. Essence of Completing an ADP- *A Transformative Journey*

Theme: Leap of Faith

This theme arose from the student investigator asking, “What was your ‘aha’ moment in relation to knowing you needed to get help for substance use disorder?” and represents the beginning of the participants’ transformative journey. The participants had struggled with substance use disorder from a relatively young age and were finally at the point where, if they did not get help, they risked losing employment and licensure. They took a leap of faith by entering the ADP.

All three had been confronted at their place of employment shortly before making the decision to enter the alternative to discipline program. One was under investigation for diversion (diversion is theft of controlled substances, that is narcotics such as morphine, for personal use, to supply the drug to another user, or for financial gain), one had been confronted in her employer’s office and one had actually been escorted home by her employer. If they did not enter the ADP and a complaint came before the state board of nursing, disciplinary action would be taken against their license.

I was diverting at work and they found out about it and they put me on suspension while they were doing the investigation (Betty Lou)

I was in crisis before I actually went into treatment...I was caught on the job and returned home by my employer and dropped off at the house. That was my aha moment.
(Carolyn)

Finally my boss pulled me into her office and I just started to cry. I remember saying it is so awful to be an alcoholic, that is the only thing you are, that is what everybody sees you as (Chloe).

Two sub-themes arose from this theme. The fact that all participants had started using and/or drinking in their high school or college years gave rise to the sub-theme “Future Nurses at

Risk”. In addition, all three participants expressed feelings of being stigmatized as a nurse with substance use disorder and this contributed to their delay in seeking treatment until they were truly in crisis. This gave rise to the subtheme, “Hidden Pain”

Subtheme: Future Nurses at Risk. This subtheme emerged when the student investigator asked “When did you realize you were at risk for substance use disorder?” All three participants recalled a need or desire to use drugs and/or alcohol at a young age. It is unsure that, at that age, they truly recognized their risk for substance use disorder, but they did recall the need.

I always knew I had a problem with drinking, but it had never gotten me a DUI...but I was always just a little too excited about drugs. When I was 16 I had my wisdom teeth pulled...I spent three weeks in bed with my mom...feeding [drugs] to me...I knew from the moment I took those they were the answer to everything (Betty Lou)

I think [I was] at risk as a teenager. Did I want to do anything about it-never, not until...my options were cut off (Carolyn)

I remember at college the first time I drank I really liked the feeling. I felt happy and goofy and so just kept drinking to keep that feeling and it worked for a long, long time (Chloe)

Sub-theme: Hidden pain. The student investigator did not ask any specific questions about the stigma nurses with substance use disorder might experience. All three participants however spoke to this, and to a double standard as to how substance use disorder is addressed in nurses versus physicians.

...because we do keep it a secret and we learn to cope...we think it's a secret for a long time. Until it gets out of control and then everyone knows-it's just there's such a stigma (Carolyn)

I think there's a lot of fear among nurses to be transparent and honest about their background (Carolyn)

It was just awful I was so embarrassed, nurses aren't drunks and if they are they shouldn't be nurses. How could I admit that? (Chloe)

I contacted the state board of nursing from a pay phone because God forbid they know who I was (Betty Lou)

...I felt there was a double standard with doctors not having their licenses as scrutinized when they have indiscretions or have problems and that doctors have kind of a code of silence on that. And I think that's a double standard in the profession. So I [would] just like to say that (Carolyn)

Theme summary

The first theme, "Leap of Faith" identifies the experiences each participant had that led to the decision to enter the alternative to discipline program. The two sub-themes, "Future Nurses at Risk" and "Hidden Pain" provide some background and context as to why nurses may be hesitant to seek treatment earlier in the disease process.

Theme: Pain of Surrender

This theme arose when the student investigator requested that participants discuss some of the requirements of the ADP. To better understand the program, a series of requirements for the ADP include:

1. The nurse must self-report substance use disorder to the state board of nursing. A nurse must self-report; if a complaint comes before the state board from a third party, the nurse is no longer eligible for the ADP and action against the nurse's license becomes disciplinary;
2. The nurse must meet with a representative from the state board of nursing and surrender his/her nursing license until they have established stable recovery and met treatment requirements in a substance use disorder program;

3. After treatment requirements are met, the nurse must agree to abide by a nonpublic monitoring agreement which includes working under a conditional license, monitored practice, and random drug testing.

While participants discussed all the requirements of the program, discussion about surrendering their nursing license prompted the most emotional response. One of the participants actually repeated, “I voluntarily surrendered my license” three times during the interview.

I went in one day and... [They] pulled my beautiful little card away from me and I thought the world had ended (Betty Lou)

So I went to meet with [them] at the board of nursing and surrendered my license. We had the actual piece of plastic then and it was like giving myself, my identity my life away. That was pretty, I guess, devastating is the word (Chloe)

Theme Summary

The theme, “Pain of Surrender” described feelings participants had as they entered the alternative to discipline program and surrendered their nursing license. Feelings expressed included: the world had ended, giving myself, my identity away, and devastation.

Theme: Feelings of Drowning

This theme arose from the student investigator requesting, “Tell me about some of the requirements of the ADP”. The participants shared their experience of entering the ADP and the first months of the program. They labeled it scary and uncomfortable because of the requirements. The ADP has many requirements, which include treatment in a substance use disorder program, individual counseling, attendance at AA meetings and nurse support group. Participants must check in daily via computer to see if they have been randomly selected for

drug testing; if so, they must go to the lab prior to close of business day. In addition, multiple reports need to be submitted to the board of nursing on a monthly and/or quarterly basis. The following examples illustrate this theme:

...at first it was scary and overwhelming and it was quite a few conditions and stipulations (Carolyn)

[The experience was] sometimes overwhelming at least at first- I would look at that report and think, I just don't know what to say-how do I cope with stress, what do I do to stay sober and in recovery (Chloe)

...it seemed like so much to me. And it took me a good year of doing everything before I finally felt like I wasn't going to drown. It seemed so much (Betty Lou)

Sub-theme: Tell Me Why. One participant felt that if she had received more information at the beginning of the program, she might have felt less like drowning. While she went to an orientation, she felt unprepared to meet the requirements of the ADP. She needed explanations as to why requirements such as attendance at AA meetings and to nurse support group were important.

...they only give you little bits of information...why did I have to go through everything that I had to go through. Why did I have to go to aftercare every Wednesday for a year? Why did I have to do nurse support group? I mean all of that finally came in time but I think if there was a little breakdown- you go to aftercare for this reason- this is the idea why we think it will help you and this is why you have to go. Nurse support group is going to get you in contact with other nurses who are going to support you and help you through this process (Betty Lou)

Betty Lou qualified her thoughts and shared what she had heard from others:

...maybe there was information there and I was just too fogged up to be able to see it. But when I hear other people tell their story they also kind of have the same type of experience. They wish they would have known what was going to come next.

Theme summary

This third theme, “Drowning”, exemplifies the experience that nurses had when they first entered the ADP and began to meet the requirements of the program. Although the requirements became clearer as they moved through the experience, at least one participant felt more information would have been helpful at the beginning. This gave rise to the subtheme, Tell Me Why.

Theme: Structured Sobriety

The alternative to discipline program has “quite a few conditions and stipulations contractually” (Carolyn). It is a very structured program.

There were many requirements. I had to check in every day by phone or computer to see if I got drug tested that day. I had to do monthly, then quarterly reports about my sobriety and talk about my stressors how I met those stressors how I talked with my sponsor and everything. I had to go to DAC [Disability Advisory Committee] every once in a while and I was never sure what would happen there. I would get all worked up but it was never really a too negative experience (Chloe)

It is very structured and I do thrive with structure. You have to do didactic courses and get treatment and aftercare and drug testing and submit evaluations and have an AA sponsor (Carolyn)

In this theme, participants discuss the assistance that structure provided for their ability to remain clean and sober.

Lots of people said they hated checking in for drug testing every single day. But I didn’t mind the check-ins-they provided some type of structure I seemed to need. I liked the structure...I know that kept me sober early in the program (Chloe)

I didn’t realize how dependent I was on that random drug screen but that was one of the only reasons I stayed sober for so long-was because if I didn’t do that-if I didn’t have to show I was clean I wouldn’t have been (Betty Lou)

And so as tough as they made it I probably wouldn’t have had the ability to stay sober for the first...year unless I had been so closely monitored and had gone through such a rigorous process (Carolyn)

Theme summary

This theme emphasizes the structure of the alternative to discipline program. The feelings participants had about that structure are exemplified in their acknowledgement that this structure helped keep them clean and sober, at least early in the program. The random drug seemed to be the most important part of the structure that helped participants maintain sobriety.

Theme: Nurse Affiliations

This theme was woven throughout participants' experience in the alternative to discipline program and arose from the question, "Can you share a story about your experience in the ADP you personally find meaningful?" Every participant shared a story that involved other nurses, specifically those in nurse support groups. Weekly attendance at a nurse support group is one requirement of the ADP. These groups are made up of between 5-8 nurses who are in the ADP and a facilitator, who is often a nurse. This group was perceived to be the most valuable component of the ADP and one participant expressed a need to have a similar group for nurses who had completed the ADP. Two of the participants felt they actually felt they received love from nurses in these groups; this was love they had experienced while growing up.

My favorite part of the program was Nurse Support Group. Really to be honest I still miss it today. Those women were so good and kind in that group...I wish there was something like that out there just for nurses. AA helps but it is not the same as being with other nurses. I didn't have much love growing up and I felt acceptance and love in that group. I would extend Nurse Support Group beyond graduation from the alternative program; have a group just for those who completed the program and still want to have a support group (Chloe)

[The facilitator's] voice in Nurse Support Group really stuck in my head to make it through a lot of things. And knowing that I would get to see women in the meeting who loved me no matter what. Because I really had not had unconditional love in my life. It just wasn't part of my family dynamic and so that was the first time being in the program that was the only time every in my life I ever felt that. (Betty Lou)

While the experience of nurse support groups was dominant in the theme, “Nurse to Nurse”, two of the participants felt that nurses should be involved in educational components related to substance use disorder. They felt nurses in recovery needed to reach out to nursing students and new graduates and one participant indicated an educational component related to 12 step programs was important. These feelings gave rise to the sub-theme, Protecting One Another.

Sub-theme: Protecting One Another. This sub-theme arose when two participants responded to the question, “Is there anything else you would like to add?” at the end of the interview. They believed that more information related to substance use disorder and the consequences of being impaired while working may protect students and new graduates.

I would provide a mandatory in-service to every graduating nurse or put it within the nursing program somewhere that they have to teach what happens if you get in trouble with your license. If you choose to go out and have a bloody beer in the morning because you worked so hard at night in the ICU and then you get a DUI, even if you don't have a problem with alcohol you now have a DUI (Betty Lou)

...because we are passing so many narcotics and other substances that are abused there should be some discussion about the hereditary component of chemical dependency...it didn't happen that my drug of choice was something that I handed out to patients but I think that discussion should be held (Carolyn)

The following comment by Betty Lou exemplifies her need to protect other nurses:

...with a driver's license- so what they take it away, you can't drive- you can still drive. You just have to take the risk of getting caught. It's not like that in nursing. You can't just go oh well by the way I lost my license, but I am going to come work for you anyway. I just doesn't work that way.

Attendance at Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) meetings are a required component of the ADP. Only one participant however integrated her experience with AA into her narrative. Carolyn spoke to her continuing involvement with AA:

[In the ADP] I went to the recommended 90 meetings in 90 days at first and then tapered off to five meetings a week which I still maintain...I have sponsored a woman who recently got off contract [and] try to stay active and helpful to nurses that are in recovery

She also thought that knowledge about 12 steps programs would be an important component related to substance use disorder in nursing curricula:

I think there should be probably a component of education that has to do with the 12 steps that are out there right now...those that recover and stay recovered are actively involved in a 12 step program. And I think there should be nurses that advocate for 12 step programs and discuss more about why they work

Theme summary

This theme emphasized the experience participants had when other nurses helped with their recovery, especially through nurse support group. Participants also indicated that it was important for nurses to reach out to students and new graduates through education related to substance use disorder and the consequences of being impaired while working. One participant also emphasized the need for information related to 12 step programs.

Chapter Summary

This chapter addressed the contributions the participants in this study made to the student investigator's deeper understanding of the lived experience of completing an ADP. For these nurses, completion of the ADP represented a transformative journey that began with a leap of faith and the pain of surrendering an integral part of their identity, being a nurse. They moved from feelings of drowning to an appreciation of the structure of the ADP to maintenance of

sobriety. The theme of nurse affiliations was woven throughout the journey through the ADP; participants expressed the need to help one another along the journey and to help future nurses understand the implications of substance use disorder on their practice. The figure depicted at the beginning of the chapter represents the transformative journey nurses in this study completed and the importance of nurses helping nurses throughout this journey.

CHAPTER VI

DISCUSSION AND INTERPRETATION

The purpose of this phenomenological inquiry was to describe, interpret and gain a deeper understanding of the lived experience of registered nurses with substance use disorder (SUD) who completed an alternative to discipline program (ADP) through a state board of nursing. In this research five themes and four subthemes explicated the experience of completing the program, the essence of which may be termed, *A Transformative Journey*.

Findings as They Relate to the Current Literature

Nurses with substance use disorder pose a unique challenge to the profession. Behaviors that result from this disorder negatively impact them, the colleagues who face the dilemma of intervening with them, and the many patients who depend on them for safe and competent care (NCSBN, 2011). In the 1970s, the problem of nurses with SUD began to be addressed and by 1978 some type of disciplinary program for nurses with SUD had been developed by boards of nursing in 48 states (Fletcher, 2001). In the 1980s, the American Nurses Association (ANA) adopted a resolution that encouraged state boards of nursing to offer treatment to nurses before disciplinary action was considered. Research related to nurses with SUD began in earnest following this resolution and focused on characteristics of nurses with SUD, the recovery process, risk factors, and impact of both disciplinary and ADP programs on nurses. A paucity of research exists however that actually explicates the lived experience of nurses in ADPs. This phenomenological inquiry sought to describe, interpret and gain an understanding of this experience.

Essence of the Experience: A Transformative Journey

From the phenomenological analysis of interview data, the essence of the experience encountered by these nurses can be described as *A Transformative Journey*. The descriptive model that was presented in the previous chapter is shown again here.

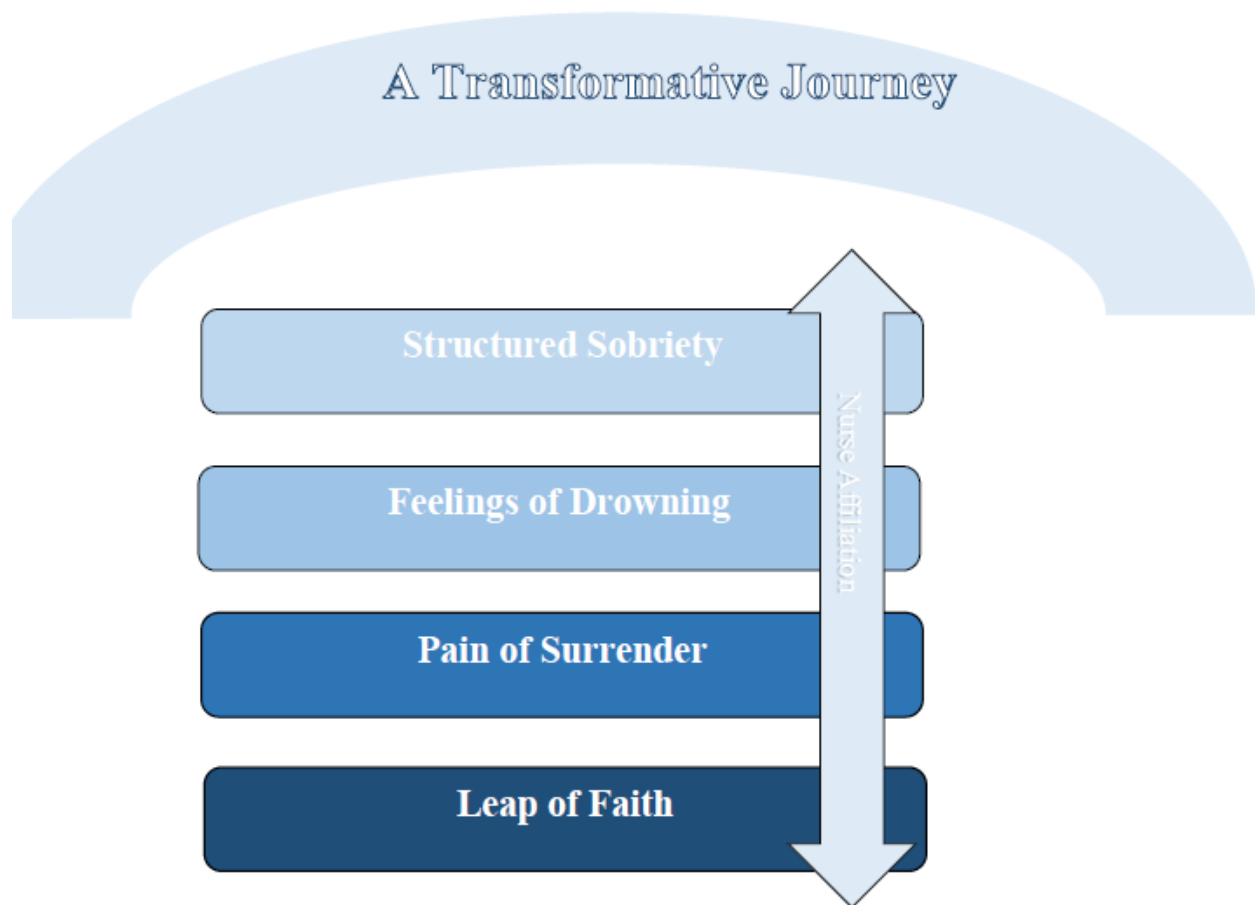


Figure 1. The essence of completing an ADP, *A Transformative Journey*

The essence was distilled from five themes that represented this transformative journey. These themes included Leap of Faith (when SUD led to interventions at work for the participants and the leap of faith that involved entering the ADP), Pain of Surrender (which represented the

temporary loss of a nursing license when the participants entered treatment), Feelings of Drowning (feelings the participants encountered as they began to meet the requirements of the ADP), Structured Sobriety (which represented the contributions of the structure of the ADP toward maintenance of sobriety). The theme Nurse Affiliations was woven throughout the journey and represented the affiliation participants in this phenomenological study had with other nurses, especially those who assisted in the journey. Four subthemes also contributed to the essence, *A Transformative Journey*. These included Future Nurses at Risk, Hidden Pain, Tell Me Why and Protecting One Another. Future Nurses at Risk and Hidden Pain were part of the Leap of Faith theme and represented the use of substances at a young age and the stigma participants felt in relation to being a nurse with SUD. Tell Me Why was a subtheme in the theme, Drowning; one participant felt the need for more information at the beginning of the program. The theme, Nurse Affiliations incorporated the subtheme, Protecting One Another and refers to the need for education related to SUD for student and graduate nurses.

In this phenomenological study, when participants reflected back on their journey they asserted it was the “best thing” that could have happened. The journey began for these participants with an intervention related to SUD at work, voluntary surrender of their nursing license and entry into treatment. This journey enabled these participants to continue being a nurse while they built and maintained recovery from SUD. This is congruent with findings in the literature (Smith & Hughes, 1996; Monroe, Kenaga, Dietrich, Carter & Cowan, 2013) that nurses report that ADPs are the most important factor in a successful return to work.

The positive impact of participating in an ADP was illustrated by Darbro (2005) who found that participation had a profound influence on nurses. She used a grounded theory

approach to describe, explain and compare the experiences of nurses who were completers and non-completers of an ADP. Whether they completed the ADP or not, these nurses experienced a gateway into the world of recovery. They had the opportunity to reduce the chaos that SUD had precipitated in their lives. They stopped drinking/using, changed dysfunctional thinking and behavior and regained physical and emotional health. Darbro's (2005) findings were reflected in the participants in this phenomenological study. They received unconditional love for the first time, began to like themselves and developed affiliations that helped maintain sobriety.

Theme: Leap of Faith

Participants in this phenomenological study had all reached a point where they had to enter treatment for substance use disorder (in this case an ADP) or risk a complaint being filed against them with the state board of nursing. All three participants were "caught at work". Being caught included intervention from an administrator, placed on suspension for suspicion of diversion of narcotics, and returned home by an employer. Thus, these nurses made a "leap of faith" into a program that changed their lives.

The literature indicates that interventions do contribute to nurses entering treatment for SUD. Freeman-McGuire (2010) reported that interventions can be from colleagues, nurse managers or administrators. They could also be related to legal matters such as arrest for driving under the influence (DUI) or writing prescriptions for controlled substances.

Lillibridge, Cox and Cross (2002), in a phenomenological study that sought to gain insight into the experience of being a nurse with SUD, found that most participants were able to identify a specific event or moment in time when they needed help. Some reached this point alone, and others were confronted by colleagues or family members.

Future Nurses at Risk. All three participants in this phenomenological study began using alcohol and/or drugs at a young age; two of them in their early teen-age years and one in college. One participant also expressed feeling isolated from or, “not part of” her family and one participant indicated she had never received unconditional love in her family. These experiences gave rise to the sub-theme, Nurses at Risk.

The literature is clear that family factors and social factors can interact to place persons at risk for substance use disorder. Family factors such as alcohol and drug use by immediate family members, family dysfunction, lack of positive family routines and trauma such as death or divorce can contribute to the development of substance use disorder. Social factors, such as early age drinking or drug use (18 years or younger) can also be a risk factor for substance use disorder (Darbro & Malliarakis, 2012).

Hidden Pain. Despite the fact that compassion is the “hallmark of the nursing profession” it often does not translate into empathy for the nurse with substance use disorder (Monroe, Pearson & Kenaga, 2008). This statement illustrates the sub-theme for this phenomenological study, Hidden Pain.

One participant in this phenomenological study was clear that stigma played a role in her delay in seeking treatment; another voiced the opinion that a person with SUD should not be a nurse. One participant in this study also felt there was a double standard in place for nurses and physicians with SUD. She commented that physicians have almost a code of silence and their licenses are not as closely scrutinized as those of nurses. This translated into a lack of transparency about sharing a background of SUD:

This subtheme is exemplified in the literature. The stigma that is attached to substance use disorder may be a major inhibiting factor for nurses to seek treatment. Society sees nurses as highly trusted health care professionals and perhaps, as such, immune to the socially frowned upon behaviors associated with substance use disorder. Brewer and Nelms (1998) found that nurses with substance use disorder who had been labeled “impaired”, experienced negative feelings such as anger, inadequacy and a lack of being whole. Nurses had also been denied employment because of the “impaired” label, even if they had been in recovery for a period of years.

Freeman-McGuire (2010) discussed similar findings. Nurses are held to a higher standard than most other health professions, including physicians, and they are more severely judged when they have SUD. Shaw et al (2004) found that, after initial treatment for substance use disorder, nurses received less follow-up care, returned to work sooner, worked longer hours, and experienced more frequent and severe work sanctions than physicians.

Theme: Pain of Surrender

Participants in this phenomenological study expressed the turbulent emotions that arose when they were required to voluntarily surrender their nursing license as they entered the ADP; while this surrender was temporary it still elicited strong emotions.

The student investigator found little literature that specifically addressed feelings and emotions that occur when a nursing license is voluntarily surrendered. One study by Lillibridge, Cox and Cross (2002) discovered that the fear of losing both their livelihood and their identity were major reasons why nurses’ would not acknowledge they had SUD and seek help. Two themes found in the literature allude to the pain of surrender. One theme is the reluctance of

nurses to report colleagues with SUD. The other theme is the “throw-away nurse syndrome”, a term developed by Bissell and Jones (1981) in response to the fact that, historically, nurses who have (or are suspected to have) SUD are terminated from an institution. There is no attempt to assist the nurse in obtaining treatment and the nurse may not be reported to the state board of nursing. Hence, the institution simply “throws away” a nurse who needs help and may have tremendous potential for future contributions to the institution and the profession if they received treatment.

An important resource for nurses with SUD may be their colleagues as they are in a position to intervene with the nurse or report that nurse to a supervisor or board of nursing. Yet, only 37% of nurses who worked with colleagues with suspected (or actual) SUD either intervened or reported that colleague (Beckstead, 2002). The most frequently cited reason for not reporting a colleague is the perception that someone else (a supervisor or administrator) is taking care of the concern. A second frequently cited reason is not wanting to jeopardize a colleague’s job or career (Bettinardi-Angres & Bologeorges, 2011; Kunyk & Austin, 2011). It may be, therefore, that nurses are concerned with contributing to the loss of a colleague’s identity as a nurse or perhaps even stealing that identity if they report a colleague with SUD. This has implications for nursing education in relation to teaching students about professional responsibility. Beckstead (2002) asserts that educational efforts aimed at informing nurses about the success of ADPs may increase the likelihood of colleagues intervening with, or reporting, nurses with SUD. Interestingly, Lillibridge et al (2002) found that nurses with SUD who finally entered treatment were angry at colleagues for not intervening. They felt their “using” behavior had been obvious enough to be identified and had been ignored by colleagues.

The participants in this phenomenological study did not express anger at colleagues for not intervening in their SUD. The focus of the interviews was the actual experience of the ADP rather than antecedents to intervention and entry into that program.

The “throw-away nurse syndrome” is a phenomenon that is woven throughout the literature on nurses with SUD. Nurses who have (or who are suspected to have) SUD are terminated from an institution but may not be reported to the board of nursing. The nurse, therefore, simply moves to another institution, placing patients in jeopardy and becoming more and more ill. Indeed, one participant in this phenomenological study was fired from her place of employment with the caveat she not be rehired. Even when she had completed the ADP, the agency refused to rehire her. So, in addition, to surrendering her identity as a nurse in order to seek treatment, she was “thrown-away”. The synergistic interaction of these two events may have further contributed to the pain of surrendering a nursing license and the loss of identity as a nurse.

Theme: Feelings of Drowning

The participants in this phenomenological study spoke of overwhelming feelings as they entered the ADP and adapted to the multiple requirements of the program. Participants were responsible for soliciting reports from employers, sponsors, and support group facilitators. In addition, they needed to document attendance at Alcoholics Anonymous (AA)/Narcotics Anonymous (NA) meetings and individual counseling and check in daily to see if they had been randomly selected for urine drug screening.

While the literature is sparse in relation to the early experience of nurses in ADP's, Hutchinson (1987) used a grounded theory approach to develop a trajectory of annihilation to

self-integration for nurses in recovery. Through participant-observation of a nurse support group, she found that nurses enter recovery in what she termed “broken pieces of the self”, that is physical, psychological, social, philosophical and spiritual disruption. It may be that the overwhelming, drowning feelings participants in this phenomenological study had are related to those “broken pieces of self”. As the participants in this phenomenological study journeyed through the ADP, those pieces become woven together and they were able to meet the requirements of the program without those drowning feelings.

Another issue related to participants in this phenomenological study may involve perceptions of autonomy and control. In some areas of nursing practice (critical care, for example) nurses develop a sense of autonomy and control over their practice. Early in SUD, these feelings may extend to the use of drugs and/or alcohol; as the disease progresses however, control over the use of substances erodes. Control becomes external; it is assumed by the substance being misused (Dittman, 2008).

Entrance into the ADP represented a situation in this phenomenological study in which external control was imposed upon the participant. The multiple requirements of the program must be met; if not, serious consequences will result. The imposition of those requirements and a perceived loss of autonomy and control by the participants in this study could also have contributed to the experience of feelings of drowning.

Tell Me Why. One participant in this phenomenological study felt that greater clarification of the requirements at the beginning of the ADP would have alleviated some the overwhelming feelings. Her need for more information may be related to Hutchinson’s (1987) process of self-integration. But it may also be related to how adults learn. Adults draw on the

accumulated reservoir of life experiences to aid learning and are ready to learn when they assume new roles (Clapper, 2010). Entering the ADP for the participants in this study may have constituted assumption of a new role, the nurse in recovery. Hence greater information at the beginning of the program may contribute to the internal motivation that drives most adults to learn.

Theme: Structured Sobriety

Participants in this phenomenological study indicated that the structured nature of the ADP assisted them in maintaining sobriety especially during their first year of recovery. The rigor of this program includes random drug screens. Each participant commented on the role of those random drug screens in remaining clean and sober.

The literature supports the feelings of the participants in this study. Darbro and Malliarakis (2012) for example, delineate both risk and protective factors for nurses vulnerable to SUD. Risk factors include family history, workplace access to drugs, and lack of education related to SUD. Protective factors include the structured format of an ADP. Frequent AA/NA meetings, contact with sponsors, therapists, and board of nursing representatives, and random drug screening were all listed as protective factors and are criteria that were part of the ADP in this study. The structure of the program therefore provided protective factors for these nurses.

In contrast, Fogger and McGuiness (2009) found that the controlled aspect of an ADP might actually place the nurse at high risk for relapse after years of a highly structured environment. Participants in Fogger and McGuiness' (2009) study reported they were concerned about being suddenly autonomous in their own recovery and felt a slow gradual return to autonomy would be more beneficial and decrease the risk for relapse.

Theme: Nurse Affiliations

The theme of Nurse Affiliations explicated by participants in this phenomenological study, emphasized the role other nurses played in the participants' successful completion of the ADP. This theme was illustrated through participation in nurse support group that was one of the requirements of the ADP. Two participants in this phenomenological study commented on the important role of the nurse support group. One expressed that, in nurse support group, she received the unconditional love she had never received from her family. The other participant expressed a sense of belonging that she had never experienced with her family.

This theme connects to the literature as Darbro (2005) found that affiliation with other nurses in recovery inspired a sense of connection; nurses felt intense relief that they were not the only ones with SUD and expressed feelings of finally belonging to a group.

One participant in this phenomenological study talked about the importance of nurse support group when returning to work. She stated that nurses in the group were in various stages of recovery and some were employed and some were not; there were helpful discussions about support and frustrations related to employment or the lack thereof. Review of the literature supports this function of nurse support group. Bettinardi-Angres, Pickett and Patrick (2012) for example, found that one focus of nurse support groups is assistance with the process of reentry into the workplace, which includes where to seek employment. Return to an environment similar to the one in which nurses were using mood-altering substances for example may be detrimental to their recovery.

One requirement of the ADP that participants in this phenomenological study had to complete was periodic meetings with a disability advisory committee (DAC). This committee,

overseen by the board of nursing, consisted of nurses who volunteered their time to review reports that nurses in the ADP and their sponsors, employers, and support group facilitators submitted. Participants in this study met with the DAC at least twice a year while they were in the ADP. One participant in this study felt nurses on the disability advisory committee should be in recovery from SUD or even graduates from the ADP. She felt this would provide stronger support and role-modeling for nurses journeying through the ADP. No literature was found that actually discussed any requirements for membership in a disability advisory committee.

This theme, Nurse Affiliations, represents the most crucial component of the ADP and recovery for the participants in this study. It was truly woven throughout their experience. For example, affiliations with nurses preceded the participants' entry into the ADP. One participant contacted a nurse at the state board of nursing for guidance, and two participants experienced interventions from nurse supervisors/employers. All participants commented on the value of participation in nurse support groups, and one participant felt that the option for attendance at nurse support group should be continued once a nurse "graduated" from the ADP. The desire for continuing nurse support groups offers valuable insight into the need for nurses in recovery to affiliate with other nurses. While nurses do have risk factors similar to the general public, there are also risk factors that are specific to nurses. Hence nurses with SUD have different stories than non-nurses with SUD. Sharing these stories with other nurses may contribute to the establishment and maintenance of recovery.

Protecting One Another. The impetus of this subtheme came from two participants who emphasized the lack of knowledge that nurses have about SUD and who felt that knowledge

should be provided to new (or soon to be) graduates and to nurses in the workplace. The need for more information gave rise to the subtheme, Protecting One Another.

One participant emphasized the need for providing new graduates with information related to SUD and the impact that SUD could have on their ability to practice nursing. This participant had volunteered with a school of nursing to present her experience of the journey through an ADP. She stated that, after she told her story, she received several phone calls from students indicating they had received a DUI and wondering how that would impact their ability to become licensed.

While the literature does not specifically speak to new graduate education related to SUD, it does discuss content related to SUD in undergraduate curricula. Hoffman and Heinemann (1987) found that SUD in undergraduate curricula focused on alcohol abuse and care of the patient with SUD. While considered a seminal study, Hoffman and Heinemann (1987) make no mention of content related to nurses with SUD. Savage, Deyhouse and Marcus (2014) looked at content related to alcohol use in baccalaureate curricula. They found that the majority of content was presented in psychiatric/mental health courses and primarily focused on withdrawal and care of the alcoholic patient.

Bettinardi-Angres & Bologeorges (2011) assert that a major barrier to helping a colleague with SUD is lack of knowledge about the disorder. Supervisors and managers who are not knowledgeable may fire a nurse rather than intervene. This, of course, contributes to unsafe patient care, continued illness for the nurse and the “throw-away nurse” syndrome.

The lack of education related to SUD therefore represents a risk factor for both student nurses and nurses in practice. Formal evaluation of nursing curricula likely reveals specific

placement of SUD content accompanied by clinical practica. It may be however, that is not meeting the educational needs of students. Recognition of risk factors, manifestations, and avenues of treatment for patients is only one aspect of meeting educational needs of nursing students. Risk factors, manifestations, and avenues of treatment for nurses is content that needs to be woven throughout nursing curricula on undergraduate and graduate levels.

Implications for Nursing

Understanding the meaning and significance of completing an alternative to discipline program has implications for both nursing practice and nursing education. Implications for nursing practice include provision of a voice for those nurses who complete ADPs, information for state boards of nursing to enhance ADPs for increased success, and creation of a practice culture that supports the professional responsibility of nurses to intervene with colleagues who have SUD. Implications for nursing education include a need for increased curricular content related to SUD in nurses, and the professional responsibilities of faculty and students when recognizing SUD in a colleague or student.

Implications for Nursing Practice

Giving voice. This phenomenological study was of critical importance because it provided a voice for nurses with SUD who had completed an alternative to discipline program through a state board of nursing. Research related to nurses with SUD has focused on gaining insight into the experience of being a nurse with SUD (Lillibridge et al, 2002), stressors experienced by nurses in ADPs (Geiger-Brown & Smith, 2003) and differences between nurses who complete an ADP and those who do not (Darbro, 2005). Little is known about the actual lived experience of completing an ADP. The purpose of a phenomenological approach was to

encourage nurses who completed an ADP to tell the story of their journey. Participants told of a journey, a transformative journey, that began with a leap of faith through entering an ADP, painful surrendering of a nursing license and feelings of drowning in the multitude of requirements dictated by the program. The journey evolved into an appreciation of the structure of the program in keeping these participants clean and sober and the acknowledgement that other nurses facilitated the entire journey.

Contributions to ADPs. State boards of nursing develop alternative to discipline programs to protect the public and to assist the nurse with SUD to receive treatment and remain in nursing. The length, and requirements, of ADPs are structured to offer nurses with SUD the greatest chance of success in completing the program, maintaining recovery and re-entering the workforce. Literature has demonstrated that ADPs have been as successful as disciplinary programs in protecting the public (Monroe et al, 2008) and have been successful in ensuring nurses with SUD receive treatment and remain in practice (Monroe et al, 2008; Monroe et al, 2013). All programs benefit from input by participants however and ADPs are no exception. One participant in this study, for example, felt that more information related to the “whys” of the requirements would have been helpful at the beginning of the program. She wanted to know why attendance at NA/AA was important and why attendance at a nurse support group would be beneficial. She said she understood all of that eventually but would have liked more information at the beginning of the program. Her need to have more information at the beginning of the ADP is characteristic of adult learners. Adult learners are generally self-directed, internally motivated and build on life experiences (Clapper, 2010). Delineation of the rationale for the requirements of the ADP at the beginning of the program may contribute to self-direction and motivation; as

the requirements of the ADP become life experiences, those may be internalized and assist the participant in recovery.

This same participant also suggested that persons on the disability advisory committee (DAC) be in recovery and perhaps, graduates of the ADP. The DAC, a standing advisory committee of the state board of nursing, evaluates nurses for SUD and monitors nurses as they journey through the ADP. It is composed of nurses who may or may not be in recovery. While the participant in this study recognized these were nurses who wanted to help other nurses, it was her assertion that nurses in recovery (and/or graduates of the ADP) would have a more “emic” view of the process of recovery and the journey through the ADP. This “emic” view may contribute to greater support of the nurse in the ADP.

The purpose of the state board of nursing is to protect the public and one way it does so is to remove nurses with SUD from practice until they have received treatment and entered recovery. One participant stated, “...I understood it was to guard against me being impaired while nursing” (Carolyn) and all of the participants respected the ADP and its contributions to their recovery. The changes suggested would contribute to greater understanding of the requirements, perhaps lessen the overwhelming feelings participants experienced at the beginning of the program, and create a relationship with other nurses in recovery.

Culture of supportive practice. All the participants in this study received an intervention at work related to SUD. One was placed on suspension for suspicion for diversion, one was escorted home by her employer, and one was confronted by her administrator. This was actually a significant turning point in each participant’s life. These actions by institution, employer, and administrator protected patients and may indeed have saved these nurses’ lives.

These interventions are unusual as it is estimated that only 37% of nurses will intervene with, or report, colleagues suspected to have SUD (Beckstead, 2002; Monroe & Kenaga, 2010). Reasons for not intervening include fear of jeopardizing a colleague's job, perception that the colleague will face punitive measures (such as being fired or having their license revoked), and lack of knowledge related to SUD.

Nurses are ethically bound, however, to intervene with, or report a colleague who is suspected of impaired practice related to SUD (or other causes). The American Nurses' Association (ANA) code of ethics specifically states, "The nurse's primary commitment is to the health, well-being and safety of the patient" and, in order to protect the patient, a nurse must address suspicions of SUD with a colleague and with supervisors and/or state professional organizations.

Reasons cited for not intervening with colleagues include fear of jeopardizing a job and the perception that the nurse will face punitive measures from the institution and/or board of nursing. Indeed, one participant not only lost employment, but was essentially "thrown-away" by the institution when they refused to re-hire her after she completed the ADP. More knowledge related to treatment options for nurses with SUD and policies that address re-entry into the work-force may create a supportive practice environment in which nurses can intervene with colleagues and meet their professional responsibility to patients. Grover and Floyd (1998) found that staff nurses were unaware of, or confused about, responsibilities, policies and the role of ADPs. Godfrey et al (2010) determined there was a reluctance to hire nurses who were in an ADP in some institutions, especially if there were restrictions (for example, unable to give narcotics) on the nurse's license. Dissemination of information about ADPs through state board

of nursing, state professional organization, and specialty organization publications may increase knowledge about ADPs and their role in protecting patients and advocating for nurses through treatment. The DAC, and other state board of nursing members, could participate in workshops that explicate ADP's roles, responsibilities and policies.

Another reason for not intervening with, or reporting colleagues with SUD is nurses' lack of knowledge of SUD. This lack of knowledge includes risk factors, especially those specific to nurses, manifestations of SUD and recognition of relapse. The lack of knowledge related to SUD needs to be addressed at multiple levels. It needs to be addressed in educational settings and the next section will address that. It also needs to be addressed in practice settings; it is in practice settings that the nurse with SUD can obtain substances for misuse and put the patient at risk. Education in the practice setting involves both staff nurses and administrators. Staff nurses need information about SUD but they also need to learn strong, clear communication skills so they are able to intervene with a colleague. Strong communication skills involve concern ("I want good things for you", curiosity ("Something's different about you") and clarity ("Your behaviors are noticeable") (Crowley & Morgan, 2014, p. 169). It may benefit an institution to have a substance use disorder committee in place. Composed of nurse advocates, and persons with recovery experience they can serve as guides for intervening with nurses, and as a resource for the nurse who has experienced an intervention and must now address their SUD.

The lack of knowledge about SUD is also related to the stigma nurses with SUD experience. Recovering nurses often experience a great deal of shame and guilt and the support of colleagues as they re-enter the workplace has been perceived as an important factor in successful re-entry (Beckstead, 2002). Educational in-services that address the requirements of

an ADP such as random drug testing and conditional licensure (inability to administer narcotics) may help staff nurses support colleagues when they must leave for drug testing or ask another nurse to administer narcotics. Establishment of peer support groups within the institution (or even an AA/NA meeting if anonymity can be maintained) may also increase the understanding by colleagues of the needs of the nurse in recovery from SUD. Nurse managers and administrators also need education related to SUD and ADPs. They will be supervising nurses as they re-enter the workplace.

Implications for nursing education

Implications for nursing education include the need for increased curricular content related to SUD in nurses, and recognition of the professional responsibilities of faculty and students when suspecting SUD in a colleague or student.

Participants in this study did not discuss content related to SUD in nursing school but felt strongly that this content needed to be addressed.

Content related to SUD in nursing education has historically focused on the patient with SUD and has been confined to psychiatric-mental health didactic and clinical courses (Pullen & Green, 1994; Savage et al, 2014). Hence, nurses have not been provided the skills to recognize SUD in other nurses, or become aware of risk factors for SUD in themselves.

Substance use disorder content needs to be threaded throughout all levels of a nursing curriculum. In an undergraduate program, for example, SUD may be introduced the first semester along with risks for nurses. This content could provide a foundation for further discussion as students' progress through the curriculum.

There are two areas of content that pertain to nurses with SUD that need to be incorporated into nursing curricula. These include risk factors specific to nurses and manifestations of SUD in nurses. General risk factors, such as family history, are often incorporated in discussions related to SUD in patients. Risk factors for nurses that need to be addressed include easy access to controlled substances, attitudes of nurses toward the use of controlled substances (a means of coping with stress, pharmacologic optimism, a means to continue working in spite of physical pain or emotional distress, feelings of invulnerability related to SUD, and self-diagnosis and self-medication), and a stressful work environment. Students need to be able to recognize these risk factors for both colleagues and themselves. Prevention of SUD also needs to be addressed in relation to risk factors. Classes that teach coping mechanisms to deal with the stress of nursing school (and practice), and the stress of coordinating family, employment and other obligations with school and practice can be integrated into the curriculum.

Manifestations of SUD in nurses also need to be addressed in nursing education. While some manifestations of SUD in are the same as the general public, some are unique to nurses. Certainly, changes in pupils, mood swings, and slurred speech are indicative of SUD across all populations. Manifestations that are specific to nurses are related to the access to controlled substances and include spending excessive time around the drug dispensing system, reports by patients of lack of pain relief, and coming into work on days off. Students also need to learn how to intervene with colleagues who may have SUD and they need to practice those interventions. Savage et al (2014) found that many baccalaureate nursing curricula did not provide students with the knowledge and skills necessary to intervene with colleagues with SUD.

Content related to risk factors for, and manifestations of, SUD in nurses needs to be linked with the nurses' professional responsibility to protect the patients for whom they care. Students must become aware, and integrate the knowledge of, the damage that could be done if patient care is impacted by behaviors related to SUD, especially if they attend clinical while impaired. When impaired, decisions related to patient care may be erroneous and cause injury or death to a patient. One participant in this phenomenological study, who volunteers to tell her story to students, reflected the lack of understanding students have about the link between behaviors caused by SUD and professional responsibility:

Pedagogical approaches to SUD are also important to address as content is introduced in the curriculum. Inviting nurses who have been through ADPs to talk about their journey may resonate with students more strongly than simply reciting risk factors and manifestations. Students could also be required to attend 12-step meetings such as AA or NA. They could attend a specified number of meetings then write a paper about some aspect of the 12-step program. Faculty may have them address Step One, for example, "We admitted we were powerless over alcohol-that our lives had become unmanageable" (Alcoholics Anonymous, 2001). Students may not be powerless over alcohol but there are other things in their lives they may feel powerless about and thinking about this may give them greater insight into SUD.

It is also incumbent upon faculty to ensure nursing students understand their professional responsibility to patients in accordance with the ANA code of ethics. The code of ethics must be an integral part of both didactic and clinical courses. Faculty also have a professional responsibility to recognize SUD in colleagues and students. Nursing faculty may not provide direct care to patients but they may be supervising students in that care; a faculty member with

SUD places the patient at risk and places the student at risk. A student who makes a mistake that causes a sentinel event, because faculty were impaired may be expelled from nursing school and lose the career they are striving toward. Ongoing faculty development that addresses SUD, especially in relation to risk factors and manifestations, enable faculty to continue to weave content throughout the curriculum, ensure nursing students understand professional responsibilities to patients, and maintain awareness of the risk of SUD in themselves, colleagues and students.

Students are not licensed yet they too can compromise patient care if they have SUD and attend clinical while impaired. Students are not eligible for state board of nursing ADPs because they are not licensed, but schools of nursing must have clear policies and procedures in place that determine courses of action for withdrawal from the program, treatment and re-entry into the program for students with SUD.

Limitations

Within the limits of this study, the intent of describing, interpreting, and gaining a deeper understanding of nurses with SUD who complete an ADP through a state board of nursing was achieved. Limitations to this study include geographical area, recruitment challenges, and lack of diversity. This study was completed in one geographical area so can only speak to the experiences of nurses who completed an ADP in that geographical area. The structure of ADPs differs from state to state. The program in this study, for example, required a 5 year monitoring contract for participants; other states require a 2-3 year contract. The program in this study had oversight by the state board of nursing. In other states the board of nursing contracts with outside agencies to oversee the ADP.

Recruitment challenges were encountered in this study. Once approved by UNLV IRB, a list of all nurses in the state where the study was being conducted was obtained from the state board of nursing. An initial recruitment flyer, that described the study and provided contact information for the student investigator, was sent via U. S. Postal Services to 4000 names randomly chosen from a list of approximately 30,000 nurses. This flyer was misunderstood by multiple nurses who expressed concern that they were being targeted for discipline by the state board of nursing. The flyer was modified; this modified flyer was approved by UNLV IRB. These flyers were sent via U.S. Postal Services, in batches of 4000, to the remainder of names on the list received from the state board of nursing. A total of 21,878 flyers were sent.

A lack of understanding remained even with the modified flyer. The student investigator was contacted by nurses who had been disciplined by the board of nursing for practice related issues, nurses who were still in the process of completing the ADP, and one nurse who believed the ADP referred to associate degree education even though ADP had been described as an alternative to discipline program (ADP) in the recruitment flyer. Recruitment may have also been impacted by feelings nurses who completed the ADP had toward that program. If nurses felt their journey through the ADP had been exceptionally negative they may not wish to re-visit the experience. Even if nurses did not perceive the journey as especially negative, they may feel that chapter in their lives was closed and not wish to re-open it.

There was also a lack of diversity in this study in relation to ethnic, gender, and educational diversity. The profession of nursing consists predominantly of white women and this was reflected in this study; 100% of the participants were white women. Approximately 12% of nurses are ethnically diverse, however statistics were not found as to what percentage of

participants in ADPs identify themselves as ethnically diverse. Greater ethnic diversity in this research would have expanded the understanding of the experience of nurses in ADPs. Men represent 6-9% of nurses in the US, however they represent between 21-36% participants in ADPs. They may experience ADPs in very different ways than women and their stories would contribute to knowledge of that experience. Two of the participants in this research held associated degrees in nursing and one held a master's degree in nursing. There was no representation from nurses prepared at the baccalaureate or doctoral level, nor was there representation from advanced practice nurses.

The student investigator is a very novice researcher. The student sought to overcome this limitation by working closely with the chair and qualitative expert on the committee throughout recruitment, data collection, and data analysis.

Recommendations for Further Research

Recommendations are made with the view of strengthening nursing knowledge related to nurses who complete an ADP and how that might impact practice and research. Further research may address these areas: 1) continued exploration of the lived experience of nurses in SUD programs overseen by state boards of nursing, 2) national research that addresses the structure and success of ADPs, and 3) curricular approaches to the development of content related to nurses with SUD.

This study addressed the lived experience of nurses with SUD who completed an ADP through a state board of nursing. All the participants in this study were female; further research could explicate the experience of men in nursing who completed an ADP. While men represent between 6-9% of nurses in the U.S., they represent a proportionately higher percentage of

participants in ADPs (McNelis et al, 2012). Literature that addresses the rationale for this disproportionate representation hypothesizes stigmatization of men in nursing, and cultural socialization that makes it difficult for men to express emotions related to phenomena such as poor patient outcomes (Dittman, 2008). Stories of these men may be different than those of women in ADPs and could contribute to the knowledge of the lived experience of nurses in ADPs.

Requirements for ADPs are not uniform across states. The length of time a nurse must be monitored, for example, can range from 3-5 years. Literature attests to the success of ADPs in protecting patients, advocating for treatment for nurses, and returning nurses to employment (Beckstead, 2002), but data related to the rate of success in individual states is difficult to find. Further research could delineate specific requirements, and the success, of ADPs in each state. In addition, other countries have begun to look at ADPs in the U.S. as exemplars to address SUD in nurses (Lillibridge et al, 2002). Research that addresses how other countries have adapted ADPs and the success of those adaptations would continue to build the science related to the efficacy of ADPs in protecting patients and advocating for nurses.

Approaches that could prepare nurses in practice to intervene with colleagues were addressed and include information dissemination through DAC committees and state and professional organizations. Further research might determine the efficacy of online continuing education that provides knowledge and skills to prepare nurses to recognize and intervene with colleagues with SUD.

Nursing education may have a pivotal role in addressing SUD in nurses. While nursing curricula incorporate content related to SUD this frequently focuses on the patient with SUD and

is centered in psychiatric mental health courses. Content is needed that is integrated into the entire curriculum and, in addition to addressing the patient with SUD, provides information about identifying and intervening with nurses with SUD.

Chapter Summary

This chapter presented a discussion and interpretation of the phenomenological inquiry into the experience of nurses with substance use disorder who completed an alternative to discipline program. Five themes were explicated from the data. These themes were Leap of Faith, Painful Surrender, Feelings of Drowning, Structured Sobriety and Nurse Affiliations. These themes contributed to the essence, or description of, completing an ADP which was - *A Transformative Journey*. Four subthemes were also explicated. Two subthemes related to the theme Leap of Faith and included Hidden Pain and Future Nurses at Risk. One subtheme related to Feelings of Drowning was Tell Me Why, and one subtheme was associated with Nurse Affiliations; this subtheme was Protecting One Another.

Nursing implications derived from this study addressed both practice and education. Implications for practice included giving a voice to nurses who complete an ADP, suggestions for providing more information at the beginning of the ADP, and development of a culture of practice that supports intervention with, or reporting of colleagues with ADP. Implications for nursing education include inclusion of content related to SUD in courses across the curriculum. Implications for both nursing practice and education include recognition of the ethical responsibility of intervening with colleagues with SUD to prevent unsafe practice.

Conclusions

Three participants voluntarily participated in this research. The findings from this research resulted in five themes and four subthemes that contribute to a thick description of the phenomenon. Findings were validated through participant review and provided a structure for the journey experienced by these nurses who completed an ADP. Understanding the meaning of completing an ADP to these participants has implications for nursing practice and nursing education.

APPENDIX A

REVIEW OF LITERATURE RELATED TO SUBSTANCE USE DISORDER

Reference	Description of Study	Results/Conclusions
<u>Substance use disorder</u>		
U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, 2010	Results from the 2010 National Survey on drug use and health.	Cites statistics related to alcohol and drug use among varied age groups and populations in the U. S.
<u>Theories</u>		
Naegle, 1988	Discussion article related to various theoretical models of substance use disorder.	Theories of abuse are categorized into person and family models, environmental models, and multiple interacting factors.
Miller, 2000	Discussion article related to mechanisms of action of addictive stimuli	Theorizes addictive drugs trigger symptoms and cravings and persons continue to use to avoid unpleasant withdrawal symptoms.
West, 2001	Literature review related to theories of addiction.	Groups theories of addiction into five categories: those that attempt to provide insight into the conceptualization of addiction, those that explain why particular stimuli become a focus for addiction, those that explain certain individuals are more susceptible, those that explore environmental and social conditions, and those that focus on recovery and relapse.
Bettinardi-Angres & Angres, 2010	Discussion article related to neural pathways that predispose a person to substance use disorder.	Discusses the biological mechanisms that underlie substance use disorder and theorizes that genetic predisposition alone does not cause SUD; psychological and social influences contribute to the process.
<u>Stigma and substance use disorder</u>		
Storti, 2002	Phenomenological study looking at stigma in women with SUD.	Eleven women interviewed. Colaizzi's steps of analysis derived six themes: 1) living with an ever-present foe, 2) keeping the secret, 3) a spiritual journey, 4) we are ordinary women, 5) redefining self, 6) challenging stereotypes
<u>Women and substance use disorder</u>		
Zilberman, Tavares, Blume & el-Guebaly, 2002	Review of research related to the impact of gender differences in substance use disorder.	Discusses gender differences in relation to screening for SUD, physiological effects, medical

Reference	Description of Study	Results/Conclusions
		consequences, psychiatric comorbidity, and family and developmental issues. Also delineates implications of future research.
Kandall, 2010	Historical perspective on women with substance use disorder.	Traces the history of substance use disorder in American women from the mid-nineteenth century forward.
Kay, Taylor, Barthwell, Wichelecki & Leopold, 2010	Literature review related to substance use and women's health.	Reviews literature that indicates women develop physical consequences earlier than men who have substance use disorder.
<u>SUD in Health Care Professionals</u>		
Monahan, 2003	Review that outlines the epidemiology of substance use/abuse among health care professionals.	Overview of risk factors (family history, workplace stress, access to drugs, and lack of education).
Kenna & Wood, 2004	Correlational and comparative study that investigated alcohol use, misuse and abuse in dentists, nurses, pharmacists and physicians.	Surveys were mailed to health care professionals (n=479, 68.7% response). Dentists had significantly greater average monthly alcohol use ($F(3,299) = 3.36, p < 0.05$) and heavy episodic drinking ($F(3,299) = 2.70, p < 0.05$) than nurses, pharmacists or physicians.
Shaw, McGovern, Angres & Rawal, 2004	Exploratory study that compared substance use disorders in physicians and nurses.	Surveys were mailed to 195 participants in a treatment program between 1995 and 1997; the 73 physicians and 17 nurses addressed in this study were a sub-sample of the 105 participants. Statistically significant differences were found between physicians and nurses related to primary treatment (nurses received less), personality disturbance (nurses had less prior to treatment), and sanctions (nurses had more frequent and more severe work-related sanctions).
<u>SUD in Nurses</u>		
Hutchinson, 1987	Grounded theory study that explored and described the process of recovery for nurses with SUD.	Participant-observation of a nurse support group and interviews with 20 nurses with SUD proposed the recovery process moves from self-annihilation through several stages to self-integration.
Brewer & Nelms, 1998	Phenomenological study that investigated the experiences of	A purposive sample of 14 nurses participated. Data were analyzed

Reference	Description of Study	Results/Conclusions
	nurses in recovery and labeled “impaired”.	using van Manen. Five themes were derived: 1) living with a negative label, 2) denial of employment because of being labeled impaired, 3) recovery as a way-of-life, 4) recovering as an identity, 5) willingness to share one’s recovery with professional peers
Grover & Floyd, 1998	Survey research that sought to determine nurses attitudes toward colleagues with SUD and knowledge of ADPs	Questionnaire measuring knowledge and attitudes was mailed to 400 RNs and 142 LPNs; 142 were returned. Majority of nurses would not confront a peer with SUD and there was a lack of knowledge of when and how to intervene if SUD was associated with a nurse’s practice. Respondents also had a lack of knowledge of ADPs.
Trinkoff & Storr, 1998a	Survey research (balanced stratified sample) the explored the association between work schedule and past-year substance use in nurses.	Surveys mailed to 4438 nurses with a response rate of 78%. Modest association was found in work schedule and substance use. Nurses working night shift > 8 hours had highest alcohol use and smoking. Nurses working rotating shifts > 8 hours had higher alcohol use. None met the criteria for SUD.
Trinkoff & Storr, 1998b	Survey research (balanced stratified sample) that explored the association between nursing specialty and past-year substance use.	Surveys were mailed to 4438 nurses to elicit use of alcohol, marijuana, cocaine and prescription-type drugs. Prevalence of use of all substances was 32%. When compared to nurses in women’s health, general practice and pediatrics, ED nurses were 3.5 time mores likely to use marijuana or cocaine, oncology and administration nurses were twice as likely to engage in binge drinking, and psychiatric nurses were more likely to smoke. No specialty differences for prescription-type drug use. None met the criteria for SUD
Trinkoff, Storr & Wall, 1999	Survey research (balanced stratified sampling) that looked at perceived availability of prescription drugs,	Surveys were mailed to 4438 nurses with a 78% response rate. Nurses with easy access were more likely

Reference	Description of Study	Results/Conclusions
	frequency of administration, degree of work-place control over storage and dispensing of drugs.	to have misused prescription-type drugs. Level of knowledge was also associated with use but did not explain relation between access and use.
Fletcher, 2001		
Lillibridge, Cox, & Cross, 2002	Phenomenological study aimed at gaining insight into the experience of being a nurses with SUD.	Twelve nurses who had experienced SUD participated. Five major themes were identified: 1) nurses' justification for using substances, 2) fear surrounding being discovered, 3) personal meaning for nurses, 4) professional impact, 5) turning point in their road to recovery
West, 2002	Descriptive correlational and comparative study that investigates early risk factors for substance use disorder and predict differences between nurses with and without SUD. Used Roger's human science and Donovan's multifactorial model of impairment.	Surveys were mailed to a convenience sample of nurses with SUD in recovery (n=100; response rate 54%) and nurses without SUD (n=100; response rate 61%) throughout the US. Statistical significance was obtained among the relationship between sensation-seeking behaviors and early risk factors of SUD and early risk factors and parental drug or alcohol history. The three risk factors significantly predicted presence or absence of substance use disorder.
Heise, 2003	Review of literature related to the history of substance use disorder in nursing.	Traces the history and social context of substance use disorder in the nursing profession from 1850-1982.
Dunn, 2005	Review of literature related to substance use disorder in nurses.	Explicates prevalence of SUD in nurses, manifestations, code of silence among nurses, board of nursing jurisdiction.
Freeman-McGuire, 2010	Mixed methods research that examined barriers to treatment, seeking treatment, and potential for long-term recovery in nurses.	Concepts associated with barriers to treatment were feelings, risk factors, addiction education, and stigma. For treatment motivation, there were intervention options, self-appraisal and support potential. Maintenance of long-term recovery concepts were self-growth, helping others, and spiritual awakenings.
National Council of State Boards of Nursing, 2011	Resource manual	Discusses risk factors specific to nurses, types of disciplinary and

Reference	Description of Study	Results/Conclusions
		alternative to discipline programs for nurses.
Darbro & Malliarakis, 2012	Analysis of specific risk factors that affect nurses and delineation of protective factors for nurses.	Risk factors specific to nurses include specialty, gender, and workplace. Protective factors include the structure of an ADP.
<u>Nursing Education</u>		
Hoffman & Heineman, 1987	Survey of schools of nursing in the US to ascertain SUD education in undergraduate programs.	1035 surveys were mailed with a response rate of 36% (332 schools). Substance use in curricula primarily centered on alcohol and drug problems in patient populations.
Pullen & Green, 1997	Expository article that outlines a curriculum and resources to address learning needs of nurses related to SUD.	Outline performance cues for SUD and continuing education outlined for SUD.
Savage, Dyehouse & Marcus, 2014	A descriptive study of schools that offered the BSN to determine alcohol related content in the curriculum. Data were obtained through online surveys.	66 schools responded; mean number of hours of alcohol-related content was 11.3 (SD = 8.3). The majority of content was presented in psychiatric/mental health nursing courses (Mean 4.9 hours, SD = 5.03). The major focus was treatment of the patient rather than screening and prevention.
<u>Monitoring Programs</u>		
Haack & Yokum, 2002	Longitudinal comparative study that sought to investigate to effects of two state regulatory policies on nurses with SUD	Six data collection points in 6 months. Compared 100 nurses and LPNs who had disciplinary actions against their license with 119 nurses and LPNs in ADPs. ADPs had more nurses with active licenses, fewer criminal convictions, and more nurses employed in nursing. No difference in relapse rates was found.
Brown & Smith, 2003	Cross-sectional survey that sought to determine types of stressors that nurse's experience during participation in ADPs.	622 nurses in ADPs anonymously surveyed. Three-fourths reported a lower burden of problems after enrolling in ADP. Most common problems in recovery were financial, eating/appetite/weight, depression, fatigue and tension.

Reference	Description of Study	Results/Conclusions
Darbro, 2005	Qualitative study that sought to describe, explain and compare nurses who were completers and non-completers of an alternative to discipline program.	Sixteen nurses who had participated in an ADP were interviewed; fourteen completed the second interview. Common issues for the nurses were medical conditions and dual diagnosis. Most worked in critical care, noted stressful work conditions, and diverted medications. Completers were highly motivated to retain their nursing licenses, and strongly affiliated with other recovering nurses. Non-completers were considering getting out of nursing and did not feel affiliated with other nurses in recovery.
Clark & Farnsworth, 2006	A descriptive study of characteristics of 207 nurses enrolled in an ADP in Idaho.	Data were obtained via retrospective review of 207 RNs and LPNs enrolled in the program between 1985 and 2000. Data obtained included demographics, referral and employment information, history of SUD, and treatment and monitoring experience in an ADP.
Monroe, Pearson & Kenaga, 2008	Literature review comparing disciplinary and ADP approaches to nurses with SUD.	More research is needed related to best practice in order to help retain valuable healthcare professionals.
Darbro, 2009	Literature review that compares issues related to monitoring and coercion between drug courts and ADPs.	Research has demonstrated effectiveness of drug courts and ADPs. Research is lacking on the impact of formal coercion, influenced of perceived coercion, and outcome of nurses entering and participating in ADPs.
Fogger & McGuiness, 2009	Mixed methods approaches to determine nurses' experience of being monitored.	Nurses actively involved in a monitoring program (N=173) completed surveys. Participants reported that the monitoring process was cumbersome yet the structure assisted nurses to remain in recovery.
Bettinardi-Angres, Pickett, & Patrick, 2012	Expository article that addresses how disciplinary and alternative to discipline programs.	A discussion of how complaints against nurses related to SUD are handled by boards of nursing and the availability, eligibility, benefits and challenges of ADPs.
Bowen, Taylor, Marcus-Alyeku, & Krause-Parello, 2012	Descriptive correlational study that sought to examine stress, coping	82 participants completed the Perceived Stress Scale, Multidimensional Scale of

Reference	Description of Study	Results/Conclusions
	and adaptation of nurses in an ADP.	Perceived Social Support and Psychological Well-Being Index. Negative relationships were found between stress and social support and stress and well-being. A positive relationship was found between social support and well-being (all $P < .05$).
<u>Re-entry into Practice</u>		
Hughes, Smith & Howard, 1998	Survey research that addressed components of re-entry into practice for nurses participating in an ADP.	Return-to-Work questionnaire was mailed to 681 participants in an ADP. 364 usable surveys were returned. The majority of nurses who participated in the ADP were 30-50 years of age, some were RNs and some were LPNs. Men accounted for 23% of study respondents although they represent 4% of nurses in the studied state. Nurses felt support of colleagues and supervisors was paramount in successful re-entry into practice following treatment for SUD.

APPENDIX B

IRB APPROVAL



Biomedical IRB – Exempt Review Deemed Exempt

DATE: January 21, 2015

TO: Dr. Lori Candela, School of Nursing

FROM: Office of Research Integrity – Human Subjects

RE: Notification of IRB Action
Protocol Title: The Lived Experience of Registered Nurses with Substance Use Disorder Who Complete an Alternative to Discipline Program through a State Board of Nursing
Protocol # 1501-5051M

This memorandum is notification that the project referenced above has been reviewed as indicated in Federal regulatory statutes 45CFR46 and deemed exempt under 45 CFR 46.101(b)2.

PLEASE NOTE:

Upon Approval, the research team is responsible for conducting the research as stated in the exempt application reviewed by the ORI – HS and/or the IRB which shall include using the most recently submitted Informed Consent/Assent Forms (Information Sheet) and recruitment materials. The official versions of these forms are indicated by footer which contains the date exempted.

Any changes to the application may cause this project to require a different level of IRB review. Should any changes need to be made, please submit a **Modification Form**. When the above-referenced project has been completed, please submit a **Continuing Review/Progress Completion report** to notify ORI – HS of its closure.

If you have questions or require any assistance, please contact the Office of Research Integrity - Human Subjects at IRB@unlv.edu or call 702-895-2794.

Office of Research Integrity – Human Subjects
4505 Maryland Parkway • Box 451047 • Las Vegas, Nevada 89154-1047
(702) 895-2794 • FAX: (702) 895-0805 • IRB@unlv.edu

APPENDIX C

ORIGINAL RECRUITMENT FLYER

RECRUITMENT FLYER

NURSES WANTED FOR RESEARCH STUDY

My name is Susan Ervin and I am nursing faculty at UNR and a doctoral student at the University of Nevada, Las Vegas where I am conducting a research study titled: *The Lived Experience of RNs who have completed an Alternative to Discipline Program through a State Board of Nursing.*

Do you have time to tell your story about your experience in the 5 year alternative to discipline program? I believe this study will give voice to nurses who were in this program and create greater understanding of the experience.

Inclusion criteria include: an RN who has completed the alternative program within 10 years, active RN license, employed in nursing at least part-time



Participants will have to agree to a face to face, audiotaped interview, to be conducted in a private location that is convenient for you.

A follow-up meeting will be used to clarify any errors of the verbatim transcription, misinterpretations of the researcher regarding themes, and allow participants an opportunity to add any additional thoughts you may have had about your lived experiences.

Total time approximately 2 hours

I hope you will consider being part of this research. If you would like to participate or have additional questions, please contact me at

rnresearch577@gmail.com- email

775-843-0603-phone

Lori Candela, Faculty Chair 702-895-2443



APPENDIX D

MODIFIED RECRUITMENT FLYER

RECRUITMENT FLYER

NURSES WANTED FOR RESEARCH STUDY

Please note: The researchers have no knowledge of which nurses have completed the Alternative to Discipline program (ADP). That information is strictly confidential to the State Board of Nursing (SBON). However, the SBON does provide a publically available mailing list of all actively licensed RNs in the state that can be purchased. Since we have no knowledge of which nurses in the state may have completed an ADP, we are sending this flyer to 4000 registered nurses from a randomized list of all RNs in the state with an active license. If you are an RN who has completed the ADP and are interested in finding out more about the study, please read on. Otherwise, kindly disregard this flyer.

My name is Susan Ervin and I am nursing faculty at UNR and a doctoral student at the University of Nevada, Las Vegas where I am conducting a research study titled: *The Lived Experience of RNs with who have completed an Alternative to Discipline Program through a State Board of Nursing.*

Do you have time to tell your story about your experience in the 5 year alternative to discipline program? I believe this study will give voice to nurses who were in this program and create greater understanding of the experience.

Inclusion criteria include: an RN who has completed the alternative program within 15 years, active RN license, employed in nursing at least part-time.



Participants will have to agree to a face to face, audiotaped interview, to be conducted in a private location that is convenient for you.

A follow-up meeting will be used to clarify any errors of the verbatim transcription, misinterpretations of the researcher regarding themes, and allow participants an opportunity to add any additional thoughts you may have had about your lived experiences.

Total time approximately 2 hours

I hope you will consider being part of this research. If you would like to participate or have additional questions, please contact me at

rnresearch577@gmail.com- email

775-843-0603-phone

Lori Candela, Faculty Chair 702-895-2443



APPENDIX E

INFORMED CONSENT



INFORMED CONSENT

Department of Nursing

TITLE OF STUDY: The Lived Experience of Registered Nurses with Substance Use Disorder who complete an Alternative to Discipline Program through a State Board of Nursing

INVESTIGATOR(S): Dr. Lori Candela, EdD, RN, APRN, FNP-BC, CNE

Student Investigator: Susan Ervin, MS, RN, CNE

For questions or concerns about the study, you may contact Dr. Lori Candela at 702-895-2443 or Susan Ervin at 775-843-0603.

For questions regarding the rights of research subjects, any complaints or comments regarding the manner in which the study is being conducted, contact the UNLV Office of Research Integrity – Human Subjects at 702-895-2794, toll free at 877-895-2794 or via email at IRB@unlv.edu.

Purpose of the Study

You are invited to participate in a research study. The purpose of this study is to describe, interpret, and gain a deeper understanding of experience of registered nurses who completed an alternative to discipline program through a state board of nursing.

Participants

You are being asked to participate in the study because you fit these criteria: you completed an Alternative to Discipline program through the State Board of Nursing in the last 15 years; you are currently licensed as a registered nurse, and you are currently employed in nursing at least 50% part-time. Participants who are currently in an Alternative to Discipline program or a disciplinary program (or completed the disciplinary program), do not have an active RN license and/or are not employed in nursing will be excluded from this study.

Procedures

If you volunteer to participate in this study, you will be asked to do the following: Participants will agree to a face to face interview that will be audio-taped. In addition, participants will agree to a follow-up interview which will be used to clarify any errors of the verbatim transcription, misinterpretation of the researcher regarding themes and allow participants an opportunity to add any additional thoughts they may have had about their lived experiences. Participation is completely voluntary and confidential. Each interview will last approximately 60 minutes and will be held at a private location that is convenient for you. Following the interview, the audiotapes will be transcribed and you will be contacted again to verify the accuracy of the transcripts and for any follow-up questions I may have. The time estimated for any follow-up is approximately 1 hour.

*Deemed exempt by the ORI-HS and/or the UNLV IRB. Protocol #1501-5051M
Exempt Date: 01-21-15*

Page 1 of 2

TITLE OF STUDY: The Lived Experience of Registered Nurses with Substance Use Disorder who complete an Alternative to Discipline Program through a State Board of Nursing

Benefits of Participation

There may not be direct benefits to you as a participant in this study. However, I hope to learn more about your experience in an alternative to discipline program. The interviews also allow the participant to self-reflect upon the alternative to discipline program and give voice to that experience. The data collected will enhance the experience of future nurses who participate in the alternative to discipline program. Data may contribute to changes that promote programs that focus on strengthening recovery skills for nurses with substance use disorder.

Risks of Participation

There are risks involved in all research studies. This study includes only minimal risks. There may be some discomfort related to discussing experiences you had while in an alternative to discipline program and feelings associated with that experience. There is the assurance that participants may choose not to answer any question they do not wish to and/or withdraw from the study at any time without penalty. There is no risk for declining participation.

Cost /Compensation

There will not be a financial cost to you to participate in this study. The study will take approximately 2 hours of your time. You will not be compensated for your time

Confidentiality

All information gathered in this study will be kept as confidential as possible. No reference will be made in written or oral materials that could link you to this study. All records will be stored in a locked facility in the office of the principal investigator at UNLV for 3 years after completion of the study. After the storage time the information gathered will be shredded.

Voluntary Participation

Your participation in this study is voluntary. You may refuse to participate in this study or in any part of this study. You may withdraw at any time without prejudice to your relations with UNLV. You are encouraged to ask questions about this study at the beginning or any time during the research study.

Participant Consent:

I have read the above information and agree to participate in this study. I have been able to ask questions about the research study. I am at least 18 years of age. A copy of this form has been given to me.

APPENDIX F

CONFIDENTIALITY AGREEMENT



Transcriber's Confidentiality Agreement

TITLE OF STUDY: The Lived Experience of Registered Nurses with Substance Use Disorder who complete an Alternative to Discipline Program through a State Board of Nursing


PRINCIPAL INVESTIGATOR: Lori Candela

CONTACT PHONE NUMBER: 702-895-2443

As a transcribing typist of this research study, I understand that I will be hearing tapes of confidential interviews. The information on these tapes has been revealed by research participants who participated in this project on good faith that their interviews would remain strictly confidential. I understand that I have a responsibility to honor this confidentiality agreement.

I hereby agree not to share any information on these tapes with anyone except the principal investigator of this project. Any violation of this agreement would constitute a serious breach of ethical standards, and I pledge not to do so.

This acknowledgement is governed by HIPAA as well as other applicable federal, state, university and local laws, rules and regulations.


Signature of Transcribing Typist

1/12/15
Date

APPENDIX G

INTERVIEW QUESTIONS

Initial Hermeneutic Interview Question

I am trying to understand the nature of alternative to discipline programs and nurses' involvement in them. From your own lived experience of the program, what was that experience like for you?

Additional questions or probes

1. What was your “aha” moment in relation to knowing you needed to get help for substance use disorder?
2. What in your life experience brought you to the point where you felt you needed to enroll in an ADP?
3. Why did you choose an ADP through the state board of nursing rather than another program?
4. Did you know you were at risk for substance use disorder?
5. Can you share a story about your experience in the ADP that you personally find meaningful?
6. Tell me about some of the requirements of the ADP.
7. What was the experience like meeting those requirements/
8. If you were to set up an ideal ADP, what would it look like? What would you keep from your program? What would you get rid of? What would you change?

APPENDIX H

DEMOGRAPHIC DATA FORM

1. You will have a pseudonym assigned to you. Your real name will not appear on any of the forms or in the interviews or in any type of data reporting.
2. Please provide your age_____
3. What is your gender? ☐ female ☐ male
4. How would you describe your ethnic background?
 - ☐ Hispanic or Latino
 - ☐ Not Hispanic or Latino
 - ☐ Prefer not to answer
5. How would you describe your racial background?
 - ☐ American Indian or Alaska Native
 - ☐ Asian
 - ☐ Black, not of Hispanic origin
 - ☐ Native Hawaiian or other Pacific Islander
 - ☐ White, not of Hispanic origin
 - ☐ Prefer not to answer
6. What is your highest earned degree? ☐ ADN ☐ BSN ☐ MSN ☐ PhD ☐ DNP
☐ Other (Please specify)_____
7. How many years have you been employed as a nurse?_____
8. In what specialties have you been employed as a nurse?
 - ☐ Med/Surg
 - ☐ Critical Care (Please specify type of unit)_____
 - ☐ Public/community health
 - ☐ School nurse
 - ☐ Long term care
 - ☐ OR/PACU

☐ Other (Please specify)_____

9. How long has it been since you completed the ADP?_____

APPENDIX I
PARTICIPANT PROFILES

Participant pseudonym	Age	Gender	Highest earned degree	Years as a Nurse	Specialty area	Year completed ADP
Betty Lou	39	F	ADN	11	Dialysis	2013
Carolyn	60	F	ADN	29	Psych mental-health	2001
Chloe	63	F	MSN	30	Trauma critical care	2012

References

- American Nurses' Association. (1984). *Addictions and psychological dysfunctions in nursing: The profession's response to the problem*. Kansas City, MO: Author.
- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders*. Washington, DC: American Psychiatric Publishing, Inc.
- Beckstead, J. W. (2002). Modeling attitudinal antecedents of nurses' decisions to report impaired colleagues. *Western Journal of Nursing Research*, 24 (5), 537-551.
- Bettinardi-Angres, K., & Angres, D. H. (2010). Understanding the disease of addiction. *Journal of Nursing Regulation*, 1, 31-37.
- Bettinardi-Angres, K. & Bologeorges, S. (2011). Addressing chemically dependent colleagues. *Journal of Nursing Regulation*, 2(2), 10-17.
- Bettinardi-Angres, K., Pickett, J., & Patrick, D. (2012, July). Substance use disorder and accessing alternative-to-discipline programs. *Journal of Nursing Regulation*, 3(2), 16-21.
- Bissell, L., & Jones, R. W. (1981). The alcoholic nurse. *Nursing Outlook*, 29, 96-101.
- Bowen, M. K., Taylor, K. P., Marcus-Aiyeku, U., & Krause-Parello, C. A. (2012, October). An examination of stress, coping, and adaptation in nurses in a recovery and monitoring program. *Journal of Addictions Nursing*, 3, 159-166.
<http://dx.doi.org/10.1097/JAN.0b013e31826f4bd6>
- Brewer, M. K., & Nelms, T. P. (1998). Some recovering nurses' experiences of being labeled "impaired": A phenomenological inquiry. *Journal of Addictions Nursing*, 10, 172-179.

- Brown, J. G., & Smith, L. (2003). Nurses in recovery: The burden of life problems and confidence to resist relapse. *Journal of Addictions Nursing, 14*, 133-137.
<http://dx.doi.org/10.1080/10884600390245712>
- Clapper, T. C. (2010). Beyond Knowles: What those conducting simulation need to know about adult learning theory. *Clinical Simulation in Nursing, 6*, e7-e14.
- Clark, C., & Farnsworth, J. (2006, August). Program for recovering nurses: An evaluation. *MEDSURG Nursing, 15*, 223-230.
- Cohen, M. Z., Kahn, D. L., & Steeves, R. H. (2000). *Hermeneutic phenomenological research: A practice guide for nurse researchers*. Thousand Oaks, CA: Sage Publications, Inc.
- Colaizzi, P. F. (1978). Psychological research as the phenomenologist views it. In R. S. Valle, & M. King (Eds.), *Existential-phenomenological alternatives for psychology* (pp. 48-71). New York, NY: Oxford University Press.
- Crowley, K., & Morgan, C. (2014). *Re/entry: A guide for nurses dealing with substance use disorder*. Indianapolis, IN: Sigma Theta Tau International.
- Darbro, N. (2005). Alternative diversion programs for nurses with impaired practice: completers and non-completers. *Journal of Addictions Nursing, 16*, 169-185.
<http://dx.doi.org/10.1080/10884600500328155>
- Darbro, N. (2009). Overview of issues related to coercion and monitoring in alternative diversion programs for nurses: A comparison to drug courts: Part 2. *Journal of Addictions Nursing, 20*, 20-24. <http://dx.doi.org/10.1080/10884600802693256>
- Darbro, N., & Malliarakis, K. D. (2012, April). Substance abuse: Risk factors and protective factors. *Journal of Nursing Regulation, 3*, 44-48.

- Dittman, P. W. (2008). Male nurses and chemical dependency. *Nurs Admin Q*, 32, 324-330.
- Dunn, D. (2005). Substance abuse among nurses: Defining the issue. *AORN Journal*, 82, 573-596.
- Edward, K. L., & Welch, T. (2011). The extension of Colaizzi's method of phenomenological enquiry. *Contemporary Nurse*, 39, 163-171.
- Evangelista, A., & Sims-Giddens, S. (2008, June). Gender differences in discipline of nurses in Missouri. *Western Journal of Nursing Research*, 30, 501-514.
<http://dx.doi.org/10.1177/0193945907303302>
- Fletcher, C. E. (2001). Michigan's unique approach to treating impaired health care professionals. *Journal of Addictive Disease*, 20, 101-116.
- Fogger, S. A., & McGuiness, T. (2009). Alabama's nurse monitoring programs: The nurse's experience of being monitored. *Journal of Addictions Nursing*, 20, 142-149.
<http://dx.doi.org/10.1080/10884600903078928>
- Freeman-McGuire, M. G. (2010). *An investigation into the barriers to treatment and recovery and factors leading to treatment and long-term recovery from substance abuse among registered nurses* (Doctoral dissertation). Retrieved from <http://0-search.proquest.com.innopac.library.unr.edu/dissertations/docview/219967219/fulltextPDF/1411FDBE8193BF8169F/1?accountid=452>
- Godfrey, G., Harmon, T., Roberts, H., McNelis, A. M., Horton-Deutsch, S. & O'Haver Day, P. (2010). *Substance abuse among nurses*. Unpublished manuscript. School of Nursing, Purdue University, Indiana, IN.

- Gossop, M., Stephens, S., Stewart, D., Marshall, J., Bearn, J., & Strang, J. (2001). Health care professionals referred for treatment of alcohol and drug problems. *Alcohol & Alcoholism*, 36, 160-164.
- Grover, S. M., & Floyd, M. R. (1998). Nurses' attitudes toward impaired practice and knowledge of peer assistance programs. *Journal of Addictions Nursing*, 10, 70-76.
- Guba, E. G. (1981). Criteria for assessing the trustworthiness of naturalistic inquiries. *ECTJ*, 29, 75-91.
- Haack, M. R., & Yocom, C. J. (2002). State policies and nurses with substance use disorders. *Journal of Nursing Scholarship*, 89-94.
- Heise, B. (2003). The historical context of addiction in the nursing profession: 1850-1992. *Journal of Addictions Nursing*, 14, 117-124.
- <http://dx.doi.org/10.1080/10884600390245695>
- Hoffman, A. L., & Heinemann, M. E. (1987, September). Substance abuse education in schools of nursing: A national survey. *Journal of Nursing Education*, 26, 282-287.
- Hughes, T. L., Smith, L., & Howard, M. J. (1998). Florida's intervention project for nurses: A description of recovering nurses' reentry to practice. *Journal of Addictions Nursing*, 10, 63-69.
- Hutchinson, S. A. (1987, November/December). Toward self-integration: The recovery process of chemically dependent nurses. *Nursing Research*, 36, 339-343.
- Kandall, S. R. (2010). Women and drug addiction: A historical perspective. *Journal of Addictive Diseases*, 29, 117-126. <http://dx.doi.org/10.1080/10550881003684491>

- Kay, A., Taylor, T. E., Barthwell, A. G., Wichelecki, J., & Leopold, V. (2010). Substance use and women's health. *Journal of Addictive Diseases*, 29, 139-163.
<http://dx.doi.org/10.1080/10550881003684640>
- Kenna, G. A., & Wood, M. D. (2004). Alcohol use by healthcare professionals. *Drug and Alcohol Dependence*, 75, 107-116. <http://dx.doi.org/10.1016/j.drugalcdep.2004.01.008>
- Kowalski, C., & Rancourt, M. P. (1997). Profile of the nurse participating in a substance abuse program of a board of registration in nursing in a New England state. *Journal of Addictions Nursing*, 9, 22-29.
- Kunyk, D., & Austin, W. (2011). Nursing under influence: A relational ethics perspective. *Nursing Ethics*, 19 (3), 380-389.
- Libby, T. A. (2009). Stigma. In G. L. Fisher, & N. A. Roget (Eds.), *Encyclopedia of substance abuse, prevention, treatment and recovery* (pp. 857-860). Thousand Oaks, CA: SAGE Publications, Inc.
- Lillibridge, J., Cox, M., & Cross, W. (2002). Uncovering the secret: Giving voice to the experiences of nurses who misuse substances. *Journal of Advanced Nursing*, 39, 219-229.
- Lovi, R., & Barr, J. (2009). Stigma reported by nurses related to those experiencing drug and alcohol dependency: A phenomenological Giorgi study. *Contemporary Nurse*, 33, 166-178.
- McConnell-Henry, T., Chapman, Y., & Francis, K. (2009). Husserl and Heidegger: Exploring the disparity. *International Journal of Nursing Practice*, 15, 7-15. [http://dx.doi: 10.1111/j.1440-172X.2008.01724.x](http://dx.doi.org/10.1111/j.1440-172X.2008.01724.x)

- McNelis, A. M., Horton-Deutsch, S., Day, P. O., Gavardinas, T., Outlaw, C., Palmer, R., & Schroeder, M. (2012). Indiana State nurses assistance program: Identifying gender differences in substance use disorders. *Perspectives in Psychiatric Care*, 48, 41-46. <http://dx.doi.org/10.1111/j.1744-6163.2010.00300.x>
- Miller, C. S. (2000). Mechanisms of action of addictive stimuli: Toxicant-induced loss of tolerance. *Addiction*, 96, 115-139. <http://dx.doi.org/10.1080/09652140020017003>
- Monahan, G. (2003). Drug use/misuse among health professionals. *Substance Use & Misuse*, 38, 1877-1881. <http://dx.doi.org/10.1081/JA-120024245>
- Monroe, T. B., Kenaga, H., Dietrich, M. S., Carter, M. A., & Cowen, R. L. (2013). The prevalence of employed nurses identified or enrolled in substance use monitoring programs. *Nursing Research*, 62 (1), 10-15.
- Monroe, T. B., Pearson, F., & Kenaga, H. (2008). Procedures for handling cases of substance abuse among nurses: A comparison of disciplinary and alternative programs. *Journal of Addictions Nursing*, 19, 156-161. <http://dx.doi.org/10.1080/10884600802306024>
- Naegle, M. A. (1988). Theoretical perspectives on the etiology of substance abuse. *Holistic Nursing Practice*, 2, 1-13.
- National Council of State Boards of Nursing. (2011). *Substance use disorder in nursing: A resource manual and guidelines for alternative and disciplinary monitoring programs*. Chicago, IL: National Council of State Boards of Nursing.
- Neale, J., Nettleton, S., & Pickering, L. (2011). Recovery from problem drug use: What can we learn from the sociologist Erving Goffman? *Drugs: Education, Prevention and Policy*, 18, 3-9. <http://dx.doi.org/10.3109/09687631003705546>

Nevada State Board of Nursing website. (n.d.). nevadanursingboard.org/discipline/chemically-dependent-nurses/

Pullen, L. M., & Green, L. A. (1997, September/October). Identification, intervention and education: Essential curriculum components for chemical dependency in nurses. *Journal of Continuing Education in Nursing*, 28, 211-216.

Sanders, C. (2003). Application of Colaizzi's method: Interpretation of an auditable decision trail by a novice researcher. *Contemporary Nurse*, 14, 292-302.

Savage, C., Dyehouse, J., & Marcus, M. (2014). Alcohol and health content in nursing baccalaureate degree curricula. *Journal of Addictions Nursing*, 25, 28-34.

<http://dx.doi.org/10.1097/JAN.0000000000000018>

Shaw, J. A., & Connelly, D. M. (2012). Phenomenology and physiotherapy: Meaning in research and practice. *Physical Therapy Reviews*, 17, 398-408.

<http://dx.doi.org/10.1179/1743288X12Y.00000000043>

Shaw, M. F., McGovern, M. P., Angres, D. H., & Rawal, P. (2004). Physicians and nurses with substance use disorders. *Journal of Advanced Nursing*, 47, 561-571.

Shenton, A. K. (2004). Strategies for ensuring trustworthiness in qualitative research projects. *Education for Information*, 22, 63-75.

Storti, S. A. (2002). *The lived experience of women in addiction recovery: the haunting spector of stigma in nurse patient interactions* (Unpublished doctoral dissertation). University of Connecticut, Storrs.

Streubert, H. J., & Carpenter, D. R. (2011). *Qualitative research in nursing: Advancing the humanistic imperative* (5th ed.). Philadelphia, PA: Lippincott Williams & Wilkins.

- Substance Abuse and Mental Health Services Administration. (2011). *Results from the 2010 national survey on drug use and health: Summary of national findings*. Retrieved from <http://store.samhsa.gov/home>
- Trinkoff, A. M., & Storr, C. L. (1998a). Work schedule characteristics and substance use in nurses. *American Journal of Industrial Medicine*, 34, 266-271.
- Trinkoff, A. M., & Storr, C. L. (1998b). Substance use among nurses: Differences between specialties. *Journal of Addictions Nursing*, 10, 77-84.
- Trinkoff, A. M., Storr, C. L., & Wall, M. P. (1999). Prescription-type drug misuse and workplace access among nurses. *Journal of Addictive Diseases*, 18, 1-17.
http://dx.doi.org/10.1300/J069v18n01_02
- Valle, R. S., & King, M. (1978). An introduction to existential-phenomenological thought in psychology. In R. S. Valle, & M. King (Eds.), *Existential-phenomenological alternatives for psychology* (pp. 3-17). New York, NY: Oxford University Press.
- van Manen, M. (1984). Practicing phenomenological writing. *Phenomenology + Pedagogy*, 2, 36-69.
- van Manen, M. (1990). *Researching lived experience: Human science for an action sensitive pedagogy*. Albany, NY: SUNY Press.
- van Manen, M. (2014). *Phenomenology of practice: Meaning-giving methods in phenomenological research and writing*. Walnut Creek, CA: Left Coast Press.
- West, M. M. (2002, Second Quarter). Early risk indicators of substance abuse among nurses. *Journal of Nursing Scholarship*, 34, 187-193.

West, R. (2001). Theories of addiction. *Addiction*, 96, 6-13.

<http://dx.doi.org/10.1080/09652140020016923>

Wojnar, D. M. & Swanson, K. M. (2007). Phenomenology: An exploration. *Journal of Holistic Nursing*, 25, 172-180. <http://dx.doi.org/10.1177/0898010106295172>

Zilberman, M. L., Tavares, H., Blume, S., & El-Guebaly, N. (2002). Towards best practices in the treatment of women with addictive disorders. *Addictive disorders and their treatment*, 1, 39-46. <http://dx.doi.org/10.1097/>

CURRICULUM VITAE

Susan M. Ervin, MS, RN, CNE
Orvis School of Nursing
University of Nevada, Reno
sme@unr.edu

Professional Certifications and Licensure:

Nevada RN License 12047
NLN Certified Nurse Educator

Education

Master of Science, Nursing	1980	University of Utah Salt Lake City, Utah Major: Physiological Nursing Clinical Focus: Cardiovascular Critical Care Functional Role: Clinical Nurse Specialist
Bachelor of Science, Nursing	1974	University of Utah Salt Lake City, Utah

Certifications

NLN Certified Nurse Educator	2010
------------------------------	------

Employment/Professional Experience

Assistant Professor	1985-present	Orvis School of Nursing University of Nevada, Reno Reno, Nevada
Staff Nurse	1982	Critical Care St. Mary's Hospital Reno, Nevada
Instructor	1981-1985	Orvis School of Nursing University of Nevada, Reno Reno, Nevada
Instructor	1979-1980	Westminster College Salt Lake City, Utah
Staff Nurse	1978-1980	Surgical/Trauma ICU St. Mark's Hospital Salt Lake City, Utah
Staff Nurse	1976	Intensive Care St. Mary's Hospital

Staff Nurse	1974-1978	Surgical ICU University Medical Center Salt Lake City, Utah
-------------	-----------	---

2012 Recipient of Division of Health Sciences (DHS) Teaching Award
2012 Recipient of F. Donald Tibbitts Distinguished Teaching Award, UNR

Refereed Publications

- Schorr, J., Farnham, R. & Ervin, S. (1990). Temporal Patterns in Community Based Elderly. *Advances in Nursing Science*. 13 (4)

- Ervin, S. (1987). The Effect of Potassium Chloride and Particulate Matter in Infusion Phlebitis. *NITA* 10 (2)

- Ervin, S. (1986). Thoughts on the Discipline of Nursing. *Information*

Ervin, S. (2014). The history of nursing education in the United States. In S.B. Keating (Ed.), *Curriculum development and evaluation in nursing*. 3rd ed. (pp. 5-32). New York, NY: Springer Publishing Company.

2008 Provided chapter review for Capriotti, T. & Frizzell, J. *Human Pathophysiology: Introductory Concepts and Clinical Connections*. Reviewed the GI Chapter

- 2003 Arnold & Boggs. *Interpersonal Relationships: Professional Communication Skills for Nurses*

2003 Orvis School of Nursing BSN Expansion, Recruitment and Retention
Pat Holden-Huchton, Project Director
Peg Farrar - Co-Project Director
Susan Ervin - Retention Coordinator
Tobey Morris
Submitted to HRSA in the amount of \$569,639.52
Not funded

124

Not funded

- 2002 Geriatric Experiences for Orvis Nursing Seniors
Susan M. Ervin, Program Director
Marge Balzar
Submitted to Department of Health and Human Services, Health Resources and Services
Administration in the amount of \$22,422
Not funded
- 1995 Ervin, S. The Evolving Phenomenon of Fahu: Fieldwork in the Kingdom of Tonga. Self
Award, Department of Anthropology, University of Nevada, Reno \$1000.00
- Ervin, S. Fahu in Modern Day Tonga: Fieldwork in the Kingdom of Tonga.
International Activities Grant. University of Nevada, Reno \$1500.00
- 1985 Schorr, J., Farnham, R. and Ervin, S. The Relationships Among Powerlessness,
Hopelessness, Chronic Illness, Death Anxiety and Temporal Orientation.
Funded by the Research Advisory Board at the University of Nevada, Reno for \$3,388.00.

Other Grant Related Activities

- 1999-2002 Worked with University of Nevada School of Medicine on a grant through
USAID: goal was to increase quality of nursing education in Kyrgyzstan.
Involved working with nurses both here and in Kyrgyzstan

Presentations:

Ervin, S. M. (February 2013). "Diversity in the workforce: Mentoring minority students for
success". *Cultural Considerations in Health Care, University of Nevada, Reno, Reno, Nevada.*

Ervin, S.M. (March 2004) "The Land Where Time Begins: Tradition, Health and Nursing in the
Kingdom of Tonga. Paper *Celebrating Diversity in Practice and Research, 3rd Annual Research
Colloquium, Nu Iota, Sigma Theta Tau International Honor Society of Nursing and University of
Nevada, Reno, Orvis School of Nursing, Reno, Nevada*

Ervin, S.M. and Schueler, P. (October 2003) Global Migration and Health Care: Nursing
Education in Central Asia post Soviet Union. Paper. *Globalization and Health Care, 29th
Transcultural Nursing Society International Conference San Antonio, Texas*
(Abstract published in conference proceedings)

Ervin, S.M. and Schueler, P. (March 2003) Only the Sky is Higher. Paper. *Celebrating
Diversity in Practice and Research, 2nd Annual Research Colloquium, Orvis School of Nursing
and Nu Iota Chapter, Sigma Theta Tau International Honor Society of Nursing Reno, Nevada*

Ervin, S.M. (April 2002) (Invited speaker). Infrastructure for designing, coordinating, and
evaluating curriculum and nursing educational programs: US experience. *Conference on Primary*

Care Nursing Reform in Central Asia: Competencies and Educational Standards
 Almaty Kazakhstan (Abstract published in conference proceedings)

Ervin, S.M. (March 2001) What is a credit? Paper *Kyrgyz State Medical Academy School of Nursing Conference*. Bishkek, Kyrgyzstan

Ervin, S.M. (February 2000). Nursing Process and Nursing Diagnosis. Paper. *Kyrgyz State Medical Academy School of Nursing*. Bishkek, Kyrgyzstan

Ervin, S.M. (February 2000). Cultural Constructs of Health and Health Care. Paper *School of Public Health*. Almaty, Kazakhstan

Ervin, S.M. (1997). The Evolution of Fahu: How Have Gender Roles Changed in the Kingdom of Tonga. Paper. *American Association of Medical Anthropology*. Baltimore, Maryland (Abstract published in conference proceedings)

Ervin, S.M. (1996). Fieldwork in the Kingdom of Tonga. Paper. *American Association of Medical Anthropology*. Albuquerque, New Mexico (Abstract published in conference proceedings)

Ervin, S.M. (1995). Fahu: The Role of Sisters and Wives in Modern Day Tonga. Paper. *Great Basin Anthropological Conference* South Lake Tahoe California

Ervin, S.M. (1994) Maintenance of Tradition and Adoption of Innovation: Tongans in the Great Basin. Paper. *Great Basin Anthropological Conference*. Elko, Nevada

Ervin, S.M. (1986). Infusion Phlebitis in Peripheral Veins. Paper. *Seventh Annual Research in Nursing Conference*. University of Cincinnati. Cincinnati, Ohio. (Abstract published in conference proceedings)

Ervin, S.M. (1986). Subjective Time and the Elderly. Paper. *Ninth Annual Research Conference*. V.A. Edward Hines, Jr. Hospital. Hines, Illinois (Abstract published in conference proceedings)

Ervin, S.M. (1984). Microscopic Effects of Potassium Chloride. Paper. *Nevada Nurses Association*, District 1. Reno, Nevada

Service to University, College and School

University

2010	Interdisciplinary Gerontologic Curriculum Committee
2009	UNR Strategic Plan for the Coordination of Aging Education, Research and Outreach Programs at the University of Nevada, Reno
2005-2007	UNR Special Hearing Committee
1997-1999	UNR Ethnic Diversity Committee
1989-1994	UNR Gerontology Committee
1989-1992	UNR Courses and Curriculum Committee, Member

1987-1988 UNR Academic Affairs Committee, Member
1985-1986 UNR Historical Preservation Committee, Member
1983-1986 UNR Faculty Senate

College

2013-present Member, DHS Teaching Award Committee
2011 Member, DHS Promotion and Tenure Committee
2010 Member, Search Committee for the Director of the Sanford Center for Aging
2009 Member, University Wide Geriatrics/Gerontology Task Force
1992-1993; 1996-2001; 2003-2006 HCS Promotion and Tenure Committee

School

2013- present Scholarship Committee
2009-2011 Coordinator, CCNE Self-Study Committee
2000- 2012 Curriculum Committee
2008- 2012 Faculty Affairs Committee
2002-2006 Peer Review Committee
1996-2000 Peer Review Committee
1983-1992 Curriculum Committee
1983-1992 Dean's Advisory Committee
1983-1992 Personnel Committee

Membership and Activities in Professional Organizations

Sigma Theta Tau International Honor Society of Nursing (1987-present)
Nu Iota Chapter, University of Nevada, Reno (1998-present)
Zeta Kappa Chapter, University of Nevada, Las Vegas (1987-1998)

Phi Kappa Phi Honor Society (1991-present)

American Association of Critical Care Nurses (1977-1982; 1991-present)

Additional Significant Activities

Book Reviews

2003 Interpersonal Relationships: Professional Communication Skills for Nurses

Consultations

1999-2002 Consultation with Faculty of Nursing, Kyrgyz State Medical Academy School of Higher Nursing Education, Bishkek, Kyrgyzstan regarding the development of academic programs for baccalaureate nursing education.