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The Process Of Work Re-Entry For Nurses After Substance Use Disorders Treatment: A Grounded Theory Study

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THE PROCESS OF WORK RE-ENTRY FOR NURSES AFTER SUBSTANCE USE
DISORDERS TREATMENT: A GROUNDED THEORY STUDY

by

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This dissertation, submitted by Deborah Matthias-Anderson in partial fulfillment of the requirements for the Degree of Doctor of Philosophy from the University of North Dakota, has been read by the Faculty Advisory Committee under whom the work has been done and is hereby approved.

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December 11, 2015
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PERMISSION

Title   The Process of Work Re-entry for Nurses after Substance Use Disorders Treatment: A Grounded Theory Study

Department   College of Nursing and Professional Disciplines

Degree   Doctor of Philosophy

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Deborah Matthias-Anderson
December 2015

TABLE OF CONTENTS

xi

xiii

LIST OF FIGURES

LIST OF TABLES

ACKNOWLEDGMENTS

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xx

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You made this study possible.

ABSTRACT

The purpose of this grounded theory study was to explicate a substantive theory/model that describes the basic social processes (BSP) operating when a registered nurse (RN) re-enters the workplace following completion of substance use disorder (SUD) treatment. There are a reported 2.6 million RNs employed in the U.S (U.S. Department of Labor, 2014). Over the past 25 years, prevalence studies have found up to 10% of nurses will meet diagnostic criteria for SUD, similar to prevalence rates in the general population. SUDs among nurses present challenges to society and to the nursing profession. State boards of nursing operate primarily to protect the public but also work to preserve the careers of substance dependent nurses by encouraging SUD treatment and recovery. A majority of states now have in place alternative-to-discipline programs to assist nurses during SUD treatment and to provide monitoring afterwards. Little research has been done on work re-entry for nurses following SUD treatment; no qualitative studies have been done that explore work re-entry from the perspective and experiences of the nurse.

The research questions of this study identified the experiences in actualizing workplace re-entry, including what processes helped and what processes hindered work re-entry. Symbolic interactionism and pragmatism provided the theoretical and philosophical foundation for the study. Twenty-two RN participants (4 males, 18 females) who had completed SUD treatment and had a work re-entry experience were interviewed. The audio-taped, transcribed interviews

were analyzed using a constant comparative method using the grounded theory approach of Strauss and Corbin (1990, 1998). Open, axial, and theoretical coding led to the emergence of axial and theoretical models that described the processes of work re-entry for participants.

Findings of the study explicate participant experiences from two perspectives: unsuccessful and successful work re-entry as two separate theoretical models emerged during data analysis. All study participants eventually experienced successful work re-entry. The core variable of the unsuccessful work re-entry theoretical model was "lacking self-redefinition" as a person with SUD, an internal process reinforced by stigma, shame and fear, and characterized by limited use of recovery strategies and reluctance to follow monitoring mandates or disclose SUD status. The core variable of the successful work re-entry theoretical model was "self-redefinition," defined by internalization and acceptance of self as a person and a nurse with a SUD. Properties of self-redefinition included altered (re-defined) definitions of perceptions, values, and priorities, responses to recovery processes, and professional relationships and processes.

The findings of this study have implications for multiple aspects of nursing: regulation, education, and practice, as well as for SUD treatment facilities. Nurses are able to re-enter the nursing workplace successfully but are a unique group among the SUD population. There is a need for increased efforts by regulatory and professional nursing bodies and healthcare systems to explore ways to retain RNs in practice and preserve careers after SUD treatment completion by supporting work re-entry success.

CHAPTER I

INTRODUCTION

Of the 2.6 million registered nurses in the United States (U.S. Department of Labor, 2014), up to 10%, or 260,000 nurses are estimated to meet diagnostic criteria for a substance use disorder (SUD). This figure is based on published prevalence rates of SUDs among nurses that is similar to prevalence rates of SUDs among the general public, at or near 10% (Monroe, Kenaga, Dietrich, Carter, & Cowan, 2013; Trinkoff, Eaton, & Anthony, 1991). Up to 90% of all disciplinary cases of nurses appearing before state boards of nursing (BON) involve SUDs (Haack & Yocum, 2002). This occurs even though a majority of states now have "alternative-to-discipline programs" that offer facilitation into treatment and post-treatment monitoring for nurses with SUDs (Bettinardi-Angres, Pickett, & Patrick, 2012). Impacting this situation are current and looming nursing shortages in the United States (U.S.) (American Association of Colleges of Nursing, 2014), making identification, treatment, and work re-entry support for nurses with SUDs desirable.

There is a gap in the literature about nurses with SUDs and their experience of work re-entry after completion of SUD treatment. The focus of this study was to explore, from the experiential perspective of the nurse with SUD, the basic social processes (BSP) operating in the workplace when these nurses return to work. Knowledge gained from the study may suggest new strategies and policy development to assist successful work re-entry, preserve nursing

1

careers, and support health care delivery. This chapter addresses the background, significance, statement of the problem and the study's purpose, research questions, methodological approach, theoretical perspective, significance, assumptions, and definitions of commonly used terms.

Substance Use Disorders

Definition of Substance Use Disorder (SUD)

Substance use disorder (SUD) is defined in the American Psychiatric Association's (APA) *Diagnostic and Statistical Manual of Mental Disorders,* 5th edition (*DSM-V*) (2013) as having wide range and variance, "…from a mild form to a state of chronically relapsing, compulsive drug taking" (p. 485). The National Council of State Boards of Nursing (NCSBN) (2011) states that the term addiction has been used as an umbrella term to describe a cluster of conditions that include other commonly used terms such as alcoholism, substance or chemical dependence, and substance use disorder. The most recent edition of the *DSM-V* (APA, 2013) has omitted the term addiction completely, citing "…its uncertain definition and its potentially negative connotation" (p. 485). Therefore, *substance use disorders* (SUD) is the term that is used throughout this study. Additionally, in this study the term *nurse* refers to nurses holding a minimum of a registered nurse (RN) license.

Incidence and Consequences

According to the Substance Abuse and Mental Health Services Administration (SAMHSA) (2014), over 21 million Americans aged 12 years or older met the criteria for a SUD diagnosis in 2013; 17.3 million abuse or are dependent on alcohol and 6.9 million abuse or are dependent on illicit drugs, which includes the misuse of prescription medications. SUDs are prominent public health problems in the U.S. In 2009 SAMHSA estimated that $24 billion was

2

spent for SUD treatment across the country (SAMHSA, 2013). Societal costs related to crime, lost work productivity, and health care expenditures from the use and abuse of tobacco, alcohol, and illicit drugs are estimated to be $700 billion in one year (National Institute on Drug Abuse, 2015b).

Health risks to individuals with SUDs are substantial because of the progressive, chronic, and potentially fatal nature of the disorders (Griffith, 1999; McLellan, Lewis, O'Brien, & Kleber, 2000). Negative health outcomes and public health problems related to SUDs include cardiovascular disease, pregnancy complications, domestic and homicidal violence, child abuse, accidents, and suicide (HealthyPeople.gov, 2013). The multi-faceted negative consequences of SUDs burden individuals, families, and communities, making them a public health problem with wide impact on U.S. society.

When nurses develop SUDs, the cost to the health care industry is substantial due to excessive use of sick time and absenteeism, practice errors or accidents, and drug diversion, all common negative consequences associated with nurses with SUDs (Griffith, 1999). Nurses who go untreated may jeopardize safe patient care because of impaired clinical judgment and decision-making, patient neglect, and slower processing of emergent patient situations (Dunn, 2005). Although SUDs are not curable, treatments exist and the disorders can remain in remission. This provides a chance for healing and a return to safe nursing practice, which benefits the individual nurse, the profession of nursing, patients, and the healthcare delivery system. However, re-entry to the nursing practice workplace has been minimally studied, hindering a comprehensive understanding of the issues related to SUDs in nurses. Few qualitative studies have explored this issue.

3

Historical Progression of Information on SUDs in Nurses

A historical review of the literature about SUDs in nurses and the response of the nursing profession to them are closely tied to the history of actions taken by state boards of nursing (BON), which are the governmental agencies in each state responsible for regulation of nursing practice. Limited consideration was given to the topic of SUDs among nurses until the middle of the twentieth century, which coincided with a period of active research culminating in an endorsement by the American Medical Association (AMA) that addictions to alcohol and drugs were diseases amenable to treatment and prevention (Heise, 2003). Increased scholarly attention to the topic of SUDs eventually led to studying the impact it had on health care professionals, including nurses. However, much of the early literature about SUDs in nurses was educational in focus and minimally supported by empirical evidence. Few studies were done that explored the issue from the perspective of the nurse with SUD. The nurse's story was minimally known.

The American Nurses' Association (ANA) first examined the topic of SUDs among nurses in the 1980's (Heise, 2003; Naegle, 2003). A policy statement published in 1984 by the ANA declared a commitment to encourage intervention, treatment, and recovery of practicing nurses who were impaired by alcohol, drugs and/or psychiatric disorders (Naegle, 2003). Prior to the 1970s and 1980s, nurses with SUDs were not offered treatment before disciplinary action was taken against his/her nursing license by the state BON (NCSBN, 2011). The timing of the examination of this issue by the ANA in the mid-1980s coincided with beginning exploration by state boards of nursing to find alternative ways to address the problem of SUDs in nurses from a regulatory perspective.

Led by the American Nurses' Association and the National Council of State Boards of Nursing (NCSBN), there was a shift in the 1980s from a focus on punishment and nursing license suspension/revocation to a focus on SUD treatment and career preservation for the affected nurse. This shift by boards of nursing occurred parallel to the development of alternative-to-discipline programs in individual states (Darbro, 2005; Heise, 2003; Naegle, 2003). In 2002, the American Nurses' Association passed a resolution calling for all regulatory jurisdictions (i.e. state BONs) to establish alternative-to-discipline programs (Monroe, Pearson, & Kenaga, 2008). As of 2010, 43 out of 59 regulatory jurisdictions (U.S. states and territories) had alternative programs in place to assist nurses to enter SUD treatment and provide aftercare monitoring (Bettinardi-Angres et al., 2012). Alternative programs offer a way to retain nurses in the nursing workforce by providing early SUD identification, intervention, treatment, and ongoing monitoring during early recovery (Darbro, 2009). The services are voluntary, confidential, and non-punitive (Monroe et al., 2008). As alternative programs became more prevalent in treating nurses with SUDs they became the focus of research studies. However, few of these studies examined work re-entry after SUD treatment and instead focused on regulations, services, characteristics of nurses who were treated by these programs, and satisfaction of nurses participating in these programs.

Impact of Stigma

Stigma is a widely discussed concept throughout the literature that provides an important contextual lens by which the topic of SUDs among nurses must be viewed. Societal stigma toward individuals with SUDs in the U.S. is long-standing and firmly rooted (Kelly & Westerhoff, 2010; NCSBN, 2011). Nurses with SUDs often face greater stigma and scrutiny due

to perceived violation of public trust because of the respected position nurses hold as caregivers (Darbro, 2005). Year after year the public endorses nursing as the most trusted of all professions (Gallup, 2014). Against this backdrop, when a SUD in a nurse becomes known, it is often highly visible and the resulting sanctions more severe than for those with SUDs among the general population or even among other health care professionals (Angres, Bettinardi-Angres, & Cross, 2010). Health care professional are often much more judgmental of colleagues with SUDs than toward the general population with SUDs (Cook, 2013). Thus, nurses with SUDs face stigma that is multi-faceted in its negative impact.

Stigma also contributes to the denial inherent with SUDs and is a barrier for nurses to get help (NCSBN, 2011). Nurses with SUDs are often reluctant to admit to having the disorder due to widespread stigma about SUDs among the nursing profession, which leads to subsequent delays for these nurses in getting treatment. Self-stigma, the actions taken by a member of a stigmatized group toward themselves, is also apparent in nurses with SUD (Corrigan, 2004). Self-stigma includes "…negative thoughts and feelings (e.g., shame, negative self-evaluative thoughts, and fear) that emerge from identification with a stigmatized group and their resulting behavioral impact" (Luoma et al., 2007, p. 1332). Underlying these challenges for nurses is the threat of disciplinary action by the state BON and possible loss of the nursing license required to practice nursing if and when the SUD is discovered (Copp, 2009; NCSBN, 2011).

Research studies about nurses who receive treatment for SUDs report, however, that nurses have better treatment outcomes than the general population, especially if offered specialized treatment specifically for health care professionals (Bettinardi-Angres et al., 2012). Research findings also indicate that once in treatment nurses have high completion rates,

demonstrate relapse rates lower than the general population, and have better long-term recovery rates than the general population (Bettinardi-Angres et al., 2012). These findings confirm the need for early intervention and continued support following treatment and during the work re-entry process. However, minimal research has been done that explores the experiences of work re-entry and their impact on the lives and careers of nurses who complete SUD treatment.

Impact of Gender

There are gender differences among the population with SUDs that is pertinent to a study of nurses, where a vast majority in the profession are female. Women with SUDs experience greater stigma than men in American society as they are often held to a different and/or higher ethical or moral standard (NCSBN, 2011). There are cultural taboos against consumption of alcohol by women in many cultures around the world (Graham et al., 2011); historically this has been true in American culture, as well (NCSBN, 2011). There are increased health risks of alcohol use/abuse for women compared to men including greater risk for breast cancer, alcohol-related liver disease, stroke, negative pregnancy outcomes, and physical violence/assault (Wilsnack & Wilsnack, 2013). As with the general population, alcohol is a common substance of abuse for nurses with SUDs because it is legal and readily available. National U.S. labor statistics indicate that 90% of registered nurses are female (U.S. Department of Labor, 2015), making gender an important variable when studying nurses with SUDs given the high percentage of females within the profession.

Drug of Choice

Trends in the use and abuse of drugs change periodically in the U.S. and are monitored by governmental agencies on the federal, state, and local levels (Falkowski, 2015; National

7

Institute on Drug Abuse, 2015a). A current trend is the use and abuse of opiates in the U.S., which has increased substantially in the past decade for all population sub-groups (Back, Payne, Simpson, & Brady, 2010). There are also gender differences among those who abuse or are dependent on opiates. Research findings indicate that females move from use to dependence on opiates at a faster rate than men and suffer more physical and psychological consequences from opiate use (Back et al., 2011). The rate of abuse and/or dependence on opiates among nurses is higher than in the general population (Baldisseri, 2007; Cook, 2013; Dunn, 2005). Nurses commonly have access to opiates in the workplace. Also, research studies report that narcotics are the most common illicit drugs of abuse for nurses who are in monitoring programs for SUDs (Bettinardi-Angres et al., 2012). Thus, opiates and alcohol dominate as main choices for use and abuse of mood-altering substances by female nurses.

Statement of the Problem

The body of literature that exists about SUDs among nurses reveals that most early publications about the topic were not research based. Empirical studies that were done in the early period focused primarily on attitudes, individual characteristics, risk factors, and prevalence rates of SUDs among nurses. As alternative-to-discipline programs became prominent in treating and monitoring nurses with SUDs, these programs became the focus of research. Missing throughout the body of literature are clear descriptions of the nurse's perspective regarding experiences, issues, and processes during re-entry to the workplace after SUD treatment. This knowledge gap is a barrier to fully understanding the issues and restricts development of employment, regulatory and educational strategies to support work re-entry for nurses after treatment. It is this gap in the nursing literature that this study addresses.

The fact that a majority of states now offer alternative programs is indicative of significant shifts in understanding, attitudes, and treatment of SUDs since the AMA labeled them treatable diseases and the ANA resolved to develop policies and action plans to address SUDs in nurses. Gender differences in the physical impact, progression, outcomes of treatment, and rates of recovery are highly pertinent to the study of SUDs in nurses because of the high percentage of women in the profession and their use of the most common drugs of abuse, alcohol and opiates. Evident in the current nursing literature on this topic are the identified goals of protection of patient safety as well as preservation of the health and the professional career of nurses with SUDs. However, the paucity of literature about workplace re-entry for the nurse following SUD treatment precludes full understanding of how to best realize these goals.

Purpose of the Study

The purpose of this qualitative, grounded theory study was to explicate a substantive theory/model that describes the basic social processes (BSP) operating when a registered nurse re-enters the workplace following completion of substance use disorder treatment.

Research Questions

A central, overarching, open-ended question is recommended for a qualitative research study, followed by sub-questions to guide the process (Creswell, 2007). The central question to this study was: What basic social processes (BSPs) are operating when a nurse approaches and actualizes re-entry to the nursing workplace after completion of SUD treatment? There were three research questions that supported explication of the purpose and central question of the study:

9

1. What does a registered nurse experience in actualizing workplace re-entry after completion of SUD treatment?

2. What helped the registered nurse re-enter the workplace after completion of SUD treatment?

3. What acted as barriers to the registered nurse's re-entry to the workplace after completion of SUD treatment?

Research Approach

A research problem from a qualitative perspective is less structured than a quantitative research problem; concepts are not pre-identified prior to beginning the study and variables are not controlled (Corbin & Strauss, 2008). This study was conducted utilizing grounded theory methodology. Grounded theory is a qualitative research methodological approach that discovers processes experienced by persons, within a social context, that lead to explication of a model or theory *grounded* in the data collected in the field (Creswell, 2007). A theoretical framework is not used to define variables or to structure grounded theory research as is done in quantitative research (Corbin & Strauss, 2008). Rather, grounded theory uses an inductive approach in which specific observations lead to broader generalizations and conceptual models and/or theories.

The study of human behavior within challenging social contexts or situations is well-suited to a grounded theory approach, especially when minimal knowledge exists about a topic area (Wuest, 2007). Grounded theory was used for this study because of the paucity of research from the perspective of the nurse about the experience of work re-entry after SUD treatment. The social, interactive setting of the workplace upon re-entry by nurses after SUD treatment is a suitable fit with the social, interpersonal, contextual foci of the grounded theory approach.

Theoretical Perspectives

Symbolic interactionism, a theoretical perspective that emerged in the U.S. in the 1930's, is widely considered to guide the epistemological and theoretical underpinnings of grounded theory (Wuest, 2007). Symbolic interactionism is closely aligned to the philosophic approach of pragmatism. Both are discussed briefly.

Symbolic interactionism views human beings as active participants in the social environment where meaning is ascribed based on one's own actions and on interactions with others (Burbank & Martins, 2009). These beliefs form the foundation on which the three theoretical assumptions of symbolic interactionism are built: (a) individuals act toward things in their lives (objects, other people, institutions, ideals) on the basis of the meanings they have toward them, (b) meanings originate from interactions with others, and (c) individuals modify meanings through an interpretive process used to make sense of the social environment (Blumer, 1969).

Symbolic interactionism guides researchers who utilize grounded theory methodology with the assumption that meaning is constructed and constantly changing because of interactions within a social context. These interactions affect choices and behaviors (Wuest, 2007). This perspective has value and applies to this grounded theory study because experiences were explored from the experiential perspective of the nurse who re-entered the workplace after SUD treatment. In applying symbolic interactionism, meanings ascribed to these work re-entry experiences are shaped by those with whom the nurse interacts. The social interactions for nurses may occur in various environments and contexts during the work re-entry process: at the

11

workplace unit and broader employer institution, within the family, and among various

supportive recovery settings.

American pragmatism provides the philosophic foundation of symbolic interactionism

(Bryant & Charmaz, 2007; Charon, 2007). The pragmatist philosophic tradition views reality as

fluid and open to multiple interpretations; the individual is viewed as active, creative, practical,

and continually interpreting and making meaning from the environment (Charmaz, 2006; Flick,

2009). Pragmatism emphasizes that development of knowledge is not value free and asserts that

truth is not deductively ascertained from a priori theory but must be developed inductively by

constant comparison and verification of data (Wuest, 2007). These beliefs are foundational to

symbolic interactionism and to the grounded theory methodology where *discovery* and

explication of theory occurs inductively by constant comparative data analysis (Glaser & Strauss,

1967). Symbolic interactionism and pragmatism provide sound theoretical and philosophical

foundations for guiding grounded theory research and are well suited to the topic of this study.

Significance of the Study

An exploratory grounded theory study about work re-entry for nurses after completion of

SUD treatment is important for several reasons. Work re-entry after SUD treatment has not been

studied from the personal perspective of the nurse. The literature supports the view that SUDs

are chronic medical conditions amenable to treatment. Nurses are the largest group among health

care professionals and work as caregivers within a clear societal mandate aimed at maintaining

public safety (NCSBN, 2011). It is important that the care nurses provide be done with cognitive

clarity, free of chemical influence and/or impairment. SUD treatment and establishment of

recovery strategies help nurses regain health before, during, and after work re-entry. Recovery is

possible for affected individuals, and involves learning and implementing self-management and self-care activities. Support for nurses to enter treatment and use recovery strategies after work re-entry benefits the nurse, the nursing profession, and the larger health care delivery system.

Exploration of the work re-entry experience of the nurse with SUD may suggest ways to develop or strengthen strategies of support during the stages of pre-treatment, treatment, recovery, and work re-entry. Research findings have indicated that health care professionals, including nurses, have higher rates of success with treatment and recovery than the general population with SUDs (Bettinardi-Angres et al., 2012). Additionally, nurses affected by SUDs are generally intelligent and highly skilled practitioners in their work settings and are a significant loss to their work units and the profession of nursing when they are not able to successfully re-enter work after treatment (Bissel & Jones, 1981; Heise, 2003; Indiana State Nurses Association, 2009). The findings of this study may be helpful for employers, state BONs, and nurse leaders to support successful work re-entry for nurses with SUDs who have completed treatment. With the increased knowledge generated from this study, strategies are suggested for nursing education, regulation, policy, and research.

Assumptions

The following assumptions guided this study. The statements in italics that follow each assumption link grounded theory methodology and/or underlying theoretical concepts to the assumption.

1. SUDs are complex, chronic medical disorders that affect all areas of a person's life; they are amenable to treatment and remission is possible. *Symbolic interactionism states people make sense of their world based on interpretations of experiences and interactions with others.*

13

Grounded theory methodology allows for the exploration and expression of complex situations and interactions.

2. Participants of this study will engage with the researcher and offer accurate and honest answers to questions about work re-entry after SUD treatment. *Grounded theory methodology allows for exploration and interpretation of experiences related to social and interpersonal processes. The dialogue process encourages the telling of the participant's story and expects the researcher to be aware and examine any personal biases that could interfere with open dialogue between researcher and participant.*

3. Nurses with SUDs likely have experienced prejudice and discrimination from others, including health care professionals and nursing colleagues. *Grounded theory methodology allows for exploration of complex social and interpersonal processes. Awareness of this possible stigma will reduce the likelihood that the researcher will make presumptive statements or impose bias or prejudice during the research process.*

4. There will be a sufficient number of participants to achieve data saturation; resulting data will support development of a theoretical/conceptual model. *In a grounded theory study, a model or theory emerges from the data during constant comparative analysis; it is not imposed on the data.*

5. The researcher is able to create an interview environment that maintains theoretical sensitivity and limits bias. *Grounded theory methodology promotes use of memos and reflective journaling by the researcher to monitor experiences and acknowledge researcher bias and preconceived perspectives. This acknowledgement is conducive to the credibility of the study and supports an audit trail.*

Definition of Terms

Abstinence: "Refraining from the use of non-medically prescribed and currently authorized drugs, including alcohol" (NCSBN, 2011, p. 235).

Alcoholism:

…is a primary, chronic disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by continuous or periodic impaired control over drinking, preoccupation with the alcohol, use of alcohol despite adverse consequences, and distortions in thinking, most notably denial. (Angres & Bettinardi-Angres, 2008, p. 696)

Alternative Program: "A voluntary, private opportunity for chemically dependent nurses who meet specified criteria to have their recovery closely monitored by program staff in lieu of disciplinary actions" (NCSBN, 2010, p. 314).

Basic social processes: Basic social processes are "…pervasive [and] fundamental, patterned processes in the organization of social behaviors which occur over time and go on irrespective of the conditional variation of place" (Glaser, 1978, p. 100).

Board of Nursing:

…is the authorized state entity with the legal authority to regulate nursing. Legislatures enact the Nurse Practice Act for each state. Boards of nursing have the legal authority to license nurses and discipline nurses for unsafe practice. The mission of boards of nursing is to protect the health, safety and welfare of the public. (NCSBN, 2010, p. 316)

Disciplinary Process (by a state board of nursing): "…consists of the regulatory procedures and activities involved in the receipt, review, investigation, prosecution, decision-making and case resolution" (NCSBN, 2011, p. 236).

Drug Diversion: "Drug diversion is a term used to describe a variety of activities used to obtain drugs illegally. It is most commonly used to refer to the misappropriation of drugs from a patient, health care employer or other source" (NCSBN, 2011, p. 237).

Drug Testing: "…is a primary preventive, diagnostic, and monitoring tool set up to identify the presence or absence of drugs of abuse or therapeutic agents related to addiction management and which can be conducted using blood, saliva, hair, breath, and urine" (Gitlow, 2015, p. 30).

Monitoring:

Ongoing assessment of the nurse in recovery by alternative program or board [of nursing] staff using a variety of methods including reports and body fluid testing to track the progress of the nurse. Monitoring is essential to assuring patient or client safety and that the nurse is competent to practice. (NCSBN, 2011, p. 238)

Nurse Practice Act: "Statutes governing the regulation of nursing practice in a jurisdiction, typically empowering a board of nursing to license individuals who meet specified requirements" (NCSBN, 2010, p. 329).

Nursing: "Nursing is the protection, promotion, and optimization of health and abilities, prevention of illness and injury, alleviation of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, communities, and populations" (ANA, 2013, para. 1).

Opiate/Opioid:

Opiates are drugs derived from opium. At one time 'opioids' referred to synthetic opiates

only (drugs created to emulate opium, however different chemically). Now the term

opioid is used for the *entire family* of opiates including natural, synthetic, and semi-

synthetic. (National Alliance of Advocates for Buprenorphine Treatment, 2015)

Recovery: An active, ongoing process for a person with a SUD to abstain from

drugs/alcohol, accept having a substance use disorder, and improve health through the

integration of body, mind, and spirit (Betty Ford Institute Consensus Panel, 2007).

Relapse: The World Health Institute (WHO) (n.d.) defines relapse as: "A return to

drinking or other drug use after a period of abstinence, often accompanied by reinstatement of

dependence symptoms. Some writers distinguish between relapse and lapse ('slip'), with the

latter denoting an isolated occasion of alcohol or drug use" (Relapse, para. 1).

Sobriety: "The state of abstinence from mind-altering drugs and alcohol" (NCSBN, 2011,

p. 239).

Stigma: "Stigma is defined as circumstances when one identifies and labels differences in

others and forms a negative stereotype about the members of that particular group" (Lovi & Barr,

2009, p. 167).

Substance Use Disorder (SUD): "The essential feature of a substance use disorder is a

cluster of cognitive, behavioral, and physiological symptoms indicating that the individual

continues using the substance despite significant substance-related problems" (APA, 2013, p.

483).   It must be noted that the terms *substance abuse* and *substance dependence* are not used in

the 2013 edition of the *DSM-V* (APA, 2013); *substance use disorder* is the term used instead.

Treatment (Chemical Dependency Treatment): Formalized and structured treatment for persons with a substance use disorder. Treatment often consists of group therapy, individual therapy and education. Treatment goals are directed toward facilitating individuals to obtain the insight and skills needed to understand and deal with their illness, problems associated with their alcohol and drug use, and attain and maintain abstinence from drug use. Treatment may occur in a variety of settings including outpatient, inpatient, and residential (NCSBN, 2011, p. 236).

Withdrawal:

…is a syndrome that occurs when blood or tissue concentrations of a substance decline in an individual who had maintained prolonged heavy use of the substance. After developing withdrawal symptoms, the individual is likely to consume the substance to relieve the symptoms. (APA, 2013, p. 484)

Work Re-entry: Refers to re-entry to a nursing practice worksite where a registered nurse license or specialty license beyond the RN (such as nurse anesthetist), is required with the intent to do the restricted or defined work of that professional (Quinlan, 2003).

Chapter Summary

This chapter introduced the topic for this exploratory grounded theory research study focusing on work re-entry experiences of nurses following their completion of treatment for SUD. The purpose of this qualitative, grounded theory study was to explicate a substantive theory/model that describes the basic social processes (BSP) operating when a registered nurse (RN) re-enters the workplace following completion of substance use disorder (SUD) treatment. Grounded theory methodology and the underlying epistemological and foundational theories of symbolic interactionism and pragmatism were briefly described and determined to be a suitable

fit for the research study because of the knowledge gap that exists about work re-entry

experiences of nurses with SUDs. Grounded theory methodology is also suitable for the study

because of its focus on interpersonal relationships and processes within a social context.

Assumptions underlying the topic of work re-entry of nurses with SUDs were identified and

definitions were provided for common concepts/terms found in the literature about this topic and

in this study.

Chapter Two provides a review of literature on this topic. A chronological survey of the

literature as it expanded from the 1980s to the end of the twentieth century is presented. A

discussion of the research from the twenty-first century that focuses on state alternative programs

is included. Analysis and synthesis of the most recent research is outlined, including

identification and discussion of gaps in the literature pertaining to workplace re-entry for nurses

after SUD treatment.

CHAPTER II

REVIEW OF LITERATURE

Introduction

The purpose of this qualitative, grounded theory study was to explicate a substantive theory/model that describes the basic social processes operating when a registered nurse re-enters the workplace following completion of substance use disorder (SUD) treatment. This chapter provides a review of the literature about SUDs among nurses and the concept of work re-entry after SUD treatment. The purpose of the review of literature is to describe related studies and policies within the historical context of the response of the nursing profession to SUDs among its members. However, this study used grounded theory methodology, where ongoing review of the literature is a part of the research process, especially as data are analyzed and theoretical concepts emerge. The literature review presented in this chapter describes what is currently known about the topic and whether there are inadequacies or an absence of knowledge related to this area of study. Additional literature will be reviewed and incorporated into the findings and discussion chapters, as theoretical concepts/variables emerge.

The first section of this literature review provides a brief historical perspective about SUDs and includes discussion about the concepts of treatment, recovery, and relapse; a discussion about gender and SUDs is also presented. The second section discusses the early nursing literature that addressed SUDs among nurses that were primarily published in the 1980s

and 1990s. The progression of professional thought and position statements from professional nursing organizations is discussed. The third section reviews the nursing literature on this topic from 2000 until the present, where alternative programs became a focus of many research studies about the topic of SUDs among nurses. The chapter concludes with a discussion of what is known about the topic of work re-entry by the nurse after completion of SUD treatment; gaps in knowledge and the need for this study are also discussed.

Historical Perspective of Substance Use Disorders

The history of SUDs among nurses has been enfolded within the history of SUDs in the U.S., hidden from early public scrutiny until the second half of the twentieth century largely because of shame and stigma (Heise, 2003). The issue of addiction in healthcare professionals (addiction being the term used at the time), was first publicly addressed in the 1950s (Heise, 2003). This coincided with a time of exploration and research about SUDs that culminated in an endorsement by the American Medical Association (AMA) in the mid-1950s that alcoholism be viewed as an illness (Bettinardi-Angres & Angres, 2011). In the 1960s the AMA declared that drug and alcohol addiction should be considered a disease (Bettinardi-Angres & Angres, 2011; Heise, 2003). Once the disease concept of SUDs was accepted by the medical and scientific communities, research and empirically-based knowledge expanded substantially.

In the early years of SUD treatment, referred to as the "pre-professional developmental years" of the 1950s and 1960s (White, 2008, p. 1), there was limited scientific evidence about SUDs and the effectiveness of strategies to treat them. Since then there have been numerous broad, rigorous national studies that have expanded knowledge about SUDs, including treatment strategies and treatment outcomes (White, 2008). SUDs are now characterized as primary,

chronic, progressive, potentially fatal diseases that develop when biology (faulty neural

pathways affecting memory, learning, motivation, decision-making and reward circuitry)

combines with genetic predisposition, psychological, and social influences (Angres & Bettinardi-

Angres, 2008; McLellan et al., 2000). SUDs are not curable, but research has shown that they are

amenable to treatment and can remain in remission when the affected person manages the

disorder through a process of recovery.

Treatment, Recovery, Relapse

The concepts of treatment and recovery are both important to the overall health and well-

being for the person affected by a SUD. The most common philosophy of treatment of SUDs in

the U.S. is based on the goal of total abstinence from the drug(s) of choice, with a majority of

treatment programs organizing their programming based on a 12-step (Alcoholics Anonymous)

model of recovery (Quinlan, 2003). It is widely accepted that SUDs are chronic diseases, yet

SUD treatment in the U.S. has been based predominantly on an acute-care model characterized

by "…its crisis-linked point of intervention, brief duration, singular focus on symptom

suppression (achievement of abstinence), professionally dominated decision-making process,

short service relationship, and expectation of full and permanent problem resolution following

'graduation'" (White, 2008, p. 6). Recent publications in the professional literature about SUDs

have begun to explore the incongruence of treating a chronic disease with an acute-care

treatment model where high expectations related to abstinence puts pressure on the affected

person to comply with treatment recommendations and avoid relapse. Treatment strategies

focused on long-term, sustained management of recovery are now being advocated as an

alternative and/or adjunct to the more prevalent acute-care model (McLellan et al., 2000; White,

2008). Focused research into the process and experiences of recovery is needed to fill a knowledge gap in the scientific literature about treatment effectiveness.

Recovery, described as integrated health of body, mind, and spirit, is an on-going process characterized by abstinence from drugs and alcohol (Betty Ford Institute Consensus Panel, 2007). It is marked by the person with SUD assuming some personal responsibility for management of the disease, just as other chronic diseases such as diabetes and hypertension involve responsibility and some self-management by the person living with those particular chronic conditions. A unique feature of recovery from SUDs, however, is the widely available and easily accessible recovery communities of support, most notably Alcoholics Anonymous (A.A.) and other related 12-step groups. A.A., founded in the 1930's, is a spiritually based program that encourages persons with SUDs to form an honest relationship with self and a power greater than self, and to engage with others within the fellowship of A.A. to learn to cope with life without use of substances (Angres & Bettinardi-Angres, 2008). Sustained emotional, spiritual, and social support offered by recovery communities and groups assist many with SUDs to avoid a return to substance use and/or abuse.

As new paradigms of treatment for SUDs emerge, interest in increasing the knowledge base about recovery, especially maintenance of long-term recovery, has led to increased scientific interest in A.A. and other recovery programs (White, 2008). Long-term recovery is delineated as a way of life:

…an enduring lifestyle marked by: 1) the resolution of alcohol and other drug problems,

2) the progressive achievement of global (physical, emotional, relational) health, and 3)

23

citizenship (life meaning and purpose, self-development, social stability, social

contribution, elimination of threats to public safety). (White, 2008, p. 25)

Expansion of empirical knowledge about recovery may lead to strategies to promote and

improve chronic SUD management once a person successfully completes a treatment experience.

This is warranted because relapse rates for SUDs are 40%-60%, similar to other diseases with a

chronic and remitting course (McLellan et al., 2000). Expansion of research about recovery may

also lead to better understanding of the common occurrence of relapse.

Relapse is defined as a return to use of the drug of choice after periods of abstinence,

with characteristic symptoms of substance abuse/dependence occurring during use (NCSBN,

2011). Relapse can occur to anyone with a SUD but is an especially common experience for

individuals who are deemed chronic and severe substance abusers, which is 10% to 25% of the

SUD population (White, 2008). Rates of relapse vary by gender, age, and drug of choice.

Research findings indicate relapse rates are higher among males, adolescents, persons whose

drug of choice is opiates, and individuals dually diagnosed with a SUD and a psychiatric illness

(White, 2008). The profession of nursing is made up of over 90% women (U.S. Department of

Labor, 2015); gender may act as protection against relapse for nurses with a SUD.

Gender

There are gender differences in the development, course, and treatment outcomes of

SUDs. Women who are heavy consumers of alcohol face more adverse health challenges than

men who drink heavily (Wilsnack & Wilsnack, 2013). Regardless of drug of choice, women

enter SUD treatment in poorer health than men (White, 2008) because of more severe physical

effects of drugs/alcohol on women, who also experience a more virulent disease progression

24

(NCSBN, 2011). Research findings indicate that women often seek medical care for other complaints while a SUD may be a serious underlying problem that goes undetected (NCSBN, 2011). Early SUD intervention and treatment is consistently recommended by researchers, giving credence to the importance of screening and the serious consequences that may occur when women are under screened and SUD treatment delayed.

There are also gender differences in rates of use/abuse of opiates. Opiate use in the U.S. has increased substantially in the past decade (Back et al., 2010). Research findings indicate that women are prescribed narcotics at a higher rate and in higher doses than men and are dying of accidental and intentional overdoses at such high rate that the Centers for Disease Control and Prevention (CDC) (2013) has termed it a "growing epidemic" (p. 1). Since 2011, escalation in the abuse of heroin and prescription opioids has dominated the drug abuse environment in the large metropolitan area of the state where many nurses participating in this study and the researcher reside (Falkowski, 2015).

Research has shown that rates of abuse and dependence on opioids are higher among nurses than the general population (Baldiserri, 2007; Cook, 2013; Dunn, 2005). Contributing factors for opiate abuse for nurses are workplace access to narcotics, educational knowledge about pharmacology, role strain and burnout due to stressful work environments, and a healthcare culture that strongly endorses medication use for treatment of pain in patients (Bettinardi-Angres & Angres, 2010; NCSBN, 2011). It is important to have an understanding of the gender differences in SUD onset, progression, treatment outcomes, relapse, and trends in drug use/abuse when studying SUDs in nurses, especially given that the vast majority of nurses are women.

25

To summarize, research findings support the view that SUDs are chronic, progressive diseases that are potentially fatal unless treatment occurs and recovery strategies are initiated and sustained. Current treatment of SUDs in the U.S. is generally short-term and based on an acute care model. There have been recent calls to put greater research focus on the chronic nature of SUDs and expand studies about recovery and relapse. There are gender differences in the physical impact, course of the disease, and outcomes of treatment that are of special concern to nurses with SUDs due to the high numbers of women in the profession. Recent increases in the use of opioids are pertinent to a study of SUDs in nurses because of workplace access to these substances and the higher rates of use/abuse of these substances among nurses.

The history of SUDs in nursing was hidden within the history of SUDs in the U.S. until the disease concept of SUDs was endorsed by the scientific community. Over the past 60 years the body of literature about SUDs in nursing has expanded greatly. The next section discusses early research in the nursing literature about SUDs among nurses.

Early Literature about SUDs in Nurses

Attitudes, Risk Factors, Prevalence

Attitudes. Research specific to SUDs among healthcare professionals had its beginnings in the 1960s and 1970s and, for nursing, first received national exposure when the American Nurses' Association (ANA) supported the formation of the National Nurses' Society on Alcoholism in the late 1970s (Heise, 2003). Following soon after was an ANA position paper on the topic of SUDs among nurses, published in 1982, and a policy statement published in 1984 (Heise, 2003; Naegle, 2003). The ANA policy statement, "…established the (ANA) organization's commitment to intervention, treatment, and rehabilitation of the nurse whose

practice is impaired by alcohol or other drug abuse or psychiatric illness" (Naegle, 2003, p. 145). Acknowledgment by the ANA of the seriousness of the issue for the nursing profession led to specialty organizations addressing the topic, which broadened professional exposure to the issue and promoted research within nursing specialty areas (Naegle, 2003). Examination of the issue by the ANA in the 1980s also coincided with beginning exploration by state BONs to find alternative ways to address SUDs among nurses from a regulatory perspective.

There were several research studies in the 1980s and 1990s that focused on attitudes of nurses and nursing students toward nurses with SUDs (Hendrix, Sabritt, McDaniel, & Field, 1987; Lachicotte & Alexander, 1990; Smith, 1992; Wennerstrom & Rooda, 1996). Results of the studies found nurses and nursing students more likely to support and endorse treatment over discipline (Hendrix et al., 1987; Smith, 1992; Wennerstrom & Rooda, 1996). Additionally, nearly all of the attitudinal studies found that prior education about SUDs promoted an understanding of them as treatable diseases. Greater education about the topic aligned with a more positive attitude toward acceptance of the person with the SUD and a belief that treatment could be effective (West, 2003). The linkage between education about SUDs and attitudes that endorse them as treatable diseases was a common theme in the early research that continued over the decades as the body of literature expanded (Cook, 2013; Godfrey et al., 2010). It is still in evidence in the literature today.

Among the early published literature on SUDs in nurses, only one study addressed the attitudes and perceptions from the perspective of the nurse with a SUD. A researcher-developed survey was administered to fourteen Pennsylvania RNs in recovery for SUDs (Shaffer, 1988). Findings from this small study included strong endorsement for viewing SUDs as treatable

diseases with high value placed on support group involvement during recovery. The belief that

nurses with SUDs could return to safe nursing practice after treatment was also endorsed by

participants. Expansion of efforts to educate nursing colleagues about the issue of SUDs among

nurses was recommended. Limitations of the study include homogeneity and small sample size,

as well as lack of standardized instrument use. However, it was one of the first studies to explore

thoughts and experiences from the perspective of the nurse affected by SUDs and coincided with

efforts by the Pennsylvania Nurses' Association to develop and publish a position paper on

chemical use/abuse among nurses in that state (Shaffer, 1988). This provides an early example of

empirical knowledge expansion on the topic occurring concurrently as state-wide efforts were

beginning to raise awareness and address the issue of SUDs among nurses.

     Risk factors. Studies on risk factors for SUD development in nurses conducted in the

1980s and 1990s suggested that nurses as a group were more likely than other health care

professionals to be children of alcoholic parents (West, 2003). Several early researchers explored

family upbringing of nurses with SUDs and found that alcoholism and addiction in family

histories were risk factors for nurses (Bissell & Haberman, 1984; Haack & Harford, 1984;

Sullivan, 1987). Evidence of a genetic link in the transmission for risk of SUD development has

been validated based on scientific evidence that has emerged in recent decades (Bettinardi-

Angres & Angres, 2010; Dunn, 2005; McLellan et al., 2000).

     Other risk factors that contributed to SUD development in nurses were explored by

Mynatt (1996). In this study, data from a peer assistance program in Tennessee were analyzed.

Findings showed that high numbers of nurses in the peer assistance program came from chaotic

families where drug and alcohol abuse was present, were frequently victims of one or more types

of abuse, often experienced a prior or co-occurring mental health issue, and reported low self-esteem (Mynatt, 1996). Although the generalizability of findings from this study were limited due to small size (n=77), the study's conclusion that the etiology of SUD development in nurses is most likely multi-dimensional has been supported in subsequent research findings (Bettinardi-Angres & Angres, 2010; Hughes, Howard, & Henry, 2002; McLellan et al., 2000; West, 2003).

Prevalence studies. The decade of the 1990s witnessed expansion of the scientific evidence about SUDs among nurses and included studies aimed at clarifying prevalence rates. A report of a survey of drug and alcohol use/abuse and depression among nurses was published by Trinkoff et al. (1991) that has become a widely cited study on SUD prevalence rates in nurses (Hughes et al., 2002). Interview data from 143 employed registered nurses (RNs) were compared with a matched group of 1,410 employed non-nurses to estimate prevalence of drug abuse, alcohol abuse, and depression. The sample was derived from a five-site collaborative study sponsored by the National Institute of Mental Health. Multi-stage probability samples came from households in five different areas of the U.S. with the RNs matched by census tract and gender to a comparison group ten times larger. Data were obtained from interviews that covered sociodemographics, utilization of health care services, abuse of alcohol and/or drugs, and symptoms of depression. The Diagnostic Interview Schedule (DIS) was used to gather data about psychological symptoms (Trinkoff et al., 1991). Author-identified limitations to the study were the small sample size of nurses in comparison to the control group (which was 10 times larger), and the retrospective self-report data collection method that may result in underestimation of drug use. Study findings reported RN substance abuse rates to be less than or equal to the matched sample of non-nurses (Trinkoff et al., 1991). This was the first study to

utilize a large data set to report that prevalence rates in nurses likely mirror those of the general public (Hughes et al., 2002; Naegle, 2003).

Two subsequent prevalence studies concurred with the findings of Trinkoff et al. (1991). A study by Blazer and Mansfield (1995) analyzed substance use data from two investigations that measured job outcomes and stress among employed females in a large eastern state (Blazer & Mansfield, 1995). The study was limited to one state; the sample of registered nurses numbered 919. The RN group was compared to two comparison groups: 399 traditional female workers (secretaries) and 198 non-traditional female workers (skilled in crafts and trade occupations). The types of drugs/substances surveyed included alcohol, tobacco, illicit drugs, and non-prescription drugs. Overall, the rates of substance use/abuse were no higher among RNs than the non-RN participants (Blazer & Mansfield, 1995). Social desirability bias, a possibility in all studies that use a self-report survey format for data collection, may have resulted in underestimation of substance use/abuse rates in all three groups of women. It is possible that the rates among the RN group were underestimated due to recruitment methods for the study, as well. The researchers purchased a mailing list of RNs from the state's professional nurses' organization although it was not made clear whether the list was comprised only of members of the professional organization or whether all nurses in the state were included on the list. It may be possible that nurses who abused or were dependent on substances chose not to participate due to concerns about confidentiality. Additionally, the response rate for the sample of nurses was low (952 responses from a pool of 5,000 nurses in the state, or 19%) (Blazer & Mansfield, 1995). Despite these limitations, findings of the study concurred with the Trinkoff et al. (1991) prevalence study results.

30

Using a methodology similar to the Trinkoff et al. (1991) study, alcohol and drug use prevalence among nurses was studied by Hughes et al. (2002). Data were analyzed from the 1984 National Longitudinal Study of Labor Market Experiences of Youth, a large, national longitudinal study that began in 1979. It focused on various experiences of participants in the labor market, including nurses. Gender was nearly evenly matched in both the nurse and control groups. Variables related to illegal drug use and heavy alcohol consumption were matched to those used in the study by Trinkoff et al. (1991). Findings from this study were comparable to the findings from the Trinkoff et al. (1991) study. When data from employed nurses were compared to the group of employed non-nurses it was concluded that there were no differences in prevalence rates of substance use between the two groups. Two limitations of the study were that the number of nurses in the study was small (50); they were also young (mean age of 24.5) (Hughes et al., 2002; Snow & Hughes, 2003). Additionally, this study also relied on self-report instruments with the accompanying limitation of possible social desirability response bias. Despite these limitations, the studies by Trinkoff et al. (1991) and Hughes et al. (2002) are cited frequently in the current nursing literature when discussing prevalence rates of SUDs in nurses, due in part to the use of a large, population-based study design.

Trinkoff partnered with other researchers in the 1990s to produce additional research results about SUDs in nurses. Trinkoff and Storr (1998) studied nearly 4,500 RNs across 10 different states to determine prevalence of drug use in four substance categories: marijuana/cocaine, prescription drugs, cigarettes, and binge (alcohol) drinking. The sampling method of this study was termed "balanced stratified" and was described by the authors as sampling that "…combines probability sampling with model based sampling" (p. 582). The 10

states were stratified and the number of RNs in each state "…was used as the auxiliary variable, because of the correlation of population size with substance use" (p. 582). Results of this study concluded that prevalence rates among nurses for the four substances studied were similar to the general population with some exceptions: nurses used prescription drugs, especially narcotics, at higher rates but smoked cigarettes and used marijuana/cocaine at lower rates (Trinkoff & Storr, 1998).

This study also examined substance use rates by nursing specialty areas, finding that nurses in emergency departments and critical care areas reported using marijuana/cocaine at higher rates than nurses in other areas; higher rates of binge drinking were reported by nurses in oncology; psychiatric nurses reported higher rates of cigarette smoking. The authors compared these findings to several studies that had been done on physician drug use by specialty and found the results to be very similar, which was confirmed in a subsequent study with a physician research partner (Storr, Trinkoff, & Hughes, 2000). Higher rates of prescription drug use/abuse by nurses compared to the general population continue to be reported in the current literature although comparisons to the "general population" often lack clarity about whether the comparisons are only to women or to the entire population (Bettinardi-Angres et al., 2012; Dunn, 2005; NCSBN, 2011). This is especially true for use of opioids by nurses.

In summary, limitations of the previously discussed studies on attitudes, risk factors, and prevalence are that they relied on data collected from self-report surveys/questionnaires or were secondary data analyzed from larger data sets (again, mainly self-report data). Social desirability response bias is always a limitation when surveys are used. Under-reporting of drug/alcohol use due to denial of the severity of the SUD is also possible given well-substantiated information in

the literature about the powerful influence of stigma on nurses with SUDs (Dunn, 2005; Godfrey et al., 2010; NCSBN, 2011). Therefore, concerns about honesty of responses obtained through self-report of a stigmatized disorder must be considered. Effects of social desirability bias may also have been higher for nurses than non-nurses in these studies because of the higher expectations placed on nurses (e.g., expectations of trust and honesty) by the public (Darbro, 2005). Despite these limitations, these early studies provided a foundation of empirical evidence from which future research could be built.

Qualitative Studies

Studies using qualitative methodologies that explored the perspectives and experiences of nurses are limited in number among the early nursing literature on this topic. One study used a grounded theory approach to examine processes operating as nurses became dependent on drugs and/or alcohol (Hutchinson, 1986). Participants of the study included nurses who admitted to dependence on alcohol and/or drugs as well as others working in state regulatory or monitoring positions. The basic social process (and core variable) in the study was "trajectory toward self-annihilation" (Hutchinson, 1986, p. 196). The study was one of the first to explore disease progression of SUDs from the experiences of the nurses dealing and living with it.

A subsequent grounded theory study by Hutchinson (1987) examined the basic social processes occurring for nurses in recovery from SUDs. The core variable to emerge was "self-integration," as nurses with SUDs became abstinent and accepted themselves as persons in recovery (Hutchinson, 1987, p. 339). Although this was one of the first qualitative studies to focus on the experience of recovery, it offered little information about workplace re-entry for the nurse participants, focusing instead on processes within the person that enhanced recovery and

well-being. The two studies by Hutchinson (1986, 1987) were important additions to the literature for explicating key social processes that helped explain the experiences of nurses with SUD progression and the processes of personal recovery.

Qualitative methods were used to explore self-perceptions of nurses with SUDs related to factors that facilitated or hindered the process of recovery (McClanahan & Sullivan, 1995). Open-ended interview questions explored the constructs of self-concept, social support and life-event stress. Semantic content analysis identified themes in the qualitative arm of this mixed methods study. Seventeen subjects were interviewed initially; 13 participated in one-year follow-up interviews. Two of the eight categories that emerged related to workplace issues: (a) stress at work and (b) workplace access to prescriptions and drugs. At both the initial and the one-year follow-up interviews, several nurses voiced plans to leave nursing although reasons for this were not articulated in the study. Recommendations included the need to explore the issue of work re-entry as it was anticipated that changes by state regulatory boards and alternative program development that were occurring at this time might improve the professional working environment for nurses in recovery from SUDs (McClanahan & Sullivan, 1995). This was one of the first qualitative studies to include work re-entry issues, albeit primarily to recommend that the issue be further explored.

The lived experience of being labeled "impaired" by the nursing profession was explored in a hermeneutic phenomenological study with nurses in recovery for SUDs (Brewer & Nelms, 1998). Two of the five themes to emerge were directly related to workplace issues: "…denial of employment due to being labeled 'impaired'…and willingness to share one's recovery with professional peers" (Brewer & Nelms, 1998, p. 175). All nurses attached negative meaning to the

34

label "impaired." Four nurses out of the sample of 14 had been denied employment due to the SUD diagnosis, despite having successfully completed treatment. The small size of the study was a limitation; there was also homogeneity among participants by race (all were Caucasian but one). However, the study is noteworthy for acknowledging the importance of language use, labeling, and stigma related to the topic of SUDs in nurses.

A more recently published resource manual from NCSBN (2011) that provides guidelines for state alternative programs makes the following statements about the use of the term "impaired" within the publication:

> The term "impaired" is specifically *not* used [emphasis added] because a person with a substance use disorder is not necessarily impaired; that is, always functioning poorly or incompetently. On the contrary, a nurse with a substance use disorder can be high-functioning and high-achieving. It's a myth that all alcoholics are skid row drunks and that all those with a substance use disorder are necessarily impaired. (p. 3)

Increased sensitivity to and change in language usage is apparent when the body of literature on SUDs in nurses is viewed over time. The term "impaired" is much less in evidence in current literature and research about this topic and is not used in this study unless it is present in authors' quotes from referenced sources.

At the turn of the century, a qualitative phenomenological study was published by Australian researchers who explored the experiences of nurses who self-identified as having a "substance misuse problem" (Lillibridge, Cox, & Cross, 2002, p. 219). A small sample of 12 nurses were interviewed, either face-to-face or over the telephone. Recruitment of participants was difficult, which the researchers attributed to participant fears about confidentiality.

Telephone interviews were perceived as being preferred by participants due to the anonymity it afforded them to share their experiences.

Findings of the study were categorized into five main themes: justification for using substances, fear of being discovered, personal meaning of substance use for nurses, the professional impact, and the turning point in the road to recovery. Fear was discussed by all participants and was clearly evident in the study findings: fear of losing employment (livelihood) and nursing identity, fear of stigma and being labeled an 'addict,' and fear of others no longer viewing the participant as a competent nurse. These fears were described by the researchers as "…major reasons for not acknowledging their problem and seeking help" (Lillibridge et al., 2002, p. 224). Other pertinent findings of the study related to reasons for using drugs shared by participants: "Nurses stated that they needed substances to feel good about themselves and to deal with the high expectations they perceived that society and the nursing profession had of them as nurses" (p. 224). Participants shared that they used drugs and/or alcohol to help cope with the stressors of a difficult job, working alternate shifts, and to deal with the complex work roles and stress of being a nurse. Nurses also expressed anger and a feeling of non-support and lack of caring from nursing colleagues once their SUD was made public.

This study had some limitations related to small sample size, gender breakdown (very few men), and the fact that some of the participants interviewed were in the acute withdrawal phase and had minimal to no experiences with recovery. Licensure in Australia is different than in the U.S., as is language use to refer to SUDs, making comparison of findings somewhat problematic. For instance, "substance misuse problem" was never defined by the researchers.

However, this study did focus on the personal experiences and perspectives of nurses with a history of substance use and misuse, although work re-entry issues were not discussed.

The qualitative studies published in the early literature about SUDs in nurses, although limited in number, were valuable additions to the literature as they gave voice to the nurses with a SUD to share their experiences within the professional context of nursing. These studies validated the pervasiveness of stigma experienced by nurses with SUDs and complemented knowledge gained from the quantitative studies done at the time. They helped set the stage for expansion about this topic which included a shift in research focus to state alternative-to-discipline programs that had been developed in several regulatory jurisdictions across the nation. However, since drug trends, beliefs, and policies/programs related to nurses with SUDs have evolved over time, it is unknown if the perceptions and experiences of today's nurses with SUDs are the same or different than those of earlier studies.

The 21st Century: Expansion of Research with Alternative Program Type as Variable

At the onset of the 21st century, the body of literature on SUDs in nursing had been accumulating for well over 20 years. Parallel to the development of this body of knowledge was the ever-changing national landscape of alternative-to-discipline program development to monitor nurses after SUD treatment completion. The decision to develop alternative programs rested with each individual state and territory, although in the 1980s the ANA strongly encouraged states to develop and use alternative programs for nurses with SUDs (Monroe et al., 2008). How these programs differ from each other and contrast with more traditional disciplinary programs is important for understanding what is currently available for nurses with SUDs.

Treatment Models for Nurses with SUDs

  Disciplinary models. The disciplinary model "…represents an official action of the board of nursing…" (NCSBN, 2011, p. 83), usually based on state statute, that involves a process of penalizing nurses and restricting their practice of nursing (Monroe et al., 2008). This is done through sanctions against the nursing license, usually suspension or revocation, thereby removing the nurse from any contact with patients (NCSBN, 2011). If discipline is instituted against the nurse, it becomes part of the public record, as all state BONs are required by federal law to report it to a national data bank (NCSBN, 2011). Disciplinary models do not protect the privacy of the nurse because of the federal reporting requirement, often making it difficult for the nurse to find future work after SUD treatment (Monroe et al., 2008). A nurse with a SUD under this treatment model has the opportunity to request a hearing about the case and appear before the BON in person (NCSBN, 2011). Some states allow the nurse to voluntarily surrender his/her license until it can be determined that the SUD is treated and recovery underway.

  Alternative-to-Discipline Models. Alternative-to-discipline programs are non-punitive, voluntary alternatives to the BON disciplinary model and are characterized by an emphasis on early detection, intervention, treatment, and aftercare monitoring (Hughes, Smith, & Howard, 1998; Monroe et al., 2008). There are several different models of alternative programs in operation across the U.S. Some programs operate independently, but with close ties to the state BON. This type of alternative program allows nurses with SUDs to avoid disciplinary actions if they sign and comply with a contract with the alternative program, which monitors the nurse throughout the processes of screening, intervention, treatment and aftercare (Monroe et al., 2008). Public disclosure of the SUD may be avoided with this option.

The second model is one where the alternative program is actually operated by an arm of the state BON: one arm runs the disciplinary model and another arm operates the alternative program (Monroe et al., 2008). Involvement with the alternative program run by the BON may maintain confidentiality of the nurse (depending on circumstances) and no public disclosure occurs. A third model is a statewide alternative program that collaborates not just with the BON but with numerous regulatory boards in the state (e.g., medicine, dentistry, pharmacy, etc.) (Monroe et al., 2008). This is the model that operates in the state where a majority of nurse participants for this study were licensed. A fourth model involves an agreement between the state BON and a state professional organization, usually the state nurses' association, for operation of the alternative-to-discipline program (NCSBN, 2011). Some states have a combination of more than one model type.

Generally, alternative programs maintain confidentiality of the nurse enrolled unless relapse occurs, which triggers a report being sent to the BON (Health Professionals Services Program, 2015). Typical to all alternative programs are services initiated through contractual agreement between the program and the nurse with SUD that includes evaluation/screening, assignment to a case manager, and treatment/aftercare monitoring (Monroe et al., 2008). Relationships between alternative programs and the state BON differ, depending on state statute and alternative program type.

In summary, since the inception of alternative programs, the goal has been to provide rehabilitation and recovery support for nurses with SUDs in a voluntary, confidential, non-punitive, therapeutic environment (Hughes et al., 1998; Monroe et al., 2008). However, as these programs came into being, there was significant variance in development, operations, and how

the state BON was involved with the alternative program (Monroe et al., 2008). This will be discussed in a later section of this review.

The number of studies published about SUDs among nurses decreased as the 21st century began, although reasons for this are unclear. Trossman (2003) asserted that it was due, in part, to nursing shortages and a greater focus on other workplace issues. There was a shift away from examining characteristics of the individual nurse with a SUD to (a) exploring and comparing features and effectiveness of different types of state programs (e.g., alternative versus disciplinary), and (b) examining ways to assist other nurses to identify, manage, and support nurses with SUDs. These are discussed in the following sections, separated into national studies and those specific to particular states. If a study includes a section pertaining to workplace re-entry for nurses with SUDs, it is also discussed.

National Studies

Data from a large national study about the health and work-life of nurses were analyzed by Trinkoff, Zhou, Storr, and Soeken (2000) to explore whether role strain, access to substances in the workplace, and freedom from negative proscriptions increased the likelihood of nurses becoming dependent on drugs. Findings showed nurses were at higher risk to use/abuse substances if they had easy access to drugs in the workplace, minimal negative proscriptions (defined as decreased religiosity and weak social affiliations), and consequences of role strain (measured in the study by exploring symptoms of depression). Strengths of this study were its large sample size (3,600 nurses participating in a national survey), high response rate (84%), and the structural equation model used to evaluate fit with workplace access, role strain and negative proscription. The use of self-report surveys and the potential for social desirability bias and

underestimation of drug use are limitations of this study. The cross-sectional design of the study was also identified as a limitation by the authors of the study because of the inability to draw temporal/causal conclusions with this design (Trinkoff et al., 2000). This study added information to the literature by its multi-dimensional examination of workplace issues and the internal/external conditions common among nurses (i.e., access to controlled substances, workplace demands), but work re-entry after SUD treatment was not explored.

A review of literature about the different treatment approaches and their effectiveness in treating nurses with SUDs was conducted by Monroe et al. (2008). Comparison between disciplinary and alternative programs was described and recommendations made for professional nursing practice. The authors determined that conclusions were difficult to reach because of a paucity of rigorous research studies about different program types and a lack of methodological consistency in how studies about program effectiveness are conducted. It was also difficult to determine the number of nurses in the different types of programs because privacy laws and a lack of transparency made access to data difficult for the investigators. Additionally, the authors cited a serious lack of studies focused on short- and long-term effects of the different treatment approaches and how success is defined and measured (Monroe et al., 2008).

To date, the study by Monroe et al. (2008) provides the most comprehensive study of alternative program types on a national level and the difficulties inherent in attempting to reach conclusions about them. Lack of uniformity among alternative programs makes it difficult to compare outcome-based data across all states and hinders clarity about treatment and monitoring of nurses with SUDs from a national perspective. Evaluation of alternative programs is not a requirement of every state; nor is public access of specific policies of the regulatory board

41

required by all states (NCSBN, 2011). Recommendations specific to research needs that emerged from the Monroe et al. (2008) study were to develop consistent definitions of commonly used terms, practice uniform data collection methods, and focus more on outcome analysis to improve understanding of what is most effective in assisting nurses with treatment and recovery.

Concerns that past estimates of prevalence of SUDs in nurses were based on anecdotal evidence or self-report survey data led researchers to conduct a study using a different research design (Monroe et al., 2013). The objectives of the study were to: (a) estimate the one-year prevalence of employed nurses who require an intervention for SUDs; (b) compare one-year prevalence of newly enrolled nurses in state BON disciplinary monitoring with those newly enrolled in alternative programs; and (c) compare the sum total of nurses newly enrolled in disciplinary and alternative program monitoring with a measure of the general population needing intervention for SUD. Secondary analysis was done of data from several sources: a NCSBN report on disciplinary programs done in 2010, the 2009 annual report on alternative programs, and two government reports: one on registered nurses from the Department of Health and Human Services and one on estimates of the general population who receive SUD treatment from SAMHSA.

Stratified balanced sampling, similar to the sampling used in the Trinkoff et al. (1991) study, was used to obtain national figures that represented nurses with a SUD. Two government reports on numbers of employed nurses were stratified into five categories based on size of RN populations. A convenience sample of 10 states with alternative programs was used to estimate the number of nurses nationally who were newly enrolled into monitoring by alternative programs and BON disciplinary monitoring programs in a given year (2009). Once the data were

ascertained, the combined prevalence of nurses enrolled in BON disciplinary programs and alternative programs was compared with the sum total of nurses in the U.S.

Results of this study indicated that the 2009 one-year prevalence of employed nurses (RNs and licensed practical nurses) newly identified to have a SUD was 5.1 per 1,000 nurses (0.51% or a total of 17,085 nurses in the U.S.). The one-year prevalence of nurses to be newly enrolled in a SUD monitoring program, either through the state BON or an alternative program, was 3.6 per 1,000 nurses (0.36% or 12,060 nurses). The denominator to identify percentage was 3.35 million nurses in the U.S. (RNs and licensed practical nurses combined), a number established from government reports. The reference point of 1% was used as the one-year prevalence of individuals in the general population requiring an intervention for SUD (although how this figure was obtained was not explained). The study also found that the numbers of newly enrolled nurses in alternative programs was nearly 75% higher than newly enrolled nurses in BON disciplinary monitoring programs.

Final conclusions of the study were in agreement with previous studies on prevalence of SUDs in nurses in showing that prevalence rates are no greater (and most likely less) than in the general population. The strength of the study is that it included more data for analysis compared with the older studies that examined prevalence by Trinkoff et al. (1991) and Hughes et al., (2002). Limitations of the study are its complex design and lack of clarity related to how the figure of 1% of the general population requiring intervention for SUD was obtained. This study also had note-worthy results that showed alternative programs being more frequently used by newly enrolled nurses into monitoring for SUDs when compared with numbers of newly enrolled nurses to disciplinary monitoring for SUDs from state BONs.

An interesting concluding point made by Monroe et al. (2013) was, "…the science of nursing regulation regarding the effectiveness of ATD (alternative-to-discipline) and disciplinary programs is in its infancy. As such, both communication and documentation of substance use data in the nursing population is not yet streamlined" (Monroe et al., 2013, p. 13). This assertion, coupled with the difference in types and operating practices of alternative programs throughout the U.S., support the need for further research. The next section discusses studies specific to the evaluation of individual state alternative programs that treat SUDs in nurses.

State Studies

  State-to-state comparison. The early part of the twenty-first century was a time when state alternative programs for SUD treatment of nurses were becoming a prominent focus of research interest. A longitudinal comparative study with six data-collection points over six months was designed to study RNs and licensed practical nurses with SUDs in four different states (Haack & Yocom, 2002). The aim of the study was to explore differences in characteristics, relapse rates, and workplace retention between nurses disciplined by state BONs compared with those engaged in alternative-to-discipline programs. Five survey instruments were used, including an employment history and current work description survey. Findings of the study showed the two groups were "statistically equivalent" (p. 8) in regard to characteristics (i.e., age, gender, time since initial licensure as a nurse, etc.). Results showed that a higher number of nurses monitored by alternative programs had active licenses and were employed in nursing than those disciplined by the state BON. The last data collection point at six months showed 76% of nurses in alternative programs were still employed in nursing compared to 49% involved with disciplinary programs. No differences in relapse rates were noted. The authors

44

concluded that alternative program policies worked as well as BON disciplinary policies in

protecting the public from unsafe nursing practice; alternative program approaches were also

deemed more humane and rehabilitative (Haack & Yocom, 2002). Although specific data on

workplace re-entry were not collected, a contribution of this study was the finding that more

nurses in alternative programs remained in practice than those disciplined by the BON.

Satisfaction of 383 nurse participants involved in alternative program monitoring in

Indiana and Michigan was studied by Fletcher and Ronis (2005). A high percentage of those who

responded indicated they were working in nursing practice settings while being monitored (79%

in Michigan; 66% in Indiana) (p. 66). The levels of satisfaction with the respective alternative

programs were similar when the two states were compared and satisfaction was high overall

(Fletcher & Ronis, 2005). This study was one of the first to compare data about satisfaction with

program involvement from two different alternative programs in two different states. Limitations

included a low response rate (43% in Michigan; 45% in Indiana). Work issues were only

discussed in relationship to a survey question about working while being monitored.

Quantitative studies in individual states. Quantitative research has occurred in a small

number of states pertaining to monitoring nurses with SUDs.

Florida. A study of life stressors experienced by nurses with SUDs prior to and during

involvement in the Florida state alternative program examined the association between

situational confidence levels and the ability to resist relapse (Brown, Trinkoff, & Smith, 2003).

Measures included a checklist of common life problems experienced by persons with SUDs and

a questionnaire to measure situational confidence (also commonly used to measure self-efficacy).

Findings of the study suggested that nurses experienced lower burden of life problems after

enrolling in an alternative program (with the exception of financial difficulties, which persisted before and during program involvement). High numbers of life stressors and a high rate of endorsement of depressive symptoms significantly reduced confidence of participants to resist relapse (Brown et al., 2003). Limitations included the retrospective, self-report format and cross-sectional design of the study, the fact that the actual occurrence of relapse was not measured, and that only nurses in alternative programs were studied, making it difficult to generalize or compare findings to nurses involved in disciplinary programs from the BON. Again, work re-entry was not specifically discussed in the study.

Idaho. Data from the alternative-to-discipline program in Idaho were analyzed by Clark and Farnsworth (2006) with the aim of developing composite information about nurses with SUDs who had participated in the program. The study involved retrospective review of 207 records of nurses enrolled in the program from 1985 to 2000. Specific findings that relate to workplace issues indicated that 85% of the nurses had practice restrictions placed on their nursing licenses during program involvement. While being monitored in the alternative program, 51% changed employment, 32% did not (other data not available). Ninety percent of those who completed the alternative program were employed in nursing afterwards (Clark & Farnsworth, 2006). Issues related to re-entry to the nursing workplace were not examined other than to report change of employment data, therefore it is unknown why those who changed employment did so and/or what factors contributed to the 32% staying in the same employment setting.

New Jersey. The variables of stress, coping, and adaptation in nurses with SUDs who were involved in nursing peer support groups in the state alternative program in New Jersey were examined in a descriptive, correlational study by Bowen, Taylor, Marcus-Aiyeku, and Krause-

46

Pirello (2012). Instruments used to measure study variables included the Perceived Stress Scale, Multidimensional Scale of Perceived Social Support, and Psychological Well-Being Index, all survey tools with reported high reliability. Study findings showed negative relationships between stress and the other two variables, social support and well-being. A positive relationship was found between social support and well-being. Bowen et al. (2012) recommended strengthening social support networks to help prevent relapse and aid in workplace re-entry for nurses with SUDs. While this study examined the relationships among stress, social support, and well-being in the lives of nurses with SUDs involved in an alternative program, it did not explore what processes and/or factors in the workplace contribute to these experiences.

Arkansas. Arkansas is one of the few states remaining in the U.S. with no alternative-to-discipline program. A retrospective study of Arkansas nurses with SUD examined the relationship between the length of disciplinary probation for substance use (mandated by the Arkansas BON) and the rate of recidivism (Davis, Powers, Vuk, & Kennedy, 2014). Probation was defined as "…a limitation or restriction of one or more aspects of nursing practice, such as limits on role, setting, activities, or hours worked" (p. 41). Recidivism was defined as "…having new violations during or after probation" (p. 41). The authors used secondary data retrieved from computer files from the Arkansas BON. Only RNs were studied.

Predictors of recidivism among nurses during probation were assessed using a logistic regression prediction model. The study was designed with two groups: a control group (n = 76) consisting of RNs with only one substance use period of disciplinary probation and a recidivism group (n = 76) consisting of RNs with two or more disciplinary probations for substance use.

Independent variables were: "…age of first violation, felony conviction, addiction to both habit-forming drugs and alcohol, and length of probation in months" (Davis et al., 2014, p. 41).

Results of this study found no statistically significant relationship between length of probation and rates of recidivism. However, there was a statistically significant association between felony substance conviction and recidivism, with the odds of recidivism being 4.6 times higher for RNs with a felony conviction than those without a felony conviction. The other statistically significant association found the odds of recidivism to be 5.9 times higher for nurses addicted to a combination of drugs and alcohol than to nurses addicted to only a "habit forming" drug or to alcohol alone.

Limitations of this study relate to missing information. It was not reported how drug of choice was ascertained: whether self-reported by the nurse with SUD or by diagnosis from a healthcare practitioner. Nor was it explained what actions were specifically mandated by the BON during disciplinary probation or what constituted a violation of it. Differences in monitoring mandates based on drug of choice or any other variable were also not discussed. No report of whether nurses in the two groups had completed SUD treatment was included. Since Arkansas has no alternative program in place by which additional comparisons could be made, the missing information about how nurses with SUD engage with the Arkansas BON seems critical.

Indiana. Perceptions of administrators and others involved as worksite monitors of nurses with SUDs have been studied in some states. A small qualitative study in Indiana involved interviews with six participants who were managers, directors, or workplace monitors to study their perceptions about working with nurses with SUDs who were involved in the state

alternative program (Godfrey et al., 2010). A stated purpose of the study was to explore the stigma associated with the topic of SUDs among nurses. Findings showed all participants understood SUDs as an illness and many voiced frustration that institutional employer policies did not endorse this same view. A theme related to work issues was a reluctance to hire nurses involved in the alternative program due to stigma, characterized by the view that nurses with SUDs have "failed" (Godfrey et al., 2010, para. 12), although how failure was perceived or defined was not discussed. A study recommendation was to strengthen educational curricula about SUDs as treatable diseases in order to counter stigma and better prepare colleagues and managers to support and supervise nurses with SUDs (Godfrey et al., 2010). Small sample size was a limitation of the study but this study again identified stigma toward nurses with SUDs. Work re-entry was not specifically addressed.

South Dakota. In South Dakota, worksite monitors are individuals who work with nurses with SUDs when re-entry to the practice setting occurs. Young (2008) surveyed the perceptions of new and experienced worksite monitors about content and teaching methodologies of worksite monitor education. An interesting study finding was a general lack of knowledge among worksite monitors about the concept of recovery. Another finding of interest was that workplace monitors identified the importance of confidentiality for both the nurse with the SUD who returned to work and the workplace monitor. These findings indicate that there is a need to better understand the processes and factors involved in the work environment when nurses with SUD re-enter the workplace. Unfortunately, no information about work re-entry from the perspective or experience of the returning nurse was included in this study. This would have significantly

added to the study by comparing perceptions and experiences of the nurses re-entering the workplace with those who provide workplace monitoring of them.

   Oregon. In Oregon, state laws require supervisor training for all nurses who provide workplace monitoring for nurses with SUDs enrolled in the state alternative program. The Fit to Perform training program for nurse supervisors acting as workplace monitors was developed and implemented utilizing a face-to-face, classroom setting that was delivered around the state (Cadiz, Truxillo, & O'Neill, 2012). Evaluation of the training program was done on a sample size of 136 nurse supervisors who completed the training across the state of Oregon. Pretest-posttest methodology was used to assess changes in participants' knowledge and attitudes.

   Results of the training evaluation showed increases in knowledge about SUDs, training utility (how to develop supervisory skills to be an effective workplace monitor), and self-efficacy (as a measure of participant confidence to effectively monitor nurses with SUDs). Substance abuse stigma toward people recovering from a SUD was also measured and found to be significantly lower on the post-tests. Limitations of the study were the non-experimental research design (no control group), potential selection bias (participants volunteered to participate in the study) and the self-report measures used (and potential for social desirability bias). However, descriptions of this workplace supervisor training is the most comprehensive of any in the literature as to its development, implementation, and evaluation of training effectiveness for nurse supervisors volunteering to assume the role of workplace monitors.

   The Fit to Perform training described above has recently been modified and put into an online format and distributed beyond the state of Oregon. A recently published evaluative study of the effectiveness of this computer-based course used an experimental design with a sample

that included workplace monitors from alternative programs in other states (Cadiz, O'Neill, Schroeder, & Gelatt, 2015). Like the research on the Fit to Perform course in the Oregon study above (Cadiz et al., 2012), participant knowledge, attitudinal outcomes (self-efficacy and intentions), ability/skills to manage/monitor a nurse with SUD, and stigma were all measured. Additionally, satisfaction with the online format was also assessed. Unlike the first Fit to Perform course evaluation study, an experimental design was used with a larger sample of participants ($n = 378$) randomly assigned to receive the online course (the experimental group) or to be on a waiting list for six weeks and them receive access to the course (the control condition group). Three online assessments were completed: baseline, two-week post-test assessment, and six week follow-up assessment.

Results of the evaluation of the Fit to Perform online course were very similar to the face-to-face classroom version described above (Cadiz et al., 2012) as there were increases in knowledge, self-efficacy, intentions to use the supervisory skills and a decrease in stigma toward SUD. The online format was also viewed positively as very useable by participants. Limitations are also similar to those listed in the first study (Cadiz et al., 2012). It is interesting to note that in the second study that the only variable with poor long-term retention on follow-up assessment was stigma, leading the investigators to comment that this "…could mean that changing stigmatizing attitudes requires more than a single exposure to an online education course" (Cadiz et al., 2015). One could also speculate that the culture of healthcare systems may re-influence the nurse who has had the Fit to Perform training. Participants could be warned of this effect from long-term immersion in healthcare systems that continue to stigmatize those with SUDs.

Both versions of the Fit to Perform training described in the two studies above are positive steps for possible changes to the workplace environment where nurses with SUDs are monitored and supervised. The additional education provided for those in the important supervisory positions of workplace monitors may benefit the nurse with SUD being supervised and the patients assigned to their care. Stigma, as was noted in the studies, may also be reduced, which may have a positive overall effect on the workplace environment.

Qualitative studies in individual states. Several qualitative studies have described various aspects of the experiences of nurses with SUDs and their experiences in being monitored, either by alternative programs or state BONs. Some of these studies include a discussion of issues related to re-entry to work and nursing practice.

New Mexico. The experiences of nurses in New Mexico who completed the state alternative program were compared with those who were non-completers (eight in each sample group). The main focus of this "qualitative, emergent research design" (Darbro, 2005, p. 170) was on the reasons why some nurses dropped out of the state alternative program, knowing that nursing license revocation would occur. The study found that participants from both groups identified benefits from participation in self-help recovery groups. Both groups also described working in "…a culture of mistreatment of addicts (as patients)" (Darbro, 2005, p. 179) that influenced the decisions of participants to conceal their own problems with SUDs from colleagues. Another finding common to both groups was concern about stressful worksites, as manifested by nursing shortages, high patient-nurse ratios, and working with very acutely ill patients. Despite workplace stigma experienced by both groups, differences between them showed the completers to be more committed to remaining in nursing and highly motivated to

52

retain their nursing licenses to practice; non-completers voiced less affiliation with the nursing profession and were more likely to contemplate leaving it. This study adds information about workplace issues based on the personal experience of a small group of participants, although the focus was more on recovery than on workplace re-entry. Conclusions based on findings of this study also agree with the previously discussed study by Haack and Yocom (2002) in endorsing alternative programs as effective and valuable for nurses with SUDs.

    Florida. The experiences of nine Florida male nurses who successfully completed the state alternative program were explored in a hermeneutic phenomenological study (Dittman, 2008). Participants were asked about their lives, upbringing, and experiences with SUDs and all indicated they had grown up in families where some sort of abuse was present. "Masterminding" the work environment was a major theme, described as the manipulation resorted to by participants to avoid getting caught diverting drugs from the workplace as the SUD progressed (Dittman, 2008, p. 327). All participants verbalized difficulty with re-entry to nursing practice, especially returning to work in environments where narcotics are present. Additionally, all participants identified having minimal to no assistance or support from nurse administrators upon re-entry to work and practice. Seven of the nine participants chose to remain employed in nursing practice after treatment. Findings of this study provided insights about the personal experiences of a small group of male nurses with SUDs. It discussed work re-entry issues from the perspective of the nurse participants but the study did not specifically address the processes in the workplace that facilitated the return to nursing practice or why those who chose to leave nursing did so.

Alabama. The goal of a study done in Alabama was to evaluate and compare effectiveness of the state BON disciplinary program and the state alternative program (Fogger & McGuinness, 2009). Exploration of attitudes and experiences of a total of 173 participants in these programs was the primary focus of the qualitative questions in a survey that included both quantitative and qualitative items. Results from the demographic questionnaire items indicated over 90% of participants were employed while being monitored. Work re-entry findings included the burden nurses in both programs perceived in not being allowed to work overtime or to administer narcotics (prohibited by state statute in Alabama for nurses being monitored for SUDs). Upon return to work, anonymity was problematic for many, especial in rural practice settings. Ninety-two percent of the participants named the monitoring structure as a positive contribution to their continued sobriety/abstinence. As with many of the studies discussed so far, self-report and possible response bias are limitations of the study.

Indiana. "Mutual accountability" was the overall theme that emerged from a qualitative study of the experiences of nurses with the alternative program in Indiana (Horton-Deutsch, McNelis, & O'Haver Day, 2011, p. 450). The participants described the perceived benefit of being held accountable for their own sobriety and for following alternative program rules during monitoring. Also repeatedly endorsed by participants was the need for on-going education of nursing colleagues in the workplace to better understand SUDs as treatable diseases and to overcome the stigma that participants experienced.

In summary, the findings of the qualitative studies reviewed have some similarities. The monitoring structure, especially of the alternative programs, was identified by participants to be beneficial to ongoing sobriety and recovery in studies by Darbro (2005), Fletcher and Ronis

(2005), Fogger and McGuinness (2009) and Horton-Deutsch et al. (2011). All of these studies noted that stressful work environments and stigma influenced the work experience of nurses being monitored for SUDs. Most of these studies focused on the monitoring experiences of the nurse with SUD by the state alternative program, the BON disciplinary program, or both. Missing in these studies is a discussion from the perspective of the participants about the processes operating in the workplace environment that facilitated or hindered the re-entry to work after SUD treatment.

As the preceding discussion indicates, diverse methods have been used and multiple variables have been studied in research about state disciplinary and alternative programs that monitor nurses with SUDs. An analysis of studies published since the beginning of the 21st century finds nearly equal numbers of quantitative and qualitative studies. Only two studies compared results across a small group or pair of states (Fletcher & Ronis, 2005; Haack & Yocom, 2002). The alternative program in Florida, the first in the nation (Hughes et al., 1998), was the focus of two of the studies reviewed (Brown, Trinkoff, & Smith, 2003; Dittman, 2008). The alternative program in Indiana was the focus of three studies (Fletcher & Ronis, 2005; Godfrey et al., 2010; Horton-Deutsch, et al., 2011). Only seven other states are represented in the nationally published studies about state alternative programs and the nurses they serve. Given that there are now alternative programs in 43 out of 59 jurisdictions (U.S. states and territories), (Bettinardi-Angres et al., 2012), two concerns arise: (a) that minimal research is being done about outcomes or effectiveness of alternative or disciplinary programs that treat nurses with SUDs; and, (b) if studies are being done, national dissemination of research results by state BONs or alternative programs is very poor.

The issue of work re-entry was not the main focus of these studies. The quantitative studies minimally covered workplace re-entry but, when it was discussed, usually recommended enhanced education for nurses about SUDs in general, and about SUDs among nurses more specifically. All of the qualitative studies (Darbro, 2005; Dittman, 2008; Fletcher & Ronis, 2005; Fogger & McGuinness, 2009; Godfrey et al., 2010; Horton-Deutsch, 2011) discussed work re-entry to some degree, although this topic was not the primary focus of these studies. Absent among the studies is evidence, gathered from the perspective of the individual nurse, about the processes operating in the nursing practice environment when re-entry to work after SUD treatment occurs.

Work Re-entry Research

There is a paucity of research studies focused specifically on work re-entry of the nurse with SUD. Publications in the 1980s, 1990s, and early 2000s specific to work re-entry were often informational rather than research-based and were usually directed at specific nursing specialty subgroups. One of the earliest published papers related to work re-entry provided general information and an interview guide developed for use by nurse administrators who made decisions about hiring/re-hiring nurses in recovery from SUDs (Veatch, 1987). Publications by Stefanik-Campisi and Marion (1987) addressed psychiatric nursing case management of nurses with SUDs. Windle and Wintersgill (1994) offered information to nurse managers about management strategies needed when a nurse with SUDs returns to work. None of these published articles were research studies.

The exception in this scant body of literature about workplace re-entry was a quantitative survey study completed in Florida in the mid-1990s (Hughes et al., 1998). Participants were

nurses with SUDs enrolled in the Florida alternative program, the Intervention Project for Nurses (IPN). The aim of the study was to explore factors associated with work re-entry. Data were obtained by an author-designed survey containing basic demographic questions as well as questions specific to the work re-entry process. There was no discussion of how this survey was developed or on what evidence it was based. Group facilitators of IPN nurse support groups were recruited to distribute the surveys to nurses in the IPN support groups. A sample size of 394 participants was obtained.

Survey results indicated that over one third of participants listed narcotics as primary drug of choice, more than one-fourth listed alcohol, and 12% listed poly-drug use when reporting their drug of choice. Work re-entry findings showed almost 45% of nurses whose primary drug of choice was alcohol returned to the same work setting after treatment, the highest ranking of all drug categories. If a work site had a policy in place related to work re-entry of nurses with SUDs, over 60% returned to the same worksite unit in these facilities. The authors acknowledged surprise that a high percentage of participants in the survey worked in nursing homes (22%) considering that only 9.5% of all nurses in Florida are employed in nursing home settings. Males were also over-represented in that only four percent of nurses in Florida are male but the sample was 23% male. It is unknown whether this is reflective of the overall percentage of male nurses who have SUDs as no evidence has been found in the literature about this. However, SUDs among males is more common in the general population (SAMHSA, 2013).

Workplace support by supervisors and nursing colleagues was perceived and cited by nearly 90% of participants as a critical factor for successful work re-entry and recovery. Over half of the participants had a "return-to-work conference," usually with a nurse administrator or

nurse manager before re-entering the nursing practice worksite (Hughes et al., 1998, p. 67);

three-fourths reported working within the guidelines of a return-to-work contract. Contract

obligations required that nurses undergo random urine drug screens, attend nurse support groups

and 12-step groups, and avoid narcotic administration, floating to other units and a rotating shift

schedule.

Limitations of the study relate to the self-report survey design. The survey instrument

was developed by the director of the state alternative program (author Smith) with the assistance

of the co-researcher (author Hughes). No information about the reliability or validity of the

author-designed instrument was provided; nor was rationale for choices of survey questions

discussed. Other limitations include uncertain generalizability to nurses with SUDs outside of the

IPN, or to those with unstable employment histories who may have chosen not to participate in

the study despite their involvement in the IPN. The importance of workplace support for

participants upon work re-entry was a substantial finding of the study. Many participants

endorsed the need for improved education to increase knowledge among nurses about SUDs in

the general population and, more specifically, about SUDs among nurses. It was also

recommended that formal policies and clear guidelines about handling workplace issues related

to SUDs in nurses be established by facilities that employ nurses.

The Hughes et al., (1998) study from the mid-1990s is now dated but remains one of the

only published studies completed on a statewide level to focus totally on workplace re-entry for

nurses with SUDs. It is puzzling that this issue has not garnered more research attention; clearly

further study of this issue is needed. Qualitative studies that focus on experiences of nurses with

SUDs returning to work after treatment will contribute substantially to the body of knowledge

about this topic. Qualitative studies may also assist with future survey tool development which is informant-based.

Nurse Anesthesia Specialty Area

The nurse anesthesia specialty area has taken a leadership role in disseminating information about SUDs among nurses, and many of these published works have some discussion about the topic of workplace re-entry. It is reported that anesthesia providers, both anesthesiologists and certified registered nurse anesthetists (CRNAs), have high prevalence rates of SUDs when compared to SUD rates in other specialties (Girimont, 2011; Wilson & Compton, 2009; Wright et al., 2012). However, as with SUD prevalence rates with nurses more generally, there are discrepancies among study results with no agreement among them. Most publications agree that access and frequent exposure to potent pharmaceutical agents is a prime reason behind high rates of SUDs in anesthesia providers, both physicians and CRNAs (Girimont, 2011).

Significantly more studies have been done on the topic of SUDs in physician anesthesia providers than in CRNAs (Wilson & Compton, 2009). However, the American Association of Nurse Anesthetists (AANA) was an early leader among nursing specialty associations to address the issue of SUDs among its members (Quinlan, 2009). CRNAs possess advanced practice degrees and practice within a highly specialized nursing role where they have great responsibility for patient safety. The practice setting where CRNAs work puts them in close contact with many potential drugs of abuse. Additionally, work re-entry for CRNAs after SUD treatment involves a return to complex and high-acuity work settings with close proximity to anesthesia drugs.

Much of the literature about SUDs in CRNAs is not empirically based. A short descriptive article about the experiences of a small anesthesia department in Kentucky discussed

use of the medication naltrexone to facilitate work re-entry of CRNAs dependent on opiates (Hudson, 1998). Also discussed were work re-entry contracts, the need for close supervision for one year, guidelines for aftercare programs (mandated by the alternative program in Kentucky), and staff education about SUDs in preparation for the work re-entry of CRNAs after treatment. Work re-entry guidelines are commonly found in the nurse anesthesia literature but with minimal reference to scientific studies in support of the guidelines being recommended.

Other educational articles related to SUDs in CRNAs were not research based but include some discussion of work re-entry. These include publications by Luck and Hedrick (2004), Girimont (2011), and Wright et al. (2012). The most comprehensive of the articles published about CRNAs and SUDs is the most recent to be published" (Bettinardi-Angres & Garcia, 2015) and includes a review of the similarities and differences of 14 state alternative programs to highlight different approaches among the states. The article provides sound arguments supported by evidence (where it exists) to initiate national approaches in treating and monitoring CRNAs with SUD who re-enter nurse anesthesia practice. The authors reason that CRNAs are a unique and valuable sub-group within the profession of nursing and more consistence and uniform approaches to work re-entry would promote a culture of safety for patients and CRNAs.

Among work recommendations unique to CRNAs made in this article are: (a) BONs must recognize CRNAs as a unique group requiring specialized and distinct SUD treatment and monitoring; (b) monitoring of CRNAs by alternative programs should be a minimum of five years; (c) addiction therapy recommendations must be followed regarding mandated time away from anesthesia practice immediately following SUD treatment; (d) prohibit working overtime for first year of re-entry and; (e) use of buprenorphine for opioid addiction should be avoided

60

(Bettinardi-Angres & Garcia, 2015, p. 50). Other mandated recommendations outlined are similar to those for any nurse with SUDs. However, this article provides very specific, evidenced-based recommendations for this population of nurses with SUD and is forthright in arguing for greater consistency in treatment and monitoring protocols as well as additional research studies. Additionally, educational strategies aimed at prevention were strongly endorsed.

Curricula in programs that educate anesthesiologists and CRNAs were also discussed in the sources reviewed about SUDs among CRNAs. There are no uniform standards for education about SUDs in medical schools or nurse anesthesia programs, although the AANA has recently developed a model curriculum about SUDs which nurse anesthesia programs may choose to include in their curricula (Wright et al., 2012). When contacted, representatives from the AANA stated they had no count of the number of nurse anesthesia educational programs which have incorporated the curriculum or whether there has been any evaluation of it (J. Rice, personal communication, July 31, 2015). These facts make it difficult to ascertain whether the curriculum for CRNAs has been effective or how widely it is used. Additional research is needed.

To summarize, recently published educational articles specific to work re-entry for CRNAs by Wilson and Compton (2009), Hamza and Monroe (2011), and Bettinardi-Angres and Garcia (2015) discussed the need for more rigorous empirical investigations on this topic, noting the unique challenges of work re-entry of CRNAs to high-risk practice environments. Viewed together, all literature from this nursing specialty area discussed the complexities of work re-entry to settings where CRNAs have continual exposure and access to powerful, addictive pharmaceutical agents. This brief analysis of the nurse anesthesia literature about SUDs among

CRNAs supports the conclusion that work re-entry has not been widely studied, what is known is not well supported by empirical evidence, and additional research is needed to expand knowledge and support formation of empirically based work re-entry guidelines.

Published Works on Work Re-entry Guidelines

Two papers about SUDs in nurses are noteworthy for scholarly application of knowledge on SUDs in nursing to support information provided for a general nursing audience. Both include sections about workplace re-entry. Quinlan (2003) published a summary of national nursing peer assistance and alternative programs that offered a thorough discussion about work re-entry of the nurse after SUD treatment. Content discussed included legal considerations, the return to high-risk practice settings, the training needed to re-enter nursing practice (including an endorsement of using clinical simulation to refresh skills), the need to address concerns of co-workers, use of re-entry contracts, classification of SUDs as a disability by the American Disabilities Act (ADA), and relapse prevention strategies. The conclusion of this paper states:

>Having a recovering member within the nursing department should encourage employers to make certain that they have written policies governing fitness for duty, health benefit coverage for drug dependency, and effective evaluation mechanisms for overall performance. These adjustments in policies and procedures will make a facility stronger and better prepared to respond to the occupational hazard of substance misuse or dependency. (Quinlan, 2003, p. 154)

Quinlan's recommendations are supportive of work re-entry of nurses with SUDs in recovery although the empirical evidence cited about work re-entry is based mainly on studies of relapse

and relapse prevention. Evidence from the experiential perspective of the nurse re-entering the workplace or from the context of recovery is missing.

A paper about successful SUD treatment and work re-entry of nurses was published in *The Journal of Nursing Regulation,* the official journal of the NCSBN (Angres et al., 2010). Work re-entry contracts, temporary bans for opioid administration, long-term monitoring guidelines, inclusion of co-workers and family in monitoring processes, and recommendations for participant involvement in 12-step recovery groups were discussed. The major focus of the paper was regulatory in nature. The authors, frequent contributors in the medical and nursing literature about SUDs in health care professionals, claim that the literature on nurses with SUDs "lags far behind that for other health professionals, especially physicians" (p. 16) and assert that this is a significant problem due to the frontline presence of nurses in the delivery of patient care. Angres et al. (2010) also discuss as problematic the lack of reliable research on recovery success rates for nurses who re-enter the work setting. The publications by Quinlan (2003) and Angres et al. (2010) agree with conclusions of authors in the nurse anesthesia literature in urging greater leadership from the nursing profession in encouraging more research about the work re-entry process for nurses with SUDs. Missing in the discussion of work re-entry in both publications is a discussion of any evaluative data about effectiveness for the recommended guidelines or for re-entry programs as a whole.

Chapter Summary

A historical survey of the issue of SUDs in nurses reveals a growing body of literature with changing foci. Early research focused on knowledge development about characteristics of nurses with SUDs and was published at the time when state alternative programs had just begun

to appear. Limitations of a majority of the empirical studies during this early period relate to data collection methods that relied on self-report instruments with the accompanying risks of inaccuracies because of reluctance on the part of participants to provide honest responses and their wish to avoid being stigmatized. Stigma is frequently cited in the literature as a barrier to nurses' disclosure of a SUD and getting early treatment for it. Much of the research produced since the turn of the 21st century has focused on alternative programs at the state level. Difficulties with this body of research are the differences among states in the definition, structure, function, and evaluation of alternative programs. This hinders attempts in making comparisons and judgments about effectiveness that could be applied at a broader national level.

An analysis of the full body of literature about this topic, from the early decades to today, makes clear that there is a need for greater leadership from professional nursing organizations in promoting rigorous scientific research about SUDs in nurses (Angres et al., 2010; Monroe et al. 2008; Monroe et al., 2013). The NCSBN (2011) published a comprehensive review of current knowledge about SUDs in nurses in a resource manual targeted for use by alternative programs. This publication is the first of its kind to provide a summary of the topic of SUDs in nursing and is a positive example of a professional organization taking a proactive role in providing education and recommending specific policies based on current empirical evidence. The shortfall is that information about work re-entry in the document is based on limited empirical data related to implementation and evaluation of work re-entry recommendations, some of which is now quite dated.

There are common themes in the literature about SUDs in nursing that remain constant during the more than 25 years of knowledge development. The concept of stigma is discussed

throughout the literature. Because of the respected positions nurses hold as caregivers, those with SUDs face greater stigma from others both inside and outside of nursing. A recent decrease in labeling nurses with SUDs as "impaired" demonstrates a shift toward a direction of greater understanding and acceptance. However, in the U.S., the societal stigma toward individuals with SUDs, especially women, is long-standing and firmly rooted (Kelly & Westerhoff, 2010). When nurses develop SUDs the response is often severe and judgmental, especially from within the ranks of nursing colleagues and co-workers.

The on-going need for education about SUDs among nurses is cited frequently by a wide range of authors and researchers. Providing education to current and future nurses that is based on existing scientific evidence has been shown to change attitudes, beliefs, and behaviors toward nurses with SUDs. For decades the medical and nursing professions have considered SUDs as treatable diseases, yet the need for enhanced education about SUDs, both broadly in the general population and more specifically among nurses, continues to be a common theme in the literature. Despite this call for increased education, it also appears there is no agreement about what content should be included or how implementation or evaluation of effectiveness of such educational programs should be done.

A frequently noted recommendation in the literature is to expand the body of scientific research, including the issue of work re-entry of nurses with SUDs who have completed treatment. This review of the literature finds there have been minimal studies published on work re-entry. Notably missing is clear delineation of the experiences and processes that nurses with SUDs face when re-entering the workplace from the perspective of the nurse. The survey nature of the preponderance of literature about SUDs in nursing fails to fully give voice to the persons

affected by the SUD, the nurses themselves. This deficit hinders full understanding of this complex issue by failing to take into account the rich, descriptive data that are generated when the full variation and the conditions of the phenomena (cause, consequences, covariance, contingencies, context and conditions) are examined (Chenitz & Swanson, 1986). This study aims to fill this gap in the literature.

The nation and the profession of nursing face looming nursing shortages that heighten the need for empirical evidence to improve policies, educational strategies, and employment protocols to support nurses with SUDs who complete treatment, engage in a recovery program, and return to work. In order to understand the processes and factors that affect nurses with SUDs when they return to work, it is important to add empirical evidence about the experiences of those nurses as voiced by them.

The next chapter will describe the grounded theory research process used in this study. The chapter includes discussion of the grounded theory approach used, sampling processes, protection of participants, the contextual and cultural environment, data collection, data analysis, evaluation criteria, and limitations based on method.

CHAPTER III

METHODOLOGY

Introduction

The purpose of this qualitative, grounded theory study was to explicate a substantive theory/model that describes the basic social processes (BSP) operating when a registered nurse re-enters the workplace following completion of substance use disorder (SUD) treatment. Grounded theory methodology provides researchers with a tool for discovering processes experienced by persons within a social context. The result is a conceptual model or theory that is *grounded* in data collected in the field, particularly data related to human actions, interactions and processes (Creswell, 2007). This chapter describes the research design, sampling, contextual and cultural environment, data collection processes, data analysis processes, trustworthiness, and study limitations based on method.

Research Design

Research design refers to the overall process of research, from the problem conceptualization to the final narrative report (Creswell, 2007). The choice of research design is guided by the research questions (Corbin & Strauss, 2008). Other considerations in choice of design are the epistemology that informs the research method, the theoretical perspective that underlies the research problem and/or questions, and the approach that links method to data and

outcomes (Creswell, 2003). The fit of qualitative methodology and grounded theory to this study is discussed in the following sections.

Qualitative Methodology

Qualitative methodology entails "…a way of thinking about and studying social reality" (Strauss & Corbin, 1998). It involves exploration of concepts and is most useful when little is known about the variables under study (Creswell, 2003; Wuest, 2007). The topic of work re-entry of nurses after completion of SUD treatment has been minimally studied by nurse researchers and no qualitative method studies focused only on work re-entry were found. A review of the literature revealed a gap in knowledge about the experiences of work re-entry for this population that could be partially filled by a qualitative research study.

Qualitative inquiry requires that a researcher collect images and words within a holistic, flexible research design in a natural setting (Creswell, 2007; Polit & Beck, 2012). Qualitative research gives voice to individuals using the language of the person's own narrative, investigating meanings within a social context. It also supports an interpersonal exchange where the researcher creates a dialogue about the topic, hence expanding understanding for the participant, as well (Flick, 2009). A review of the literature about nurses with SUDs found that stigma and discrimination are commonly experienced among this population, creating barriers to seeking and receiving early treatment because of shame or fear of exposure (NCSBN, 2011). Giving voice to participants to share meanings and experiences expands knowledge and may offer suggestions for development or changes to nursing regulatory, educational and/or policy processes. Additionally, the reflective process experienced during interviews may enhance meaning of the work re-entry process for participants.

Grounded Theory Approach

"Grounded theory research aims to understand what is going on in a given instance, particularly in common social settings that are not well understood and have not been exhaustively researched" (Hunter, Murphy, Grealish, Casey, & Keady, 2011). The end result is a theory or conceptual model, generated from the relationship between concepts that explain variation in behavior of emerging processes (Glaser, 1992). Exploring and explicating social processes and the interactions inherent among them is the core purpose of grounded theory methodology (Heath & Crowley, 2004; Morse, 2001). A basic social process (BSP) is often the core variable or central category to emerge during data analysis and acts to tie the different parts of the theory together (Hernandez, 2010; Morse, 2001). The central/core variable in all grounded theory approaches is the primary theme to emerge in the research.

Corbin and Strauss (2008), authors of the grounded theory approach used in this study, define process as: "Ongoing responses to problems or circumstances arising out of the context. Responses can take the form of action, interaction, or emotion. Responses can change as the situation changes" (p. 229). In nursing, Benoliel (1996) noted that grounded theory research explains the social processes experienced by individuals in various health-illness situations. This study aimed to explicate the BSPs for nurses with SUDs within the social context of work re-entry, making it a good fit with grounded theory methodology.

The epistemological and theoretical underpinnings of grounded theory provide additional support for its choice as an appropriate research approach for this study. American pragmatism is the epistemological and philosophic foundation of symbolic interactionism, providing the theoretical underpinning which guides grounded theory. The pragmatist position claims

69

knowledge "…arise(s) out of actions, situations, and consequences" and focuses on the problem being studied, not the method (Creswell, 2003, p. 11). In pragmatism, reality is open to different interpretations and is a fluid process; the individual interprets and finds meaning from the environment through active and practical engagement with it (Charmaz, 2006; Flick, 2009). Pragmatism studies the human being by studying the causes, consequences, and perceptions of actions, especially in how humans relate and make sense of their environment (Charon, 2007). These beliefs are foundational to grounded theory methodology where *discovery* and explication of theory occurs inductively by constant comparative data analysis (Glaser & Strauss, 1967).

Symbolic interactionism (SI) is a theoretical perspective that views human beings as active participants in the social environment, forming one's own actions and processes rather than passively responding to the world (Burbank & Martins, 2009). These beliefs form the foundation on which the three theoretical assumptions of SI are built: (a) individuals act toward things in their lives (objects, other people, institutions, ideals) on the basis of the meanings they attribute to them, (b) meanings originate from interactions with others, and (c) individuals modify meanings through an interpretive process used to make sense of the social environment (Blumer, 1969). Explication of BSPs in grounded theory links back to the premise from symbolic interactionism that individuals use interpretive processes and make meaning of human interactions within social contexts (Blumer, 1969). The interpretive processes vary based on a person's level of introspection of their current life. Processes change with time and experiences. The researcher and the data collection process will affect the participant's current understanding. Ultimately, the interaction will affect both individuals (researcher and participant). Therefore, there are strong links between the epistemological perspective of pragmatism, the theoretical

perspective of symbolic interactionism, and the methodology (grounded theory) which add

support to the research design choice for this study.

<div align="center">**Sampling**</div>

Theoretical Sampling

In qualitative studies, researchers "…sample for *meaning*, rather than frequency" (Morse,

2007, p. 530). Qualitative sampling involves recruitment and selection of participants based on

the best fit of the experience of the participants to the study question, as well as the qualities of

the participants to be good informants (Morse, 2007). For this study, purposive sampling (or a

sample of convenience) preceded theoretical sampling based on the data that emerged; a

common process used in GT to maximize variation of data (Glaser, 1978). Purposive sampling

is defined as the process of locating available individuals "…who have already gone through, or

have observed, the process [under study]" (Morse, 2010). An example of this is that participants

for this study all had completed SUD treatment and had at least one re-entry experience.

Theoretical sampling is considered by some to be a type of purposive sampling (Polit and

Beck, 2012). It is unique to grounded theory methodology and is defined by Glaser (1978) as

"…the process of data collection for generating theory whereby the analyst jointly collects,

codes, and analyzes his data and decides what data to collect next and where to find them, in

order to develop his theory as it emerges" (p. 36). Theoretical sampling directs the researcher to

explore varied conditions, ask new questions, and interview participants with different

roles/traits from the initial sample of convenience, thereby expanding the sampling process based

on the theory that emerges from data analysis (Strauss & Corbin, 1998; Wuest, 2007). For

example, when a new concept emerges during constant comparative analysis, the researcher may

<div align="center">71</div>

need to seek out new participants who can speak to that concept in order to explicate it fully. This study began with purposive sampling with clear inclusion and exclusion criteria, based on the research question.

Maximum Variation Sampling Strategy

A sample reflecting maximum variation of experience is recommended for a purposive sample within grounded theory (Flick, 2009; Glaser & Strauss, 1967). Maximum variation is a commonly used sampling approach in qualitative research that aims to maximize variation of experiences among sample participants at the beginning of a study, because "…it increases the likelihood that the findings will reflect differences or different perspectives – an ideal in qualitative research" (Creswell, 2007, p. 126). For this study, maximum variation sampling involved recruiting participants who varied by age, gender, race and ethnicity, specialty area in nursing, length of time licensed as a nurse, highest nursing degree obtained, drug of choice, length of time of sobriety/abstinence, and region of country where participants lived and practiced nursing. Maximum variation was achieved for this study as there was diversity among these different categories, which are discussed in more depth in the demographic section of Chapter Four.

Inclusion/Exclusion Criteria

Inclusion criteria for participants for the proposed study included: Registered nurse (RN) status with license to practice nursing (advanced practice or specialty status was acceptable as these degrees require a RN license); completion of at least one substance dependence treatment at a state licensed (or state approved) chemical dependency treatment facility; had re-entered the

workplace at the participant's professional level of entry in a work setting that required RN licensure. All of the participants in this study met the inclusion criteria.

Exclusion criteria for participants for the study included: current suspended or revoked registered nurse license; not employed after treatment in a workplace at participant's professional level of entry; and participant self-identified as having a SUD but had not completed SUD treatment from a state licensed (or state approved) treatment program.

Recruitment Strategies

For this study, a sample was sought among the population of nurses who had re-entered the workplace after completion of treatment for SUDs. While it was impossible to pre-determine the sample size needed, grounded theory studies typically aim to recruit 20-30 participants, although ultimate determination of sample size is based on when saturation occurs (Wuest, 2007). Saturation is defined as the point when no new information emerges to change properties of coding categories (Glaser & Strauss, 1967). A total number of 22 RNs who met inclusion criteria participated in this study, by which time data saturation had been attained.

Recruitment of participants was done in several ways. Written ads were placed in various media sources, including printed newspapers and recovery websites. Written recruitment cards were posted at Alcoholics Anonymous (A.A.) meeting sites and a recovery focused church. Postings about the study were also placed on the alumni websites of SUD treatment facilities. Snowball sampling, where initial participants suggest or recruit subsequent participants who voluntarily make contact with the researcher for possible inclusion, was a highly effective way of recruiting several participants. Recruitment processes and the concept of snowballing is depicted in Figure 1.

Figure1. Processes of Informing and Recruiting Participants for Research Study
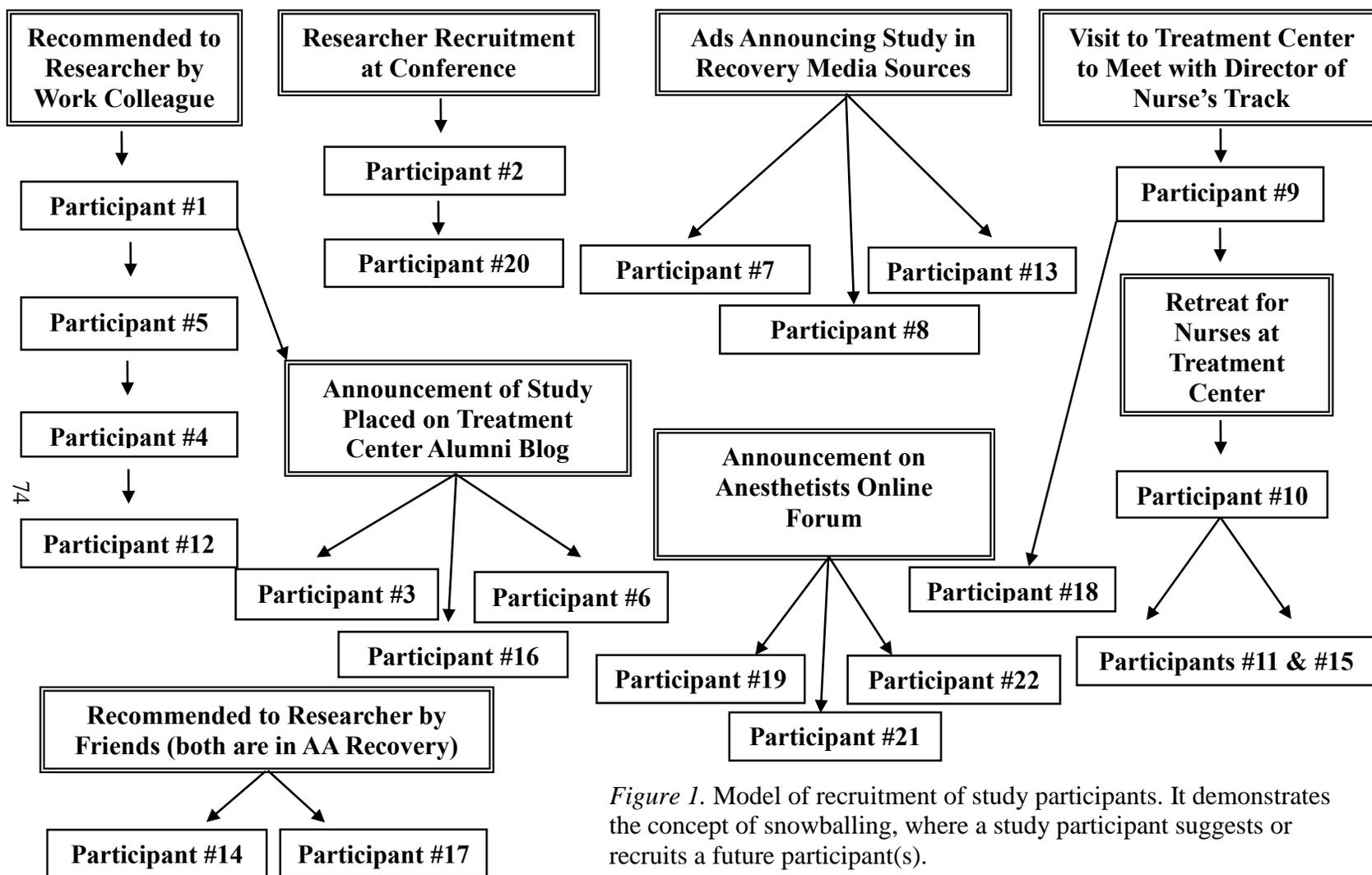
Figure 1. Model of recruitment of study participants. It demonstrates the concept of snowballing, where a study participant suggests or recruits a future participant(s).

Others who had already participated in the study verbally shared information about the study with acquaintances and/or gave these individuals a written recruitment card. Over one-third of the participants (36.4%, $n = 8$) enrolled in the study because a previous participant had encouraged them to do so.

Participants initiated contact with the researcher which helped maintain confidentiality. Two options for contacting the researcher were given on the recruitment documents: e-mail or phone. During initial contact with the researcher, an explanation of the study was given and questions asked to determine whether the potential participant met inclusion criteria. If so, the person was invited to join the study and, for face-to-face interviews, a meeting location was agreed upon jointly by the participant and the researcher. The location had to insure comfort and privacy for the participant because audio-taping of the interviews occurred. The final four participants were interviewed over the phone, which afforded an even greater level of anonymity and confidentiality for those participants.

Protection of Human Subjects

Consent process. Stigma is a clearly documented issue in the nursing literature related to SUDs among nurses (Dunn, 2005; Godfrey et al., 2010; NCSBN, 2011). Because of the highly stigmatized content of the topic of this study, a *waiver of signed consent* was sought in the Institutional Review Board (IRB) application to help insure confidentiality and anonymity of participants. The consent form (see Appendix A) was presented to participants prior to conducting the interview. Understanding of informed consent was ascertained by verbal agreement and a copy of the written consent form was given to each participant. Participants were informed they could refuse to answer any question and withdraw from the interview or

study at any time. Contact information for the researcher and the Office of Research Development and Compliance at the university was included on the consent form, along with a participant code. These were stored securely and separately from all other data.

Data storage protocol. The researcher kept all interview transcripts from the study in a locked secure file; they will be held for a minimum of three years after completion of the study, thus providing additional safeguards to confidentiality. After three years the files will be shredded. Files of transcripts were encoded through a system of assigning codes to interviews instead of using other participant identifiers. This coding information was stored in a locked file with contact information for purposes of reconnecting with participants, if necessary, for clarification, validation, or confirmation. Coding information was kept separate from transcripts and other documents containing data. The researcher kept the keys to these locked systems in a separate, secure location.

If a second interview was done with a participant, all safeguards listed above were also applied to transcripts and notes from the second interview. Memos, field notes, and journal entries will be kept for a minimum of three years after completion of the study and then shredded. Only the researcher, the faculty advisors, a research assistant who completed University IRB education (hired from a grant obtained by the researcher), and the University's Office of Research Development had access to the data. Confidentiality standards of the IRB of the University of North Dakota were strictly maintained throughout the research process. All audiotapes were kept until data analysis was completed; then they were erased.

Participant Risks/Benefits

   Risks. Risks to potential participants of the study included emotional discomfort or psychological distress when sharing the personal story of their experiences with SUDs and work re-entry. If significant distress or anxiety in a participant was noted, the researcher was prepared to give the participant the option to stop the interview and/or withdraw from the study. The researcher reserved the right to stop the interview if a participant was assessed to be unduly distressed. The researcher is an experienced psychiatric nurse and was confident about being able to ascertain if an interview needed to be stopped. No interviews were stopped due to participant distress; all progressed to a natural conclusion. There were no manifestations of serious distress displayed by any of the participants. The researcher had available a list of regional mental health and crisis providers if emotional distress and the need for emergency care became evident in a participant. No crisis referrals were necessary.

   Benefits. Potential benefits to participants of the study included reflection/introspection and enhanced understanding of their own experiences with SUDs and work re-entry. Additionally, participants were told that the study findings may inform the discipline of nursing in how to better facilitate and support workplace re-entry for nurses with SUDs. Risks and benefits were discussed in separate paragraphs on the written consent form which was given to each participant (see Appendix A).

   Appreciation for the participation of the participants in the study was demonstrated by providing a $25 debit card at the time of the interview. All accepted the debit card except for two of the participants, who both asked the cards be donated to a recovery-based non-profit agency. Each stated involvement in the study was part their service work in recovery.

77

Contextual and Cultural Environment

This section of the chapter discusses the contextual and cultural environment at the time of data collection, including unexpected media coverage of nurses with SUD in the researcher's home area. Also discussed are researcher preconceptions, experiences, and personally held biases at the onset of the study.

Media Coverage Critical of State Board of Nursing

Grounded theory methodology requires that researchers be mindful of context, the set of conditions or properties where problems and situations arise to which individuals respond about any given phenomena (Corbin & Strauss, 2008). One such context was highly public media scrutiny of the state board of nursing (BON) in the state where the researcher resides which occurred at the onset of this study. A series of articles published by a large regional newspaper were highly critical of the state BON's processes of providing oversight of nurses deemed to be unsafe, including those with SUDs. This series of articles included a front-page Sunday edition article focused on nurses in the state with SUDs who had faced disciplinary action by the state BON. As a result of this media attention, public hearings at the state legislature occurred in the fall of 2013 and again when the legislature resumed in early spring 2014. The state alternative program also came under scrutiny for their management of healthcare professionals with SUD and a revision of state statute was considered by the legislature to change how the BON and the state alternative program interact to monitor nurses with SUD.

The researcher was aware that the media attention about the state BON and nurses with SUDs provided a critical context by which potential participants and the public might view nurses with SUDs. As a result, the researcher attended the two legislative hearings at the state

capitol to witness the legislative response to the issues raised in the media. The state legislature did ultimately amend state statutes related to how and when the state alternative program reports nurse participants to the state BON, making it more restrictive in terms of mandates about nursing license suspensions related to alcohol and drug use and/or relapse.

Nursing organizations in the state also responded to the media attention. The researcher attended one meeting of the state nurses association and two public forums held by a newly formed state nursing peer support group to gather additional information about the professional response to the media attention about nurses with SUDs. This provided additional contextual data and validated that not all attention to the issue of SUDs among nurses was negative and that there was professional support for nurses with SUD to re-enter the workplace.

Such events were not anticipated by the researcher yet they proved important to the recruitment of participants for the study. As a result of this public attention, the researcher was concerned that potential participants for this study would be reluctant to be interviewed. In actuality, several research participants came forward to participate in the research study as a result of the media coverage, citing a wish to contribute and give voice to nurses with SUD living in recovery who can and do return to work successfully. These nurses believed the media coverage was too narrow and too negative; they wished to share their own, more successful stories about recovery and work re-entry after SUD treatment.

Another consequence of this widespread media attention was the formation of a small group of nurses recovering from SUDs whose purpose was to develop a peer support network for nurses in this state. At the conclusion of the interview phase of the study, the state nurses association and the new state peer support group had voiced public support for recovering nurses

with SUDs returning to work in nursing practice settings. In essence the media exposure benefitted this research study by bringing the topic into the awareness of future research participants and providing them with the opportunity to contribute to nursing research.

Discussions with Content Experts

The influence and importance of nurse managers and nurse leaders in the work re-entry processes of RNs with SUDs emerged as important contextual data fairly early in the interviewing and data analysis processes. The researcher had a conversation with two nurse leaders of hospital systems who are considered as content experts for this study as they had extensive professional experience dealing with workplace issues of nurses with SUDs. These leaders were from different states and represented both rural and urban settings. Both nurse leaders voiced that in their experiences, work re-entry to acute care hospital settings by nurses with SUDs had not resulted in large numbers of nurses being successful in maintaining sobriety/abstinence or retaining employment in acute care settings. High stress work environments were attributed as a possible reason for this poor success rate. However, several participants of this research study were back to work successfully in acute care settings. Therefore, the reason for lack of work re-entry success by nurses with SUD has greater complexity than attributing it to stressful work environments.

Early in the study, at the time of the state legislative hearings about the BON and the state alternative program, the researcher had a discussion with a staff member of the state alternative program to gain greater understanding of the impact that the negative media publicity had on this agency and their monitoring of nurses with SUDs. During that conversation, the alternative program staff member voiced the opinion that the cultures of healthcare systems frequently view

80

nurses with SUDs as "disposable," unlike the view often taken toward the careers of physicians, which, according to the staff member, healthcare systems work hard to preserve. This particular state alternative program model has numerous healthcare boards under one umbrella and the staff deal with members of many healthcare disciplines, including nurses, physicians, pharmacists, dentists, etc. The staff member indicated that the stigma for nurses with SUDs is amplified because of the stance taken by healthcare systems that nurses are easily replaced; individual nursing careers are not deemed worthy of salvaging. The alternative program staff member who conversed with the researcher is not a nurse and is therefore able to provide a unique perspective based on many years of monitoring nurses and other healthcare professionals with SUDs.

The period immediately following SUD treatment is a time of significant vulnerability for nurses wishing to return to work. One could speculate that non-supportive work environments where nurses with SUDs are viewed as "disposable" presents a formidable cultural barrier for nurses wishing to return to work. This cultural norm, pointed out by a non-nurse, was a powerful contextual backdrop for participants in the study, especially for those who experienced difficulty finding nursing employment after SUD treatment.

Preconceptions and Researcher Bias

      Professional/personal experience of researcher. The researcher has had several professional nursing practice work experiences in providing nursing care to individuals diagnosed with SUDs over a professional nursing career that spans several decades. Past practice sites included medical-surgical units in acute care hospital settings, acute care psychiatric settings, an outpatient methadone clinic, and an outpatient clinic for individuals dually diagnosed with both a SUD and a chronic, persistent mental illness. From these experiences the researcher

learned about the chronic and persistent nature of SUDs, the common proclivity for relapse, and the societal stigma experienced by individuals with these disorders.

The researcher of this study is familiar with 12-step based recovery programs from professional, family, and personal experiences. Based on this familiarity, the researcher was mindful throughout data collection and analysis of the importance of reflexive journaling about her personal responses to participant disclosures. The grounded theory methods advisor was told of the researcher's various work experiences and familiarity with 12-step recovery programs; discussions about possible researcher bias and preconceptions were held periodically during the data analysis processes. Experiences with 12-step recovery were very helpful in understanding the "language" of recovery that was shared frequently by participants in the study.

Work experiences related to stigma toward SUDs among nurses. Many years of working in various nursing practice and academic settings in nursing education has validated to the researcher that there exists widespread and persistent stigma toward individuals with SUDs by members of the nursing profession. Validation that these experiences are currently present in nursing also came in the form of participants' sharing that described their role as both victimizer and victim of negative attitudes and behaviors towards those with SUDs.

The topic of stigma toward SUDs among nurses is also prevalent in the nursing literature about SUDs (NCSBN, 2011). Awareness of negative biases about SUDs from members of the nursing profession led to a preconceived notion by the researcher that stigma and shame would be discussed by study participants and would be identified by them as barriers to identification, screening, and treatment of the SUD by the affected nurse. This was endorsed by study participants during interviews as they discussed feelings of shame for violating their own moral

82

values and, in some cases, the code of ethics for nurses. Denial about the severity of their alcohol/drug use and keeping it a secret due to fear of losing the RN license, thus delaying treatment, was another preconceived idea held by the researcher that was also endorsed by many study participants.

   Preconceptions about the impact of the nursing practice environment. Because of the previous professional experiences of the researcher, the research field was entered with the researcher holding a preconception that a major barrier to work re-entry for nurses would be overt stigma and discrimination from others in the nursing practice setting directed at the nurse with SUD. This preconception was identified and discussed with advisors early in the interview processes. However, as the study progressed it became clear that this preconception was not endorsed by many participants. In fact, many shared that it was internalized shame and self-stigma that impacted both personal and nursing identity and the work re-entry process. These were much more influential than overt discrimination experienced from others in the nursing practice environment.

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Data Collection Processes

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   The following section discusses the interview processes used in data collection for this study. A discussion of pilot testing the interview guide and the demographic data collection processes is also included.

Interviews

   Interviews in grounded theory are semi-structured with a central research question and a few accompanying sub-questions prepared by the researcher ahead of time (Wuest, 2007). The central question to this study was: What basic social processes (BSP) are operating when a nurse

re-enters the workplace after completion of SUD treatment? The following research questions were investigated with each participant in every interview:

1. What does a registered nurse experience in actualizing workplace re-entry after completion of SUD treatment?

2. What helped the registered nurse re-enter the workplace after completion of SUD treatment?

3. What acted as barriers to the registered nurse's re-entry to the workplace after completion of SUD treatment?

The research questions assisted the researcher to develop a semi-structured interview guide that focused on the connections among known concepts from the extant literature. The delineation of specific research questions and the use of a semi-structured interview process is consistent with the grounded theory approach of Strauss and Corbin (1990, 1998). See Appendix C for the Semi-Structured Interview Guide.

The intent of the interview was to create open and interactive dialogue between the researcher and the participant. This helped instill comfort for the participant and promote honest communication during the interview. The researcher was prepared to shift focus and questioning based on the content that emerged in discussion with the participant and did so as needed. Additionally, the questions in later interviews changed somewhat as concepts and categories emerged during constant comparative analysis (Polit & Beck, 2012). Participants were not given interview questions ahead of time. At the end of each interview the researcher asked participants for permission to re-contact them by email or phone if clarification or expansion of their

thoughts or ideas was needed. The consent form also noted the possibility of follow-up contact for this purpose.

Pilot testing the semi-structured interview guide. Prior to the onset of interviews, an expert in grounded theory methodology and members of the dissertation committee reviewed the semi-structured interview guide. This guide was also submitted to the University Institutional Review Board (IRB) as part of the approval process prior to beginning the interviews. The researcher entered the field and pilot tested the semi-structured interview guide with two participants. During the pilot interviews, data were easily and readily obtained in a dialogue process that answered the three primary research questions of the study, indicating that the semi-structured interview guide was well-designed and applicable for the purpose of this study. The pilot interviews provided an opportunity to assess effectiveness and clarity of the interview questions. Data from the pilot interviews are included in the final analysis.

Feedback about the wording and clarity of the interview questions was obtained from the two pilot interview participants with no changes being recommended by them. These participants were also asked to identify if anything else of significance had been missed and should be included in the questions or interview process. Nothing specific was noted by them to be missing. However, as a result of information shared in the two pilot interviews the researcher made the decision to add a question to the guide about pre-existing medical conditions or history of trauma and/or abuse as these emerged as relevant for the participants. Also, a question about leadership experience of the participants was added as a result of data obtained in the pilot interviews.

A grounded theory methods advisor read the transcripts of the pilot interviews and assisted the researcher in early open coding techniques. Substantial discussion was also held with this advisor about the researcher's use of memo-writing and reflexive journaling with each of the pilot interviews, insuring that the grounded theory research process was well-understood and operationalized. Experience gained from a research practicum course where the researcher learned and practiced coding and data analysis was also beneficial in conducting analysis of data for this study, beginning with the pilot interviews.

Interview formats: Face-to-face and phone interviews. The study began with the intent of doing all interviews in a face-to-face format. Eighteen of the 22 (81.8%) interviews were done face-to-face. The face-to-face interviews were conducted in a variety of locations including the homes of participants, coffee shops/restaurants, public libraries, the researcher's work office, a hospital waiting room, and a retreat center at a SUD treatment facility. The length of the interviews ranged from 45 to 90 minutes.

Late in the data collection process, a change to the way the interviews were conducted became necessary due to difficulties recruiting additional participants to do face-to-face interviews. This occurred seven months after the onset of recruitment for the study. Discussion with key consultants, including a grounded theory methods advisor, the dissertation committee chairperson, and a national expert in the topic of SUDs in nurses resulted in the recommendation that phone or computer video-based interviews be done to increase the potential participant pool. A protocol change was submitted and approved by the University Institutional Review Board.

The final four interviews were done over the phone and included participants from different regions of the country. Inclusion of participants from other regions of the country

86

increased maximum variation of data in the study. These four interviews were similar in length to the face-to-face interviews, 45 to 90 minutes each, and were interactive dialogues as well. All interviews were audio-taped, transcribed by a qualitative research transcription service, and reviewed for accuracy by the primary researcher by comparing transcripts to the taped interview.

Demographic Data

Demographic data collected at the beginning of each taped interview included age, marital status, race/ethnicity, highest degree achieved in nursing, length of time licensed as a RN, current employment status and work setting, length of time the participant had been back in the workplace since completing SUD treatment, time elapsed between SUD treatment completion and return to the workplace, number and type of substance dependence treatments, drug(s)/substance(s) of choice, number of episodes of relapse, involvement with the state board of nursing or alternative program, type of recovery strategies used, and how each participant found out about the study (see Appendix B). Collection of demographic information helped identify variation of data and helped confirm that the participant mix was fairly inclusive and reflected the general population of nurses with SUDs. Potential participants were informed that no individual personal data would be reported or discussed that would create a risk of them being identified; all finding were reported in the aggregate.

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Data Analysis: Constant Comparative Analysis

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Data analysis processes followed grounded theory procedures, based on the Strauss and Corbin (1990, 1998) approach. The aim was to develop a theoretical model grounded in the data and aligned with the research study goals. Constant comparative analysis is the process of "…comparing all elements in the data to each other" (Flick, 2009) (See Figure 2). It is an active

Figure 2. *Planned* Constant Comparative Analysis

Explicating Research Problem Area

DESCRIPTIVE

CONCEPTUAL

THEORETICAL

SAMPLING

DATA COLLECTING

CODING
(Process varies by GT perspective)

THEORETICAL SAMPLING

MEMOING

SORTING BY IDEAS
(Memos, Diagrams)

EMERGING THEORY

WRITING

Emerging Core / Central Variable

REVIEWING THE LITERATURE
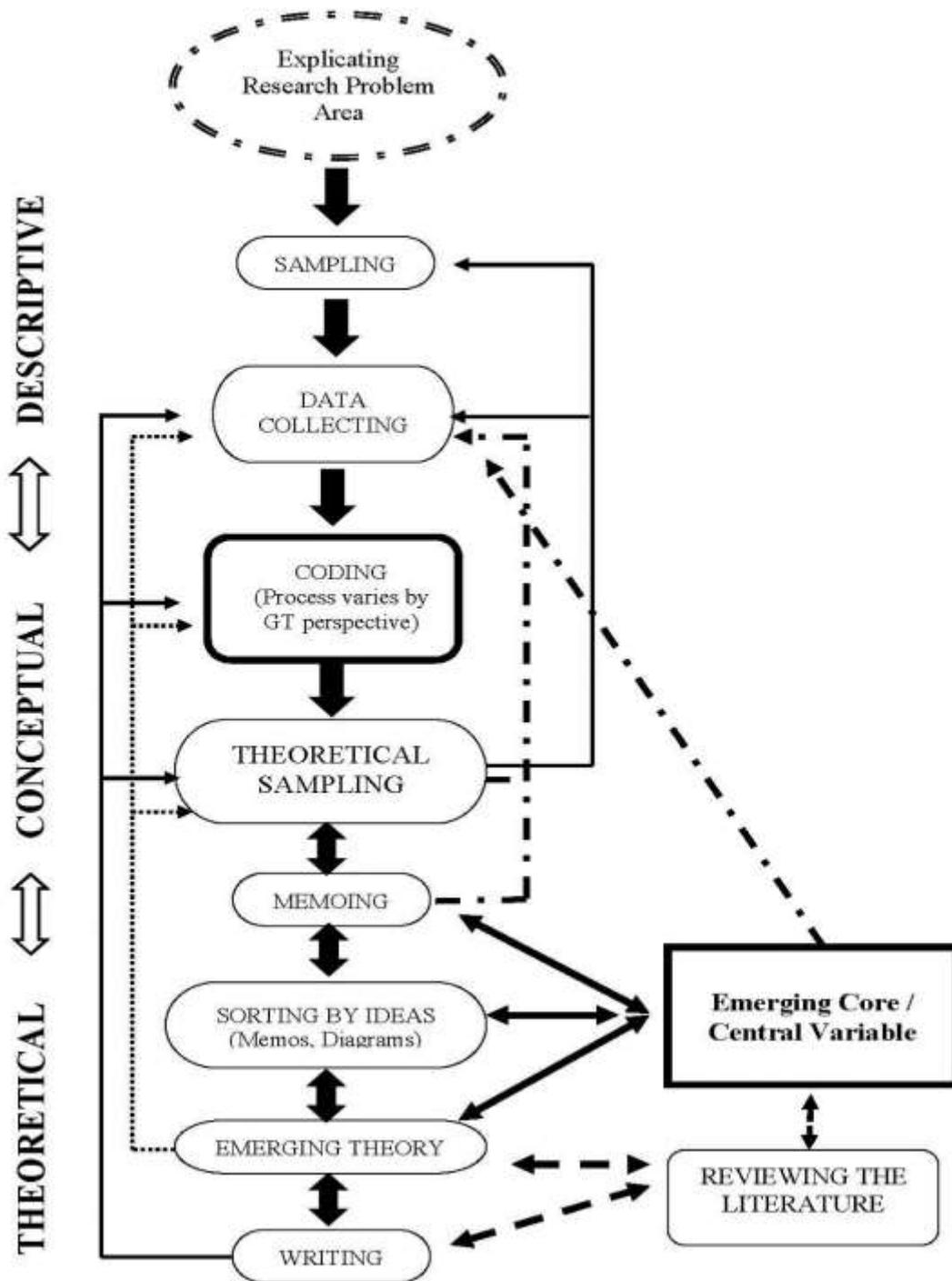
process where the researcher "…moves back and forth from the micro to the macro level, staying grounded in the data, but thinking about how they are related to the domain of study" (Wuest, 2007, p. 253). Figure 2 is a model of constant comparative analysis based on the Strauss and Corbin (1990, 1998) approach that was developed by the researcher before entering the field. This figure was modified during data analysis and reflects important additions based on the interviews, contextual influences, and discussions with content experts. The contextual influences occurring at the time of this study supported the need to converse with content experts. Their contributions were relevant and were evaluated as important to include in the analysis, as were the unique, unexpected features of the contextual environment at the onset of the study. These components were added to the constant comparative analysis diagram and are depicted in Figure 3.

Constant comparative analysis utilized multiple sources for data comparison: interview transcripts, code notes, memos, theoretical writing, and diagrams. Data that were conceptually similar were then grouped together and labeled with a code; differences within codes were examined. Three types of coding are used in the Strauss and Corbin approach: open coding, axial coding, and selective coding. The coding types and other data sources used and analyzed in the study are discussed below. The back and forth process of constant comparative analysis across these data sources resulted in an understanding of the basic social processes of both successful and unsuccessful work re-entry for nurses with SUD who participated in the study.

Open Coding

Open coding of transcripts and other written data sources involved "fracturing" of the data to determine categories, properties, and dimensions (Strauss & Corbin, 1990). Hand coding

89

Figure 3. Process of *Actualized* Constant Comparative Analysis
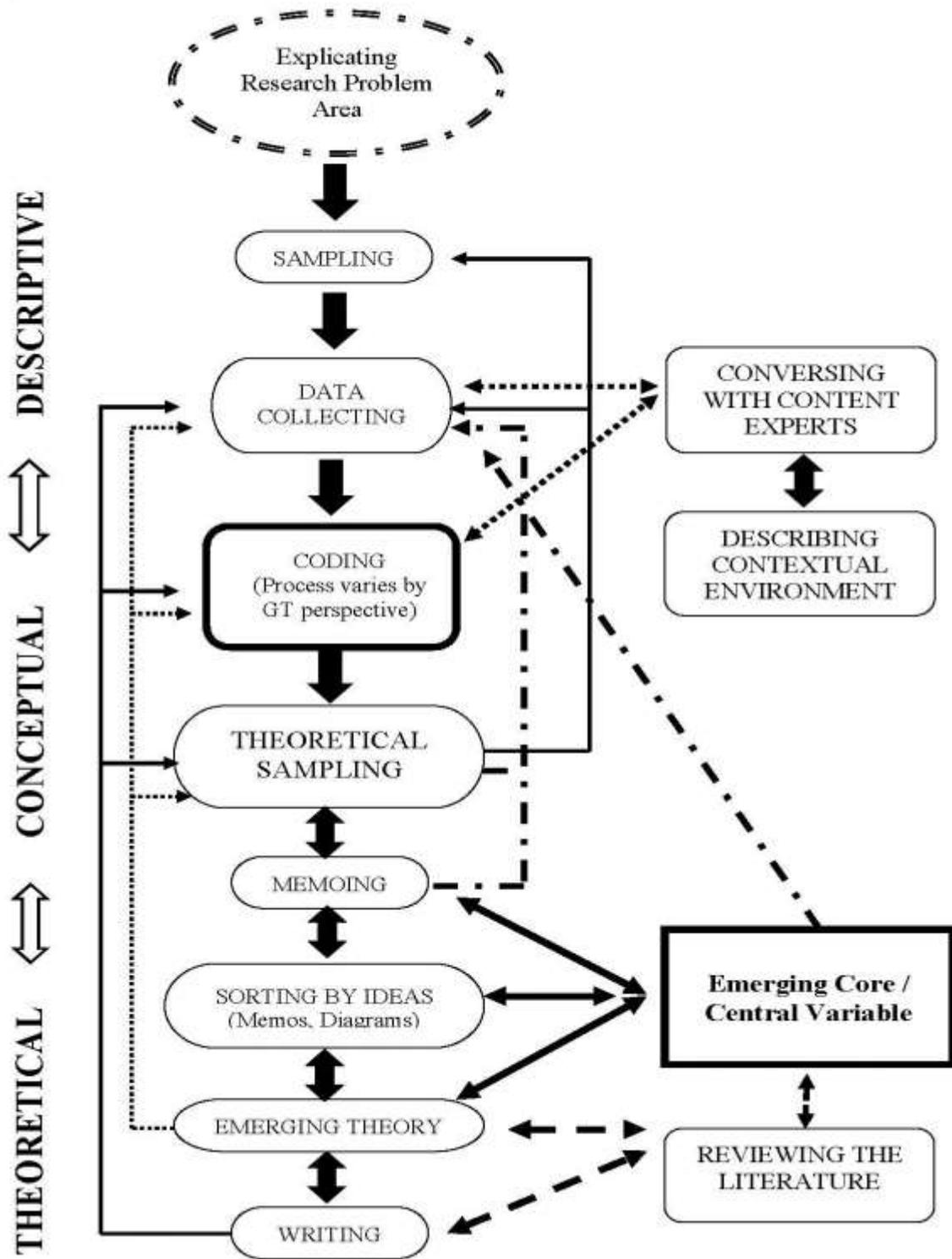
was the primary method used on all transcripts, memos, and reflexive journal entries. Use of the qualitative data software program HyperRESEARCH© augmented the hand coding by allowing for an alternative way to store and organize emerging data. Features of this software program that were particularly helpful in analysis were thematic phrase frequency reports and locating exemplar quotes related to themes and categories. No identifying participant data were put into this software program and access to it was password protected.

Open coding involved a line-by-line examination of concepts followed by categorizing the concepts and phenomena that emerged (Strauss & Corbin, 1998). To start this process, *in vivo* codes, direct wording that participants used in the interviews, were analyzed in order to remain as close to the data as possible (see Figure 4). The researcher then interpreted the *in vivo*

In vivo codes	Researcher assigned descriptors	Category	Barrier (Research Question #3)
• "I led a double life" • "I had a very secret life for a long time" • "We're very secretive; master manipulators and hiders" • "Secrecy around nurses is huge" • "I couldn't accept myself that this was happening" • "Don't talk about it"	Dishonesty Secrecy Denial	Shame	Identified as an internal barrier finding for research question #3 that contributed to lack of self-redefinition (core variable for unsuccessful work re-entry)

Figure 4. Open Coding Model: Representation of one subset of the process of open coding in the emergence of the category of shame as an internal barrier to workplace re-entry, partially answering research question #3.

codes, labeling them with a descriptor term. An example of this is the collection of data related to findings of research question three and barriers to workplace re-entry, as depicted in Figure 4.

Memos and Journal Entries

Immediately following each interview, memos were written and served as a way for the researcher to record events, impressions, and observations. Memos track the descriptive and abstract processes inherent in all of the grounded theory coding steps. All memos were labeled with the same code as the transcript, avoiding other participant identifiers. The researcher downloaded the memos into the HyperRESEARCH© data analysis software where it was added to interview transcript data coded in this computerized software program.

Journaling was also used to document the interpretive processes that occurred during coding. Reflexive journaling is a descriptive process that documents the researcher's personal experiences, thoughts, and feelings about the progress and processes in the field (Polit & Beck, 2012). Following each interview, the researcher took time to reflect on perceptions and experiences that occurred during the interview. These reflections were valuable in detecting any possible personal responses and/or biases and to record observations about any experiences that occurred across various interviews.

As the number of interviews increased, the memos and journal entries served as a means to raise questions, make comparisons between interviews, and begin rudimentary analysis about common themes and categories that were emerging. For example, during some of the early interviews, the researcher noted significant differences when participants discussed successful work re-entry experiences that were free of subsequent drug/alcohol relapses compared with unsuccessful work re-entry experiences that usually included relapse. In particular, participants

gave different accounts of how they viewed themselves as an addicted person and as a nurse. Recovery involvement and use of recovery tools were strongly correlated to work re-entry outcomes. Participants who admitted to limited use of recovery strategies were more likely to experience relapse and an unsuccessful work re-entry outcome. As a result, it was deemed necessary to separate successful and unsuccessful work re-entry as two distinct processes. The need for this separation became evident during early coding and constant comparative analysis of the transcripts, memos, and reflexive journals entries.

Axial Coding and Development of Axial Coding Models

Relationships between the concepts and categories emerged during *axial coding* (conceptualization), the second coding strategy, characterized by the use of sub-categories to systematically think about data in complex ways (Strauss & Corbin, 1990, 1998). The most recently published text by Corbin and Strauss (2008) notes that open and axial coding "go hand in hand" (p. 198) but that axial coding focuses on "crosscutting or *relating* (emphasis added) concepts to each other" (p. 195). The purpose of axial coding is "…to begin the process of reassembling data that were fractured during open coding" (Strauss & Corbin, 1998, p. 124). Strauss and Corbin (1998) caution that these early coding steps are not sequential and axial coding must always be considered within the context of its relationship to open coding. Multiple drafts of diagrams that depicted concepts as they emerged were developed during axial coding in this study.

Axial coding models depicting the processes of both successful and unsuccessful work re-entry for nurses with SUD provided visual representations of the processes being explored, supporting a higher level of abstraction of the data and a means to visualize connections between

93

categories using the Strauss and Corbin (1990, 1998) approach. Axial coding model diagrams

that present context, antecedents, phenomenon, strategies, consequences/outcomes, and

intervening conditions were developed early in data analysis and involved numerous revisions

during the process of constant comparative analysis. These models were important to the

emergent theoretical models. Because successful work re-entry and unsuccessful work re-entry

were highly divergent experiences, axial coding model diagrams for each of these processes were

developed. More in-depth discussion of axial coding and the axial coding models is presented

later in this chapter, in Chapter Four, and is depicted diagrammatically in Figure 6 and Figure 7.

Code Notes

In addition to memo writing, notes were kept during the different stages of coding. In the

open coding process, code notes were kept that initially involved a list of key words and phrases.

As repetition of these concepts and themes occurred, notes were written to describe possible

similarities or differences among the ideas that emerged during axial coding as well as other

general impressions held by the researcher. Code notes during axial coding helped to develop

properties and characteristics of the emerging categories (Strauss & Corbin, 1998). These

became important discussion points with the grounded theory advisor and with the nationally

known expert on nurses with SUDs who consulted for the study. Code notes decreased as data

analysis became more complex.

Code notes and memos often took the form of note-worthy ideas or phrases from

participants. For instance, the researcher kept a table that chronicled the answer to three of the

questions on the interview guide. Those questions were: (a) What advice would you give to other

nurses who return to work after treatment? (b) Of all the things that we've talked about today,

what do you think is the most important for me [the researcher] to understand? (c) Tell me what

motivated you to join this study. This table was very useful in helping to keep the early coding

and data analysis process firmly rooted (grounded) in the data from participants.

Demographic data were also a source for code notes, especially related to gender, age,

highest nursing degree obtained, presence of a co-morbid medical or psychiatric illnesses, and

leadership experiences. Other code notes addressed themes based on experiences of participants

during drug/alcohol use, SUD treatment, recovery, and return to the nursing practice work

setting. These helped define the variation present in the research group.

Theoretical Notes

Theoretical notes were kept by the researcher primarily during axial and selective coding.

Theoretical notes expanded and helped identify the meaning of concepts that may have been only

implied by participants during interviews, supporting movement toward higher levels of

abstraction. Theoretical notes focused on the relationships between the concepts that emerged

during early coding and traced how the conceptual relationships evolved into categories and

themes. The theoretical notes also included the researcher's ideas and thoughts about future

sampling, especially related to achieving maximum variation and other issues that emerged

during recruitment of participants and the interview processes. The theoretical notes and model

drafts supported and validated the decision to develop two distinct models for the axial coding

models and the theoretical models to depict successful workplace re-entry and unsuccessful

workplace re-entry. The complexity present in these notes supported the realization they are

distinct basic social processes (BSP).

Operational Notes

      Operational notes kept during the research process involved the methodological and personal notes of the researcher that offered directions toward next steps in the research. This is in keeping with the definition from Strauss and Corbin (1998) of operational notes as: "…memos containing procedural directions and reminders" (p. 217). For instance, early in the interviews, a significant number of participants shared having attention deficit hyperactivity disorder (ADHD). This led the researcher back to the literature where there is substantiated evidence of the connection between ADHD and development of SUD. Studies have found that the diagnosis of ADHD is a risk factor for SUD development (Breyer, Lee, Winters, August, & Ralmuto, 2014); it is also associated with a high co-morbidity with onset of drug/alcohol use and abuse at an early age (Ohlmeyer et al., 2008). ADHD also was found to lead to a longer duration and more chronic course of SUD and involves a longer time to achieve remission of the SUD (Wilens, Biederman, & Mick, 1998). These findings provided validation that the researcher's decision to add a question to the semi-structured interview guide related to co-occurring physical and/or psychological illnesses was sound. The operational notes and other types of notes and memos helped maintain order and organization to the data supporting a solid analysis, which became very important as the number of interviews and the amount of collected data increased.

Integrative Model Development

      The use of diagrams to visually represent the relationships between concepts in a grounded theory study is strongly endorsed by Strauss and Corbin (1990, 1998) as a tool to integrate data. These diagrams depict the "…logical relationships between categories and their subcategories, in terms of the paradigm features…" (Strauss & Corbin, 1990, p. 197). They are

96

valuable in depicting abstract representations of the data, including the different parts of the theory or conceptual model that emerge at the culmination of the research process.

An example of an integrative model (diagram) based on data from this study is a gerunds diagram of the processes operating prior to successful work re-entry, depicted in Figure 5. This figure was developed as a means for the researcher to depict abstractly the "-ing" words (gerunds) pertinent to successful work re-entry for nurses with SUDs. Grounded theory co-originator Glaser (1978) recommends that gerunds be used in grounded theory methodology to uncover and depict the core variable/core phenomenon, because gerunds "…give the feeling of process, change, and movement over time" (p. 97). The construction of the gerunds figure went through many revisions during constant comparative analysis and contributed to the emergence of the axial figures and the final theoretical models by visually representing the processes operating for participants prior to and during a successful work re-entry experience.

Selective Coding and Theoretical Model Development

Selective coding is the process of identifying the emerging core variable/central category that relates to all other categories and which confirms linkages among the categories, a step characterized by a higher level of abstraction (Strauss & Corbin, 1990, 1998). "The aim of selective coding is to integrate the categories along the dimensional level to form a theory (model), validate the statements of relationship among concepts, and fill in any categories in need of further refinement" (Strauss & Corbin, 1998, p. 211). The development of the theoretical models, like the axial coding models, were modified numerous times as data were collected and analyzed. The researcher frequently returned to interview transcripts and the literature when further clarity was needed.

97

Figure 5. Processes Operating during Successful Work Re-entry (Using Gerunds: "-ing" Words) (Matthias-Anderson, 2015)

Figure 5. Model of "-ing" words depicting processes operating for nurses with SUDs who re-enter the nursing workplace successfully
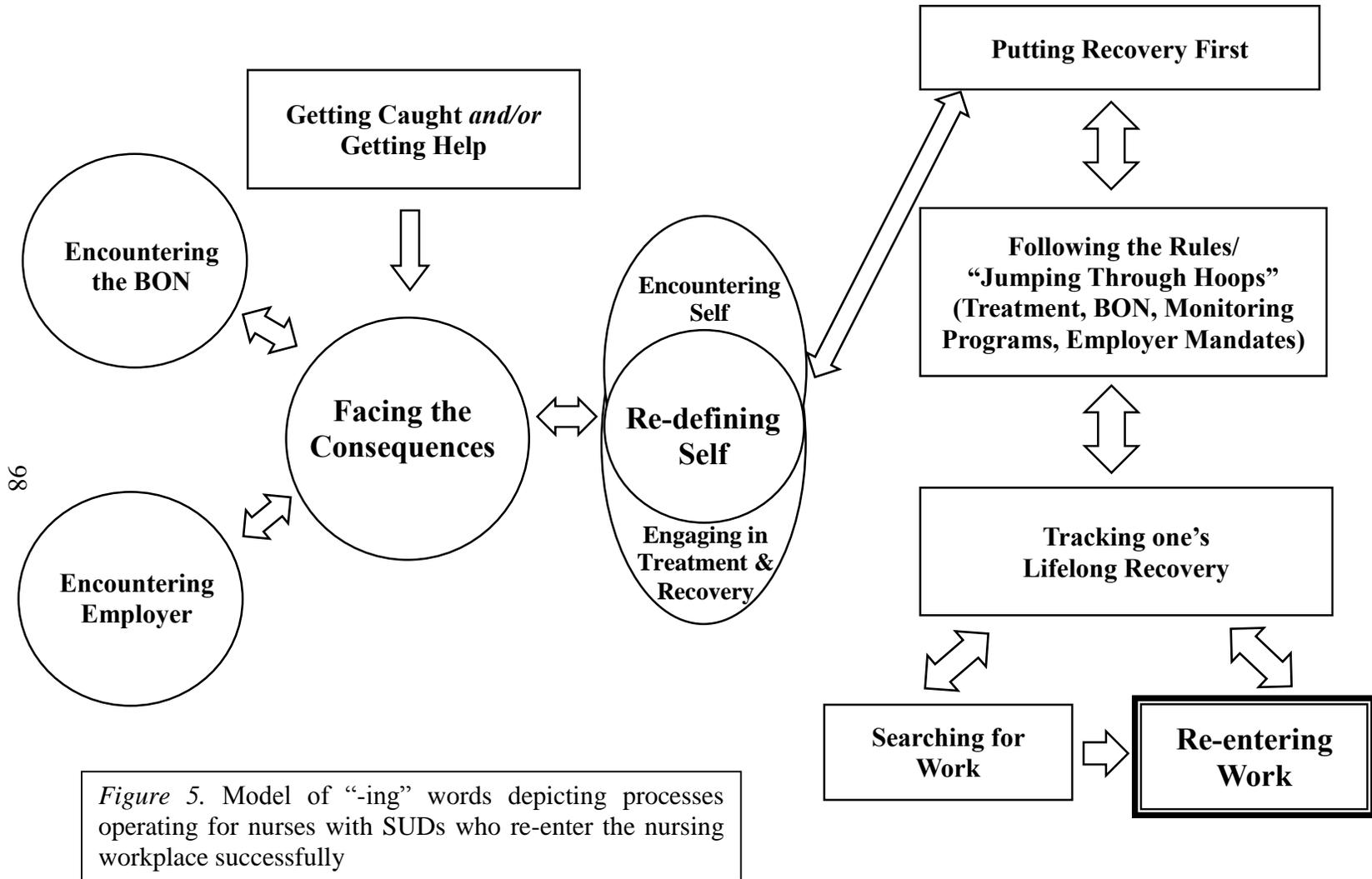
The emerging descriptors in the axial diagrams and their discovered relevant relationships provided a helpful way to organize the data in a logical manner, allowing for the theoretical models/diagrams to emerge as the axial diagrams were modified (Strauss & Corbin, 1990). As with the axial coding models, there are two theoretical models, one depicting successful work re-entry and one depicting unsuccessful work re-entry for RNs with SUDs after completing SUD treatment. These theoretical models are presented diagrammatically and discussed with the study findings in Chapter Five.

Member Checking

Member checking and re-contact with key participants assisted with data analysis in the later stages of the constant comparative analysis process. A member check is "…a method of validating the credibility of qualitative data through debriefings and discussions with informants" (Polit & Beck, 2012, p. 733). This took the form of a second interview with four study participants. These key informants were chosen because of introspection displayed during the first interview, their SUD and work re-entry experiences, and their ability to clearly articulate their personal stories. During the member check interviews, the researcher provided drafts of diagrams and information about emerging themes and interpretations from the research, asking for the participant's reaction to them (Lincoln & Guba, 1985). The aim was for member check participants to confirm the accuracy of the researcher's interpretations and/or provide critical feedback of results that may be deficient or inaccurate (Polit & Beck, 2012). The process provided a "check" for the researcher that the emerging diagrams and interpretations made sense to participants based on their experiences.

Three member check interviews were done face-to-face; one was done over the phone.

Both males and females were represented in the member check group; variation in nursing

educational preparation, work experience, and geographic location were also represented among

this group. Each participant agreed to review drafts of tables and diagrams, including drafts of

the axial coding models and the theoretical models. During the member check interview the

researcher gave a verbal description of each document, asking for feedback about the accuracy

and logic of the conclusions. Participants were encouraged to ask questions about the documents.

All of the participants of the member check interviews voiced keen interest in the study findings

and appreciated being able to view the findings in diagrammatic form.

As a result of the member check interviews, the axial coding models and the theoretical

models were revised to incorporate feedback from participants. Critical feedback from member

check interview participants clarified for the researcher the legal dimensions of post-SUD

treatment monitoring and common features of the work environment post-re-entry. The concept

of resentment and the role it plays in unsuccessful work re-entry was also illuminated during the

member check interviews. Changes to the theoretical models were made as a result of new data

that emerged from the member check participants. This was particularly relevant in

understanding how relationships in a nurse's life influence personal and professional identity. As

a result of the member check interviews, modifications were made to the theoretical models in

the way relational concepts were depicted.

Revisiting the Literature

Review of the literature occurred prior to the onset of the research and helped identify

this topic as a relatively unexplored topic. A return to the literature also occurred throughout data

analysis and near the end of coding processes as understanding and interpretation of the data emerged. As relevant information and concepts emerged, the literature on the emerging concept was reviewed. Examples of this are: a) searching for additional information about prevalence of anxiety and attention-deficit disorders among individuals with SUD, b) exploring the literature for information on self-identity change among individuals with SUD in recovery, and c) reviewing additional information about management of SUD as a chronic illness. Information from these additional literature searches became part of the coding process where it stimulated further questions, confirmed findings, directed additional theoretical sampling, and added rigor to the study's findings (Strauss & Corbin, 1990, 1998). This process supported the fluidity that occurred during data collection and acted as a check of the accuracy of the data that emerged.

Writing

Memos, diagrams, and relationships among categories uncovered during coding provided the basis for writing about the study. The writing was focused at a conceptual level and provided a foundation for the theoretical models that emerged (Strauss & Corbin, 1990, 1998). Glaser (1978) instructs that the writing be focused on the concepts, not the participants or the descriptions of their experiences. Descriptions of the experiences and relevant quotes from participants were used to confirm validity of concepts and to flesh out understanding shared by participants. The goal of writing is to share new theoretical knowledge which, for this study, informs the nursing profession about workplace re-entry of RNs after completion of substance use disorder treatment. Written dissemination of findings expand the knowledge and understanding of nurses in the practice environment and inform the discipline of nursing about

101

possible policy changes and development, thus partially filling a gap in the literature about workplace re-entry of RNs after completion of substance use disorder treatment.

Trustworthiness

Trustworthiness, as described by Lincoln and Guba (1985), is one of several frameworks to determine the presence of rigor in qualitative research. Trustworthiness refers to the degree of confidence that qualitative researchers have that their data are credible, dependable, confirmable, and transferable (Lincoln & Guba, 1985; Polit & Beck, 2012). Qualitative research is contextually situated within social processes and relies on language and interpretive practices: "Trustworthiness becomes a matter of persuasion whereby the scientist is viewed as having made these practices visible and, therefore auditable…" (Sandelowski, 1993, p. 2). The four criteria of the trustworthiness framework (Lincoln & Guba, 1985) are defined, followed by a discussion of the various qualitative research strategies that were employed to meet each criterion.

Credibility

Credibility, viewed as a main goal of qualitative research, refers to the "truth value" (Lincoln & Guba, 1985, p. 294), or the confidence in the truth of the data and the researcher's interpretation of them (Polit & Beck, 2012). Constant comparative analysis and theoretical sampling provided the means to determine theoretical saturation, a concept integral to grounded theory methodology and the achievement of credibility (Tuckett, 2005). Theoretical saturation according to Strauss and Corbin's (1998) grounded theory approach is: "…the point in category development at which no new properties, dimensions, or relationships emerge during analysis" (p. 143) and is a component that is vital for theory/model development.

102

Other considerations important in achieving credibility are whether the manner in which the study was conducted leads to believability of the study results and whether the findings make sense to participants. Four participants agreed to member check interviews, second interviews at which time the researcher shared core variable diagrams and key categories that emerged from data analysis, explaining how the coding led to the conclusions reached. Feedback from the member check interviews became crucial data for the study and were used to validate clarity, soundness, and relevance of the emerging conceptual model.

Several other strategies strengthened credibility. Data from field notes and the reflexive journal provided an audit trail of how the emergence of concepts occurred and how confident the researcher was in the adequacy of the data. The researcher worked to create a comfortable interview setting where an open dialogue supported the gathering of truthful data. Investigator triangulation among the researcher, an expert grounded theory methods advisor, a nurse researcher who was an expert on this topic, and the evolving literature searches also enhanced credibility.

Dependability

Dependability, analogous to reliability in quantitative studies, refers to data stability over time and in various conditions. Polit and Beck (2012) assert that the crucial question regarding dependability is: Would findings be repeated if the study were replicated with same/similar participants in same/similar context? Additionally, dependability is closely aligned to credibility: "Credibility cannot be attained in the absence of dependability, just as validity in quantitative research cannot be achieved in the absence of reliability" (Polit & Beck, 2012, p. 585).

A sound research design consistent with the research questions, aims, and philosophic/theoretical underpinnings assisted the researcher in accurate data collection and analysis. Clear, precise documentation of the research process in field notes, memos, and the reflexive journal also enhanced dependability (Lincoln & Guba, 1985; Polit & Beck, 2012; Tuckett, 2005). The audit trail monitored and insured procedural dependability and was another strategy employed with this evaluative criterion (Flick, 2009). The audit trail is discussed more in depth in the next section.

Confirmability

Confirmability refers to the objectivity of the data (Lincoln & Guba, 1985) and is noted by explicit and transparent documentation in the audit trail. According to Polit and Beck (2012), the audit trail consists of six classes of qualitative records: raw data (from interviews), data reduction (coding), process notes (memos), materials relating to researchers' perceptions (reflexive journal), instrument development information (pilot data), and data reconstruction products (p. 591). Polit and Beck (2012) state: "For this criterion to be achieved, findings must reflect the participants' voice and the conditions of the inquiry, not the researcher's biases, motivation, or perspectives" (p. 585). In addition to careful documentation in the audit trail, other research strategies that were employed included collaboration with an expert grounded theory researcher (investigator triangulation) and requests for feedback from participants during the interview process when ideas and concepts being shared were unclear. Broad ideas that emerged from earlier participants were occasionally shared with later participants, especially when discussions and experiences appeared similar. This was presented to the current participant with the statement, "I've heard from a few other participants that *(X experience)* occurred for them.

How does that fit for you?" This method of validation allowed the researcher to maintain confidentiality of all participants while confirming that what she was hearing was similar among participants and required close scrutiny in coding and data analysis.

Transferability

Transferability refers to "fittingness" (Tuckett, 2005, p. 31) and "extrapolation potential" (Polit & Beck, 2012, p. 585). Lincoln and Guba (1985) state that a qualitative researcher: "…cannot specify the external validity of an inquiry; he or she can provide only the thick description necessary to enable someone interested in making a transfer to reach a conclusion as to whether or not transfer can be contemplated as a possibility" (p. 316). Thick description is the term used by Lincoln and Guba (1985) to refer to a thorough description about the environmental context in which the research took place (p. 125), including the research setting and aggregate data about participants (Tuckett, 2005). A thick description that is sufficiently detailed allows the reader to transfer information to other situations and settings (Creswell, 2007, p. 209). The *reader is ultimately responsible for transferability* (emphasis added) although the researcher is charged with making this easier by providing a rich, detailed thick description (Lincoln & Guba, 1985; Tuckett, 2005). Thick descriptions most often took the form of researcher memos and reflexive journal entries, all of which became a part of the audit trail.

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Limitations Based on Method

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Limitations are inherent in every research study and are defined as potential weaknesses that relate to data collection and analysis (Creswell, 2003). Qualitative research studies always have the limitation of not being generalizable to other populations in the same way that a representative sample can in a quantitative study. This applies to purposive sampling procedures

where there is initial intentional selection of participants who must all have a common trait; in the case of this study the common trait was being a nurse with a diagnosed SUD who had re-entered the workplace after completion of SUD treatment. However, efforts to maximize variation to the fullest extent of the parameters of the research was done, including sampling nurses with diverse demographics and working in urban, suburban and rural settings within four different regions of the U.S. If a grounded theory study has sufficient rigor, it will produce a theory/model that may be transferable to other nurses with SUDs in other settings and situations.

Another limitation relates to the possibility of social desirability response bias, "…a tendency of individuals to deny socially undesirable traits or behaviors and to admit socially desirable ones" (Randall, Huo, & Pawelk, 1993, p. 186). The literature review about SUDs in nurses revealed that stigma is a commonly reported phenomenon, creating a likelihood that study participants may have minimized, denied, or were not truthful about their SUD experiences and history. Much of the literature about social desirability response bias focuses on self-report instruments, such as questionnaires and surveys. This study did not include a written survey; instead data were collected verbally by face-to-face or phone interviews. There could have been similar response biases in answering interview questions. To reduce this limitation, the demographic questions were asked at the onset of the interview as a way to break the ice in the researcher/participant relationship. Subsequent questions were then asked in an open dialogue format with encouragement of the participant to tell their story.

A common limitation in qualitative studies is that findings could be subject to other interpretations. In consideration of symbolic interactionism, all people take information and relate it to stored knowledge and experience. Thus, all individuals may have some variation of

the interpretation of data. However, strict adherence to the trustworthiness framework (Lincoln & Guba, 1985) and close consultation with expert qualitative and grounded theory researchers occurred to insure that the analytical criteria were met.

Chapter Summary

This chapter outlined the research design, sampling, contextual and cultural environment, data collection procedures, data analysis processes, trustworthiness, and limitations based on the method of this research study. Grounded theory methodology is a non-linear, interactive process that involves planning, data collection in the field, and data analysis that moves from descriptive to conceptual and finally to theoretical understanding. Constant comparative analysis, the fluid back-and-forth process of comparing all elements of the data to each other, helped integrate all elements of the grounded theory process (Flick, 2009). Figure 3 is a diagrammatic depiction of constant comparative analysis as understood and developed by the researcher once this study was underway. A preliminary review of the literature was completed (see Chapter Two) but literature was reviewed throughout the process. Writing involved integration of findings from the constant comparative analysis of data from memos/field notes, reflexive journaling, and emerging diagrams. The relationships among identified categories that emerged during coding became the focus of the writing. Findings of the study are presented in the next chapter (Chapter Four). Discussion and diagrammatic depiction of the theoretical models (core variables that emerged from these data) are presented in Chapter Five.

CHAPTER IV

RESEARCH FINDINGS

Introduction

Chapter Four presents the findings of this study. The purpose of this qualitative, grounded theory study was to explicate a substantive theory/model that describes the basic social processes (BSP) operating when a registered nurse (RN) re-enters the workplace following completion of SUD treatment. The researcher conducted semi-structured interviews with 22 RNs from different regions of the country who presented with diverse educational and professional nursing backgrounds, varying length of sobriety/recovery, and personal work re-entry experiences. From these data emerged core variables with their properties for both successful and unsuccessful work re-entry processes. Constant comparative analysis of the transcribed data, conversations with content experts, researcher memos, reflective journal entries, and field notes revealed significant changes in self-identity after completion of SUD treatment for participants who experienced successful work re-entry.

The first section of this chapter reports the demographic data collected from the participants. The second section of the chapter discusses findings related to each of the research questions of the study. The final section presents the axial coded data and the models that emerged from this coding framework and constant comparative analysis of data related to the three research questions.

Note: In order to simplify descriptions and maintain confidentiality, all participants discussed in this chapter will be referred to using the female pronouns 'she' or 'her' since females were the dominant gender represented.

Demographics of Study Participants

The following section describes the study participants. All participants met inclusion criteria for the study: (a) possessed a registered nurse (RN) license to practice nursing (advanced practice or specialty status acceptable, e.g., CRNA, nurse practitioner); (b) had completed at least one SUD treatment at a state licensed (or state approved) facility; and (c) re-entered the nursing practice workplace at the participant's professional level of entry in a work setting that required RN licensure. Two RNs were interested in the study but were excluded due to no formal SUD treatment experience; both had become sober through A.A. Two licensed practical nurses (LPNs) inquired about the study but did not have RN licensure and were excluded.

Each state sets its own standards for the licensing of facilities that provide SUD treatment; variation among states is evident. Some states require that treatment facilities obtain state licensure while other states require approval, accreditation, certification, or a combination of these endorsements (Center for Substance Abuse Treatment, 2005). All study participants verbally endorsed that they had completed a minimum of one SUD treatment at a facility that met state mandated standards. Each participant had a minimum of one work re-entry experience to a work setting that required RN licensure. At the time of the interviews, all participants held a registered nurse license; four of the 22 participants (18.2%) also held an advanced practice nursing license and were working in an advanced practice role.

Reasons participants chose to participate in the study

Near the end of each interview, study participants were asked to share what motivated them to join this study. When viewed collectively, participant responses overwhelmingly pointed to altruism as a motivating factor to participate. Eight participants responded that their motivation to participate centered on being able to be of "service" by affecting change or helping others in some way. Five participants expressed a desire to help others, especially nurses, to better understand SUDs. As one participant stated, "…if this helps somebody else understand more about addiction and that I'm still an effective and valuable nurse, that's a good thing."

Five participants were motivated to join the study because they viewed it as an opportunity to speak out and share their own stories. Three participants interviewed early in the study specifically cited the negative regional media attention toward the BON and their oversight of nurses as incentive to participate. One of these participants stated:

It was just curious that this opportunity came up right at the time I was reading those articles. I was reading the articles and then, when I was asked, "Would you be interested in doing this study?" I thought, I need to tell somebody. I don't know if this is who I need to tell, but yes, I want to tell somebody, to let somebody know that there are success stories out there; it's not all what you're reading.

Emphasis on sharing experiences, especially hope, is a firmly rooted tenet of 12-step recovery programs and is guided by the Alcohol Anonymous (A.A.) premise that by sharing one's own experience (story) one can help others; this also supports one's own recovery. As is noted in the A.A. literature, "It is the great paradox of A.A. that we can seldom keep the precious gift of sobriety unless we give it away" (Alcoholics Anonymous World Services, 1952, p. 151).

These concepts were strongly reflected in participant responses to this question but may also reflect that altruism is an innate value for many nurses.

Maximum variation sampling strategy

A maximum variation sampling strategy aims to find participants with wide and diverse perspectives and attributes so that the resulting patterns and processes that emerge are comprehensive (Polit & Beck, 2012). Maximum variation factored into the decision to request an IRB protocol change to allow phone interviews of participants from other regions of the U.S.

Of the 22 participants, the researcher met 18 participants for a face-to-face interview in a location chosen by the participant. The last four participants were interviewed over the phone and resided in three regions of the country that were different from the earlier participants. This broadened representation and increased variation in participant experiences with state BONs, alternative programs, and work re-entry. It also broadened the variation of the sample in the categories of gender, race/ethnicity, specialty areas in nursing, type of nursing degree, practice experience, and monitoring status. Each of these demographic categories is discussed for study participants.

Gender, age, and race/ethnicity. The mean age of the study participants was 48.6 years, as noted in Table 1. This is slightly older than the national mean age of RNs. National statistics of the RN workforce find that the mean age of RNs is 44.6 years (Health Resources and Services Administration, 2013).

Nearly 20% of the study participants were male, as shown in Table 1. This percentage is over two times higher than the 9.1% of male registered nurses in the national workforce (Health Resources Services Administration, 2013). This difference may be partially explained by the

fact that three of the four male participants were certified registered nurse anesthetists (CRNA), a

specialty area in nursing with a much higher percentage of male representation. Statistics of

gender breakdown among CRNAs is 58.1% females; 41.9% males (Kaplan, Skillman, Fordyce,

McMeniman, & Doescher, 2012). It has also been reported that male nurses are over-represented

in alternative program demographics (Dittman, 2008; McNelis et al., 2011). The gender

breakdown among participants in this study may then be more representative of the group of

nurses with SUD who enter alternative program monitoring than of nursing as a whole.

Table 1. *Age, Gender, and Race/Ethnicity of Study Participants*

Age[*] (years)	%	n
30 – 39	22.7	5
40 – 49	27.3	6
50 – 59	27.3	6
60+	22.7	5
Gender	%	n
Female	81.8	18
Male	18.2	4
Race / Ethnicity	%	n
Caucasian	86.4	19
Bi-racial	4.5	1
Hispanic	4.5	1
Native American	4.5	1

Note. [*]Mean age = 48.6 years

Over 80% of study participants were Caucasian (*n* = 19). This is a higher percentage than

the national statistics for race/ethnicity of RNs: 75.4% are Caucasian, 9.9% are African

American, 4.8% are Hispanic/Latino, 8.2% are Asian, and 0.4% are Native American (Health

Resources and Services Administration, 2013). As discussed previously, race/ethnicity is a

demographic attribute included in maximum variation sampling efforts with two of the three

non-Caucasian participants being among the last few participants interviewed. Table 1 presents

data for the age, gender and race/ethnicity of study participants.

Nursing educational preparation. Study participants were generally well educated with over 40% holding a graduate degree in nursing, as depicted in Table 2. Representation of graduate degrees earned by participants were: (a) Master's Degree in Public Health (4.5%, $n =$ 1); (b) Master's of Science in Nursing (4.5%, $n =$ 1); (c) Master's Degree in Nursing Education (4.5%, $n =$ 1); (d) an Adult Nurse Practitioner Master's Degree (4.5%, $n =$ 1); and (e) Certified Registered Nurse Anesthetists (CRNA) with a Master's of Science Degree (13.6%, $n =$ 3). One participant held a Doctorate in Nursing Practice and was also a CRNA (4.5%, $n =$ 1); this participant is not included among the previously stated CRNA statistic ($n =$ 3).

Table 2. *Nursing Educational Preparation*

Highest Nursing Degree	%	n
Associate Degree	27.2	6
Bachelor's Degree	31.8	7
Master's Degree	36.4	8
Doctorate in Nursing Practice	4.5	1

National workforce statistics find that only 10.6% of all RNs have a Master's or Doctoral degree in nursing with 44.6% educated at the bachelor's degree level, 37.9% at the associate degree level and 6.9% having a diploma in nursing (Health Resources Services Administration, 2013). The fact that nine (40.9%) of the study participants hold advanced degrees in nursing is noteworthy. The literature has consistently reported that nurses with SUDs are high achievers, often have a graduate degree, and hold advanced and/or leadership roles in nursing, (Bissell & Haberman, 1984; Cook, 2013; Heise, 2003). Whereas educational achievement is partially supported by evidence in the literature, it does not completely explain the high percentage of well-educated participants in this study. One might speculate that nurses with advanced degrees

have greater knowledge and education about the role and importance of research. Because of this, they may be more willing to participate in a nursing research study.

Employment history in nursing, current employment, and leadership roles. Given the mean age (48.6 years) of the study participants, the amount of time working as a registered nurse is also fairly lengthy, with 19 (86.4%) of the participants stating they had worked in a RN position for 11 years or more. It should be noted, however, that most participants calculated length of time as a RN from date of graduation and did not subtract time when the license to practice nursing may have been suspended. Length of time away from the nursing practice worksite due to license suspension involved one or more years for some participants.

Leadership positions among participants varied considerably. They ranged from working as unit charge nurse during an eight hour shift to holding director of nursing and nurse manager positions. All of the nurses with graduate degrees in nursing had spent extensive portions of their nursing practice experience in leadership positions, an expected outcome of a nurse with a graduate degree. Of the seven nurses who had a baccalaureate degree in nursing, five (71%) had not worked in any nursing leadership position while all six (100%) nurses who had an associate degree had held leadership positions. In this study, this may be more reflective of the age of the participants and their length of time working in nursing than related to their nursing degree. Four of the five nurses with baccalaureate degrees who had no leadership experience were some of the youngest participants in the study, all being in their 30's in age. The length of time employed as a nurse for these four participants ranged from 5 to 12 years, with an average of 7.75 years. The length of time employed in nursing for the six nurses with associate degrees ranged from 16 to

114

26 years with an average of 19.7 years; their ages ranged from 44 to 65 years with an average of

52 years.

Unlike baccalaureate or graduate nursing degree programs, associate degree curricula do

not include much theoretical content and/or clinical preparation for leadership positions in

nursing. Associate degree prepared nurses may experience added stress in the workplace when

put in leadership positions, especially if the nurse is also struggling with a SUD. As shown in

Table 3, 17 study participants (77%) had held some sort of leadership position in nursing over

the course of their professional nursing careers.

Table 3. *Employment History, Current Employment, and Leadership Roles in Nursing*

	Female ($n = 18$)		Male ($n = 4$)	
Length of time as a registered nurse (years)	%	n	%	n
1 – 10	16.7	3	0	0
11 – 20	44.4	8	25	1
21+	38.9	7	75	3
Currently employed as a registered nurse	%	n	%	n
Yes	83.3	15	100	4
No	16.7	3	0	0
Leadership Experience: Administration, management, charge positions	%	n	%	n
Yes	72.2	13	100	4
No	27.8	5	0	0

Nursing specialty areas represented. Participants were working in a variety of nursing

practice settings at the time of the interviews, as shown in Table 4, helping to meet criteria for

maximum variation in sampling.

Drug(s) of choice. Seventeen (77.3%) participants self-identified one primary "drug of

choice." Five (22.7%) participants self-identified more than one drug as "drug of choice,"

depicted on Table 5 as "Combination of drugs."

115

Table 4. *Participant Nursing Worksites at Time of Interview*

	%	n
Hospital-based Nursing Positions	(40.9%)	(9)
Surgery (CRNA)	13.6	3
Emergency Department	9.1	2
Maternal/Child (Obstetrics)	4.5	1
Pediatrics	4.5	1
Critical Care	4.5	1
Neurology	4.5	1
Non-hospital Nursing Positions	(45.5%)	(10)
SUD or SUD/Mental Health	22.7	5
Phone Case Management/Triage	9.1	2
Home Care	4.5	1
Hospice	4.5	1
Nursing Administration/Nursing Education	4.5	1
Currently Not Working in a Nursing Position	(13.6%)	(3)
Retired	4.5	1
Seeking a Nursing Position	4.5	1
Student Full-time (Non-nursing, health field)	4.5	1

Table 5. *Drug(s) of Choice Self-identified by Participants*

Drug	%	n
Opioids	36.4	8
Alcohol	27.3	6
Methamphetamine	9.1	2
Cocaine	4.5	1
Combination of drugs		
Alcohol/Opioids	9.1	2
Alcohol/Benzodiazepines	4.5	1
Alcohol/Marijuana	4.5	1
Methamphetamine/Cocaine/Alcohol	4.5	1

Early literature about SUDs among nurses reported that alcohol was the most prevalent

drug of choice, just as it is in the general population (Bissell & Haberman, 1984; Sullivan, 1987).

There has also been substantial evidence in the literature that nurses use prescription pain

medications at a higher rate than the general population (NCSBN, 2011; Trinkoff & Storr, 1998).

116

Opioids are now the most common drug of choice among nurses being monitored by state BONs or alternative programs (Bettinardi-Angres et al., 2012). Ten participants (45.4%) identified opioids alone or in combination with alcohol as drug(s) of choice in this study.

Alcohol was named by all five participants who identified a combination of drugs to be "drug of choice," although the substances used in combination with alcohol varied. Additionally, at the time of the interviews, three different participants who identified opioids as their current (and only) drug of choice disclosed having had a previous SUD treatment in early adulthood when their drug of choice at that time was alcohol. For all three of these participants, this first treatment for alcohol dependency occurred prior to becoming a nurse. Each of these participants went on to abuse and divert opioids from the workplace after obtaining a nursing license.

When study participants are viewed as a group, only 13.6% ($n = 3$) named something other than alcohol or opioids to be their drug of choice. This finding is consistent with the literature; opioids and alcohol are main drugs of choice for nurses (Bettinardi-Angres et al., 2012; NCSBN, 2011; Trinkoff & Storr, 1998). It is also strongly evident that central nervous system (CNS) depressants are by far the most common drug of choice (86.4%, $n = 19$) for the study participants. One of the member check interview participants noted this high percentage of CNS depressant use among study participants when viewing a table of participant drug(s) of choice, stating: "Well, the interesting thing here is that [nurses] are choosing depressants as their drug of choice. I think that might say a little bit about stress levels. I used [them] to calm down."

Length of sobriety and number of SUD treatments. As shown in Table 6, at the time of the interviews, slightly over half (54.5%, $n = 12$) of the participants of the study had been sober/abstinent from all drugs and alcohol for five years or less. Over 20 percent of the

117

participants ($n = 5$, 22.7%) had long-term sobriety of 11 years or more. Additionally, over two-thirds (68.2%, $n = 15$) had participated in and completed only one or two SUD treatments; 31.8% ($n = 7$) had completed three or more SUD treatments, providing rich variation in the data.

Table 6. *Length of Sobriety and Number of SUD Treatments*

Length of sobriety (in years)	%	n
0 – 5	54.5	12
6 – 10	22.7	5
11 – 20	9.1	2
21+	9.1	2
Chose not to disclose	4.5	1
Number of SUD treatments	%	n
1	54.5	12
2	13.6	3
3	13.6	3
5	13.6	3
7	4.5	1

Of the ten participants who had more than one SUD treatment, eight (80%) of these had an unsuccessful nursing work re-entry experience (36.4%; N = 22 participants). These eight participants relapsed with their drug(s) of choice, lost their nursing positions, were reported to the state BON and/or the state alternative program, and returned for additional SUD treatment. The remaining two participants of those who had more than one SUD treatment had returned to work successfully since their last SUD treatment; previous treatments occurred prior to these participants becoming a nurse.

Participant self-disclosure about relapses since last SUD treatment. The demographic interview guide included a question that asked participants to share the number of slips or relapses they had experienced since completion of the last treatment for SUD. Relapse was defined in Chapter One as: "…the return to drug or alcohol use after a period of abstinence. A

relapse may last for a few days or for many years" (NCSBN, 2011, p. 238). Of the total number of participants, 22.7% (*n* = 5) admitted to at least one relapse since the last SUD treatment completion. All were female. One participant referred to what she identified as "slips," indicating these to be very short-term use of her drug of choice. The literature defines "slip" in a similar way, "…an isolated occasion of alcohol or drug use" (World Health Organization, n.d., Relapse, para. 1). Of the five participants who admitted to one or more relapses/slips, four identified their drug of choice to be alcohol; one participant identified her drug of choice to be a combination of drugs that included alcohol.

Relapse is common in all chronic illnesses and is frequently cited in the SUD literature as a challenging feature for those diagnosed with SUD and to those providing treatment for them (Kalivas & Volkow, 2005; McKay & Hiller-Sturmhöfel, 2011). The one-year post-discharge (from SUD treatment) abstinent (adherence) rate for SUDs is estimated to be 40-60%, which is very similar to one-year treatment adherence rates of the common chronic illnesses of Type 1 diabetes (30-50%), hypertension (50-70%) and asthma (50-70%) (McLellan et al., 2000, p. 1693). There is evidence that relapse is most prevalent in early recovery (White, 2008). This was supported in participants in this study who admitted to relapse after the last SUD treatment completion, in that three of the five participants had less than two years of sobriety. Of the remaining two participants, one declined to disclose actual length of sobriety and number of relapses, stating they were "numerous." The other only admitted to "slips" and claimed ten years of sobriety. Therefore, firm conclusions about relapses in study participants are difficult to ascertain except for the fact that less than one-fourth of total participants had experienced relapse since the last treatment completion. It has been reported that treatment outcomes for nurses are

119

better than the general public, resulting in lower relapse rates for nurses (Bettinardi-Andres et al., 2012; Monroe et al., 2008). Therefore, study results are congruent with these reports in the literature.

Participant self-disclosure about medical conditions or history of trauma/abuse. An unforeseen outcome of the pilot interviews was unsolicited self-disclosure by participants about medical conditions, including psychiatric illnesses, or history of trauma and/or abuse which were presented as significant to the development of the SUD process and recovery. Nineteen (86.4%) participants endorsed some sort of physical and/or psychiatric medical condition or history of trauma/abuse, as shown in Table 7. When a participant disclosed more than one condition, she was classified under the condition that she identified as the primary issue.

Table 7. *Self-Disclosed Medical Conditions or History of Trauma/Abuse*

Condition disclosed	%	*n*
Trauma/abuse history	9.1	2
Chronic pain	4.5	1
Headaches	13.6	3
Insomnia / Sleep related conditions	9.1	2
Psychiatric disorder:	31.8	7
(Anxiety, Depression, ADHD, PTSD, Undisclosed)		
Other physical condition:	9.1	2
(Specific condition not disclosed)		
Combination of physical and psychiatric disorders	9.1	2
No condition disclosed	13.6	3

An exploration of the literature about illnesses that co-occur with SUD revealed considerable information. "Adverse childhood experiences" (ACEs) are experiences that occur during childhood that are traumatic and stressful and leave enduring negative effects. Poor coping skills frequently result, including the development of substance use/abuse (New York State Nurses Association Statewide Peer Assistance for Nurses, 2014). An ACE study,

120

completed by Dube, Anda, Felitti, Edwards, and Croft (2002), was a large, longitudinal study which produced findings linking ACEs to problem drinking behavior in adulthood. In another study, ACEs were found to substantially increase prescription drug-use and abuse in adults (Anda, Brown, Felitti, Dube, & Giles, 2008). While questions about childhood trauma or growing up in an environment of dysfunction were not included in the semi-structured interview guide for this study, two participants freely offered this information during interviews. The literature on SUDs in nurses indicates that nurses are more likely to have been raised in homes with one or more parent being alcoholic (Dunn, 2005; NCSBN, 2011). Several participants shared this to be true of their family of origin experiences.

When psychiatric disorders co-occur with SUDs the result is that each disorder is more difficult to manage. Additionally, psychiatric disorders are known risk factors for the development of SUDs (Dunn, 2005; NCSBN, 2011). Conversely, close monitoring and treatment of depression is one factor that does predict success in recovery for healthcare providers with SUDs (NCSBN, 2011). For participants in this study, co-occurring psychiatric illnesses and/or history of abuse/trauma were strongly evident. Management of the co-occurring conditions is discussed more in-depth later in this chapter. There was also no indication from study participants that use or abuse of drugs was for recreational use only; purposeful use of opioids and other use/abuse of drugs was reportedly used by participants to relieve pain (physical or psychological) and/or decrease stress.

Licensure of participants by region. At the time of the interviews, participants resided and worked in four different regions of the U.S. As shown in Table 8, the majority (81.8%, $n = $ 18) of the participants were licensed in states of the Upper Midwest. This is the area where the

researcher resides. Participants from the Upper Midwest area represented three different states. Participants from the areas outside of the Upper Midwest regions were those who were interviewed over the phone. Recruitment of these participants was done through a national recovery website for nurses and by word of mouth from other participants. A nurse consultant and expert in SUDs among nurses referred the researcher to the person who monitors the national recovery website where three of the last four participants were recruited.

Table 8. *Nursing Licensure by Region of the U.S.*

Region	%	n
Upper Midwest	81.8	18
Southeast	9.1	2
Southwest	4.5	1
South	4.5	1

Four of the study participants held nursing licenses in more than one state or region primarily because they were employed by national companies and worked over the phone with clients from numerous states and regions. Several participants noted that they completed SUD treatment and were licensed in different states from where they currently reside and work. Some of these individuals came to the Upper Midwest region for SUD treatment where they subsequently decided to stay to resume nursing careers and engage in recovery support systems close to the facilities where they had completed treatment. In total, participants discussed differences in licensing and monitoring experiences from ten different states in the U.S (20% of the country). This was valuable in meeting maximum variation sampling goals, especially since each state BON has unique policies related to SUDs among licensed nurses. Additionally, several different models of alternative programs were represented in the different states; one

122

state represented had no alternative program at all. Differences in state BONs and alternative programs are discussed in the next section.

Monitoring status of participants. At the time of the interviews, 50% of the participants ($n = 11$) were currently being monitored by a state alternative program or a state BON. Eight participants (36.4%) had successfully completed monitoring by a state alternative program or a state BON. Two participants of the eleven who were currently being monitored were being monitored by two state alternative programs simultaneously due to the participants' desire to maintain a license in both states. One participant (4.5%) had never been monitored by either a state alternative program or a state BON as her treatment completion and subsequent sobriety had been achieved prior to formation of the state alternative program; the BON had not been involved in her case as she was monitored by her worksite only.

Commonalities and differences in state BON licensure regulations. In each state, nursing practice is regulated by two components, state statutes and the nurse practice act (Dunn, 2005). There exists significant variability in state statutes and policies/regulations for the monitoring and discipline of nurses with SUD (Aluni-Kinkle & Rundio, 2015). This variability in BON procedures and operation of alternative programs was evident in study data.

A commonality for study participants in all states relates to "due process" that is granted to nurses because they possess a nursing license. Due process gives the nurse the right to receive and understand charges he/she faces, the opportunity to appear before the BON, and the right to appeal the decision once it is made (NCSBN, 2011). Only one (4.5%) of the participants shared that she had filed and had been granted a hearing to appeal a BON decision. This information was unsolicited by the researcher as no questions regarding BON appeals were included on the

123

semi-structured interview guide. State boards of nursing differ in disciplinary policies for investigation and monitoring of nurses with SUDs. For example, the one state represented in the study that does not have an alternative program requires that nurses with SUDs who are being monitored must not only have random urine toxicology screening but also quarterly hair follicle testing to detect any drugs of abuse in the body. State BONs also differ in how often monitoring requirements are scheduled and the length of time monitoring occurs.

Commonalities and differences in state alternative program models. As noted in Chapter Two, there are different models of alternative programs across the U.S. However, even alternative programs of the same model type have their own unique regulations and policies, based on state statutes, making it somewhat difficult to discern commonalities. Among study participants, commonalities in aftercare monitoring by alternative programs were shared. These included mandates to: (a) only work the day shift; (b) work no more than 40 hours per week; (c) no narcotic administration early in the work re-entry process; (d) comply with random urinalysis screening for a stipulated length of time; and (e) verify attendance to meetings with supervisors, therapists, and/or recovery/therapy-based groups.

Differences in the various state alternative programs were also evident. These differences as discussed by the participants were: (a) the mandated length of time of monitoring (two to five years was typical); and (b) mandated protocols the nurse was asked to follow for recovery support. For example, two study participants were monitored by alternative programs in states that require attendance at peer support groups specifically aimed at nurses with SUDs; other state alternative programs require validating attendance at 12-step recovery or other therapy groups but don't mandate the groups be focused specifically for nurses or healthcare professionals.

124

Once a nurse returns to work, rules about workplace monitoring varied by state alternative programs, as well. Some states have a specific framework for assigning a workplace monitor, which included specific training for those who take on this role. In other states, workplace monitoring was expected from the participant's nurse manager, charge nurse, or person in a supervisory position. Minimal information was shared by participants about training and support for individuals in the worksite monitoring role in the different states represented. Participants shared experiences with worksite monitors that ranged from helpful to burdensome, depending on the site and individuals involved.

Participation in state alternative programs. A large majority of the study participants (86.4%, $n = 19$) participated at one time or another with a state alternative program: fifteen (78.9% of the 19 participants who were monitored) participated in only one state alternative program (although some participated in the same state alternative program more than one time); four (21.1% of the 19 participants who were monitored) were monitored by more than one state. Three (13.6%) participants had no contact or involvement with state alternative program monitoring. Reasons for this varied. In one case, the participant resided in one of the few remaining states that does not have an alternative program and was therefore monitored by the state BON. Two other participants, representing two different states, went through treatment many years ago, before the states had developed and implemented an alternative program; one was monitored by the state BON, the other by her worksite.

Two participants identified they had not been involved with a state alternative program but instead had been monitored by their state BON. Upon investigation of the BON websites in these states, the researcher discovered that these participants had been monitored by an

125

alternative program that was an arm of the BON. This demonstrates the lack of clarity about alternative programs and their relationship to the state BON that was evident even among some of the participants. Participants involved in state alternative programs separate and distinct from the BON, especially those programs that worked collaboratively with several different healthcare regulatory boards, seemed to have the clearest understanding of the distinct policies and the relationship between the alternative program and the state BON.

Findings Based on the Study Research Questions

As has been noted, many participants experienced two distinct processes upon work re-entry depending on whether it was successful or unsuccessful. For purposes of this study, successful work re-entry was defined as a return to work with no reported subsequent relapses that interfered with the participant's ability to provide safe nursing care. Unsuccessful work re-entry is defined as a return to work that is ultimately characterized by a return to drug or alcohol use (relapse) that interferes with the nurse participant being able to safely practice nursing. Job loss, suspension or loss of the nursing license, and return to SUD treatment were the usual outcomes of unsuccessful work re-entry.

The following research questions were investigated in this study:

1. What does a registered nurse (RN) experience in actualizing workplace re-entry after completion of SUD treatment?

2. What helped the RN re-enter the workplace after completion of SUD treatment?

3. What acted as barriers to the RN's re-entry to the workplace after completion of SUD treatment?

126

Table 9. *Facilitators to Workplace Re-entry after SUD Treatment Completion*

External Facilitators to Workplace Re-entry after SUD Treatment	
Pre-SUD Treatment	Experiences intervention by family or work colleagues to encourage admission into SUD treatment
	Seeks and receives assistance for legal consequences
During and Post-SUD Treatment (Pre-Work Re-Entry)	Follows suggestions of treatment staff regarding readiness / parameters for work re-entry
	Engages in multiple levels of treatment and aftercare
	Uses coping strategies learned in treatment
	Experiences and accepts family support
	Receives support from recovery community
	Crosses paths with instrumental person(s) who assists / supports recovery and readiness for work re-entry
	Takes adequate time between treatment completion and work re-entry
Post-Work Re-entry	Chooses part-time work schedule for work re-entry initially
	Works routine, non-varying schedule
	Receives and accepts support from manager/supervisor or work colleagues
	Receives and accepts support from BON and alternative program
	Has "experienced" nurse status
	Maintains connection with treatment, aftercare, and counseling providers and services
	Adjusts work habits to adhere to monitoring and worksite restrictions (e.g., medication administration, overtime restrictions)
	Expands upon coping strategies learned in treatment
	Becomes a workplace resource about SUDs
Internal Facilitators to Workplace Re-entry after SUD Treatment	
Pre-SUD Treatment	Has strong professional nursing identity
	Has strong faith / spiritual life
During and Post-SUD Treatment (Pre-Work Re-Entry)	Accepts self as "addict" and continues to grow in a positive understanding
	Is honest and open regarding SUD status
	Focuses on recovery and healthy self-care
	Complies with all requirements from BON and/or alternative program
	Views BON and/or alternative program monitoring as important to personal and professional accountability
	Effectively manages pre-existing medical conditions
	Pro-active in working to get nursing license back
	Carefully plans work re-entry strategies
	Retains strong personal identity as a nurse
Post-Work Re-Entry	Remains committed to central focus on personal recovery
	Fears relapse and subsequent losses, including job / nursing license
	Is honest with work colleagues regarding SUD status
	Retains strong focus on healthy self-care, including importance of managing pre-existing medical conditions
	Willingly sets healthy boundaries around work issues
	Retains strong professional nursing identity

Table 10. *Barriers to Workplace Re-entry after SUD Treatment Completion*

External Barriers to Workplace Re-entry after SUD Treatment	
Pre-SUD Treatment	Works in high acuity / high stress nursing practice setting
	Discrimination toward individuals with SUDs by healthcare providers experienced in nursing work settings
	Manages pre-existing medical conditions ineffectively
	Personal history of trauma / abuse
	Experiences numerous interpersonal stressors
	Experiences multiple losses related to SUD
	Faces legal consequences related to SUD
	Faces consequences from BON regarding nursing license
Post-SUD Treatment and Pre-Work Re-Entry	Difficulty in finding nursing position after treatment (once license reinstated)
	Slow pace of BON in making decisions regarding status of license
	DHS barrier in passing a background check (for nurses with felony history)
	Financial barriers related to UA monitoring and other work restrictions
	Works non-nursing job(s) at lower pay until cleared to return to nursing position
Post-Work Re-Entry	Experiences discrimination from healthcare team when SUD status becomes known
	Chooses to return to high acuity / high stress nursing practice settings
	Knowledge deficit among nurses about topic of SUDs in nurses
	Pre-existing conditions and stressors continue to impact person negatively
	Mandated to do BON or alternative program monitoring
	Lack of recovery support (from family, supervisors, other nurses)
	Limited time off between treatment completion and work re-entry
	Re-entry nursing job is outside of one's previous work experience or specialty area
	Returns to work in a full-time position
	Limited availability of nursing positions once SUD status is disclosed
	Experiences minimal or no family support
Internal Barriers to Workplace Re-entry after SUD Treatment	
Pre-Treatment	Driven to working excessively (inability to set healthy boundaries or needing to work extra to support drug/alcohol use or due to family financial situation)
	Does not value healthy self-care or view management of pre-existing medical conditions as priority
During and Post-Treatment (Pre-Work Re-Entry)	Struggles with internalization of self as "addict"
	Strong negative emotions: shame, guilt, worry, and fear lead to secrecy about SUD
	Internal drive to push too hard and too fast to return to work
	Refuses to engage in recommended aftercare or recovery strategies
Post-Work Re-Entry	Reluctant to view self as "addict" and disclose SUD status to others
	Values work more highly than staying connected to recovery support
	Poor boundary setting related to working excessively continues
	Continues to experience strong negative emotions (shame, guilt, embarrassment, worry, fear, and anxiety) that lead to continued secrecy about SUD history
	Fails/reluctant to see connection between management of pre-existing medical conditions and recovery from SUDs
	Fears relapse and subsequent job loss
	Resents mandated protocols from BON or alternative program
	Feels isolated due to perceiving self as only nurse with SUD working in workplace

Participants generally offered specific, fully articulated responses to questions two and three, giving clear examples when describing facilitators and barriers to workplace re-entry. See Tables 9 and 10 for facilitators and barriers to work re-entry after SUD treatment. These distinct external and internal dimensions to the facilitators and barriers emerged early in the open and axial coding processes and were the source for development of tables and diagrams. These helped clarify broader, common experiences of participants that were more imbedded in their whole stories and are presented as answers to research question one. Therefore, supporting this natural emergence of the data, discussion of findings for questions two and three will precede findings for question one in the following section.

Findings related to Research Question Two

What helped the RN re-enter the workplace after completion of SUD treatment?

External facilitators. Of the many external facilitators to workplace re-entry identified and discussed by participants, most relate to the importance of support.

Interventions. In the time period prior to entering SUD treatment, participants expressed gratitude to family, friends, and work colleagues for their support in helping them enter SUD treatment. Some families of participants were involved in an intervention: "A structured method of penetrating the delusional system of an impaired individual to help that person recognize his or her problem and the need to seek treatment immediately" (Dunn, 2005, p. 574). One participant described the "family intervention" experience she had that led her to SUD treatment and expressed sincere gratitude to her parents for their involvement and support in helping her get the help she needed. Others described being faced with legal charges related to their SUD use

129

and discussed the important role legal counsel played in helping with their legal problems. A participant made the following comments about the importance of the lawyer she hired:

I've had other health care professionals in recovery that I've turned to for support, and also another big support was the lawyer that I worked with. He worked with me at a reduced cost, given my situation, and has been a huge advocate and kind of helped me stay on top of what I needed [in order] to meet the requirements for the Board of Nursing.

Multiple levels of aftercare. Participants also identified the importance of engaging in aftercare strategies and support to regain a healthy footing free of drugs and alcohol. Use of such strategies helped participants make sound choices in their pursuit of returning to the nursing practice workplace. Staff at treatment centers, the state BON, and the state alternative programs emphasized the importance of support and engaging in aftercare as being significant to recovery and work re-entry success. Many participants heeded this advice and engaged in extensive aftercare services following treatment. A few participants who had been through treatment more than once voiced that putting in place extended treatment and multi-layered aftercare services helped them to ultimately be successful in staying sober and return to work successfully. One participant explained:

It was a long term commitment [to aftercare], and I was 37 years old at the time, and I wanted to get it right; I didn't want to do this again and do this again and do this again. I was really at the end, you know. During my last treatment I found complete surrender. I was to a point of brokenness within my family and my job and my life, where I was really able to make a change. After that year passed, I started diligently working on the things that I needed to do for the board [of nursing].

130

Crossing paths with "turning point" people. Another external facilitator to work re-entry for several participants was the fortuitous meeting or crossing of paths with a person who became important in the participant's early recovery. Described by one participant as a "turning point person," these individuals usually helped facilitate work re-entry by pointing the participant to a job they ultimately obtained and successfully retained. In other cases, these individuals offered recovery support at critical times in early recovery. Most of the "turning point" people discussed by participants had personal experiences with SUDs and were either in recovery themselves or had a loved one in recovery.

12-step program recovery support. After treatment completion and during the post-work re-entry time period, external recovery support was described most frequently in terms of 12-step based recovery support. Many participants viewed this type of support as vital to their work re-entry success. For instance, advice related to 12-step program involvement was noted from many participants when answering the question, "What advice would you give to other nurses who return to work after treatment?" Some of the replies were: "Go to meetings." "Give back; do service." "Stay in touch with somebody else, with other recovery peers and talk about how it's going, very often." "Be open to accepting support from others." "(Find) support in other people who are in recovery; other nurses and people who are in (a similar) kind of field, where there's support and an understanding." "Relax…take it a day at a time and get a sponsor, for sure." "Spend a lot of time with another woman, and especially a nurse in recovery, learning the difference between guilt and shame. Guilt is a real feeling…feeling sorry for what we did. But shame is feeling bad about who we are, and we shouldn't feel bad about who we are."

Setting healthy boundaries. Healthy boundary setting, especially with work issues, was identified by some participants as an important aspect of recovery and work re-entry success. For several this external facilitator was actualized in finding the means to take adequate time off between treatment completion and work re-entry. One participant who had experienced both unsuccessful and successful work re-entry stated, "Take the time to get into *good recovery*." For others, healthy work boundaries entailed returning to work part-time during the early work re-entry period so as to keep the primary focus on one's recovery. As one participant advised:

> Number one is put recovery first. That is absolutely the prime objective of the thing, because the minute that it's not, you're going to lose the job, you're going to lose whatever you managed to hold onto, and it's just going to be gone. That is the absolute first thing. In putting recovery first, that speaks to the type of job you get, the type of schedule you take, the people that you're going to be working with, the environment that you're going to be working in. All of those things play into putting recovery first. It's not just about getting your license back and making some money again.

Re-evaluation of the career trajectory. The above quote illustrates the multiple dimensions and decisions faced by RNs in going back to work. For many, SUD treatment completion and keeping a major focus on recovery meant re-evaluation of their nursing career trajectory. Some made the conscious decision not to return to nursing positions in high-stress, fast-paced, acute care hospital settings. Others wished to return to such acute care settings but could not procure such positions for various reasons, the primary one being past disciplinary action on their RN license. In hindsight, some participants acknowledged that finding a nursing

132

position in a less stressful, non-acute care setting was vital to success in work return in early recovery. A participant stated:

> My job was held for me for a year at the hospital, but it was recommended to me by my
>
> counselors that I not return to that [intensive care] environment, at that time anyway, and
>
> I knew that I couldn't function well enough to do that work. That's when I took a
>
> [nursing] job with an insurance company, a large corporate desk job on the telephone.
>
> What that allowed me to do was, number one, I felt that I could be open with most people
>
> because I wasn't in direct patient care, and my life revolved around everything recovery.

Positive encounters with state BONs. Positive encounters with state BONs was an external facilitator that impacted self-worth in an affirming way for some. Generally, nurses with lengthy sobriety/abstinence were able to reflect on the positive features and the personal learning that was gained as a result of contact with the BON. Several participants discussed being treated "professionally" by BON staff. One stated, "I must say that the nursing board treated me most graciously." Others were keenly aware that the BON was doing their job in keeping the public safe through their disciplinary decisions related to drug/alcohol use in nurses. One participant who faced the BON several times while pursuing reinstatement of her license stated: "…they (BON) were very happy with the extent of treatment (and aftercare) that I did. So, I don't have anything against the BON or am angry with them...just that it's a tough process. That it's all a part of recovery."

Internal facilitators. As with the external facilitators, participants identified numerous internal facilitators to workplace re-entry.

Nursing pride and spiritual strength. Internal workplace re-entry facilitators prior to

SUD treatment were not verbalized explicitly by participants but can be understood within the

broader analysis of interview data. Many participants clearly articulated the pride they have in

the quality of the nursing work they do. A strong spiritual life also helped drive and sustain many

during treatment and the search for nursing employment after treatment.

Professional nursing identity. Deep pride in one's nursing abilities and having a passion

for the profession sustained participants during periods of license suspension and during the

search for nursing employment after treatment. One participant stated: "My career as a nurse is

one of those things that gives me purpose and value." Others stated: "Nursing was more than just

what I did. It really was a big part of my identity…it was also a source of great pride for me." "I

love what I do…I never thought I wasn't going to go back to it. I guess it really is a part of my

identity." "(Nursing) is the only thing I ever wanted to do and I really love it…" One participant

put it in a broader family context:

> In my family, I'm the only one that's graduated from college. It's the only thing I really
>
> wanted to do…It was like, I am not going to lose my license; plus, it enables me to be a
>
> single mom, to take care of my daughter and live comfortably. I love what I do,
>
> absolutely love it. I can't imagine doing anything else.

Acceptance of "self as addict." Participants reflected on internal processes within

themselves related to acceptance of viewing the "self as addict" and the willingness to put in

place a strong recovery system. Participants who had experienced an unsuccessful work re-entry

experience prior to a subsequent successful one were especially articulate in identifying the shift

that occurred in internalizing the disease concept of SUDs. When describing the difference

134

between the second (successful) work re-entry experience after relapse and a previous unsuccessful work re-entry experience, one participant stated:

> By the second time I was much more secure in my own chemical dependency issues and really had the firm understanding that I am chemically dependent. I wasn't just struggling with that diagnosis; I got it. That made it much easier for me to be able to share that piece of myself with somebody else, if that makes sense.

Acceptance of disease concept of SUD. Other participants became more accepting of "self as addict" within the context of family-of-origin issues and growing up in an alcoholic home. A participant with numerous alcoholic family members voiced an increase in understanding and acceptance about the disease concept of addictions with this statement:

> I spoke at [a treatment facility] to the nurses group, and I said you have to treat it just like diabetes, that this is the hand that I've been dealt. So I have to monitor. I have to check my sugars, and this glass of wine might not kill me today, just like this cupcake is not going to kill me today with my diabetes, but it's going to kill me somewhere down the road and it will kill me.

For some, shame and fear proved to be powerful motivators to better one's self. A researcher who studies shame in addiction notes: "Overcoming shame is part of overcoming addiction. Shame is also normally a crucial factor motivating the addict's attempt to reclaim, reconstruct, and improve himself. It motivates the addict to want to get a grip" (Flanagan, 2013, p. 8). According to participants, information learned in treatment definitely helped address stigma, shame and fear. In fact, two study participants verbalized a nearly identical statement, learned during treatment and diligently pursued in recovery: "We're not our disease. We're not

135

bad people trying to be good. We're sick people trying to get better." The internalization of this message appeared to lessen stigma, shame and fear and make workplace re-entry less difficult for some. Stigma, shame, and fear will be discussed more in depth in the section about findings related to research question three.

Valuing healthy self-care strategies. Coming to value the importance of healthy self-care actions was cited as an internal facilitator that promoted success in work re-entry for many participants. This included diligent monitoring and management of co-existing medical and/or psychiatric conditions. Some of these strategies were learned in treatment to manage the chronic nature of SUDs and also proved to be helpful in managing co-occurring medical conditions. Strategies cited included endorsement and willingness to utilize 12-step or other support groups, meditation, prayer, yoga, individual counseling or therapy, connections with supportive family and friends, exercise, getting adequate nutrition and sleep, and avoiding highly stressful work environments. Discussing self-care strategies for her recovery from alcohol dependence and for managing a diagnosed anxiety disorder, a participant stated:

> I feel like I have found a happy medium of meetings and yoga and meditation and work. Before I used to work a lot of hours, and now I know I can't do that, so I have learned to listen to my body. I've learned to listen to my psyche; I've learned to pay attention to signs and signals that I'm getting overwhelmed. So I know this is when I'm most vulnerable to relapse so I can't do that. I need to take a day off and see if someone will work for me.

Honesty with others. Willingness to be honest was an internal facilitator to work re-entry identified by many as being closely tied to their individual programs of recovery. Eleven (50%)

of the participants at some point in the interview discussed the value of being honest with family/friends, the BON, the alternative program, and work colleagues. A participant who had faced challenges in her dealings with both the BON and the alternative program reflected on the lessons she had learned from these challenges:

> Honesty is probably the best, even when it's scary and you're fearful of the outcome. I pray a lot and I'm very honest and I think (about) when I was using. It's not that I did anything illegal or anything bad, it's just that I don't think I was very honest with myself, and I probably wasn't as honest with other people.

Enhanced accountability because of monitoring mandates. Individual involvement with state BONs and state alternative programs required an internalization of the positive role played by BON and alternative program monitoring in participants' recoveries. Nearly one-third of the participants ($n = 7$) reflected and shared the belief that the required monitoring after SUD treatment completion enhanced personal accountability, helped their recovery programs, and assisted with relapse prevention. One participant verbalized:

> [The alternative program] was very helpful [as it] really gave me accountability for long enough that I was able to integrate my life with A.A. and live differently, so that by the time I was off monitoring, it didn't matter that I was on it.

A participant still being monitored at the time of her interview stated, "I'm kind of thankful for [alternative program]; it kind of keeps me in check for now, and accountable. So I feel like that's a really good support." Another participant, also in monitoring at the time of her interview, discussed the realization that the alternative program worked not just to help nurses but ultimately "…to help the patients that we're taking care of. So once that got straightened out in

my head, things have been a little bit on a different level [with my case manager at the alternative program]."

In summary, external factors that helped participants return to work after SUD treatment focused primarily on support. Extensive and varied aftercare and 12-step program engagement, support from family/friends/work, and professional encounters with the state BON and alternative program were deemed important to work re-entry success. Internal factors to facilitate successful work re-entry focused on acceptance of self as addict, strong nursing identity, honesty, and accountability that helped sustain participants during treatment, aftercare and monitoring, including the search for and return to the nursing practice workplace.

Findings related to Research Question Three

What acted as barriers to the RN's re-entry to the workplace after completion of SUD treatment?

External barriers. There were numerous external barriers identified by study participants that influenced work re-entry experiences and outcomes.

Lack of education about SUDs. Data collected from study participants are congruent with the literature on SUDs in nursing which states there is poor understanding and a lack of education about SUDs among healthcare professionals, including nurses (Cook, 2013; Godfrey et al., 2010). Several participants noted that poor understanding and lack of education about SUDs is coupled with negative attitudes and discriminatory behaviors by nurses toward *patients* with SUD. These participants included themselves as part of the group of nurses holding negative attitudes about SUDs before having to face their own issues with SUD. A participant shared these observations about her unit milieu prior to her personal struggles with SUD:

138

The atmosphere with the people that I worked with, the coworkers that I worked with...

there was not very much support for people with chemical dependency issues, patients

that came in with chemical dependency issues. The lack of support that was there, the

comments that staff members would make, you just get that internal feeling when you

know *you* [emphasis added] won't be supported. I wasn't willing to risk opening up.

Another participant discussed similar negative attitudes among the nursing staff where she works

in a setting that serves inner city, underserved patients: "We serve many drug addicts and have

'drug-seekers' left and right and there is so little tolerance [among staff] for it." These

perceptions and work experiences were cited by participants as reasons for fear and/or reluctance

to self-disclose their SUD diagnosis and seek treatment for it.

Lack of education and/or knowledge about SUDs among human resources staff, nurse

managers, and worksite monitors was also noted by participants to be an external barrier to

workplace re-entry. A participant now working in the specialty area of SUD nursing stated:

My hope is to see more understanding about addiction by HR people, nursing supervisors

and that sort of thing so that they can better relate to…staff members who have a lot of

mistrust. They [staff] have been violated [by the nurse with SUD] and supervisors could

diffuse that a bit.

Discrimination in work settings. Overt discrimination from work colleagues when the

SUD of the participant became known was not experienced by many participants and appears

partially dependent on whether the nurse was willing or comfortable to disclose her SUD status

at work. Some participants shared the belief that being open with work colleagues about their

SUD status increased the likelihood of work re-entry success. When the nurse kept her SUD

status secret because of fear and stigma, unsuccessful work re-entry was the outcome for some.

A participant, now sober for many years, shared that she returned to a work environment several years ago where everyone in her hospital knew her SUD history. She described a work re-entry atmosphere of "indirect hostility" from nursing staff colleagues:

> There were definitely people that didn't want me to succeed because they felt that what I did was a moral downfall; that if I had any ethics, how can a nurse do what I did? There were plenty of people that really didn't understand the disease aspect of it.

The above quote supports the premise that lack of education, understanding, and knowledge about SUDs may lead to discriminatory behavior. This topic was discussed in Chapter Two as being well established in the literature; it was also endorsed by some participants in this study.

Financial stressors. Another external barrier discussed frequently by study participants related to the many financial stressors experienced because of SUDs. The loss of jobs and health insurance, coupled with the costs incurred by treatment, urine toxicology testing, legal costs, and other family expenses, are cited as challenges to nurses with SUDs in the literature (Brown et al., 2003; NCSBN, 2011, Thomas & Siela, 2011). Table 11 depicts the behavioral and financial implications/issues for nurses with SUD based on participant report.

Several participants were major wage earners for their families and found that financial stressors presented serious hardships and led to significant debt. A participant shared the following information about the amount of money she spent for treatment, monitoring, and urine testing:

> [My debt is] now over $200K, because the fees that have to be paid, there was an initial processing fee when they suspended my license of $1,200. Then going through treatment,

and the six weeks [at aftercare] was not paid for by insurance. So I ended up washing out

one of my 401Ks and then coming back and trying to find a job, and was making less

than half of what I was making as a nurse from the previous year.

Table 11. *Behavioral and Financial Implications/Issues Reported by Nurses with SUD*

Behavioral Consequences/Issues Reported	Financial Implications
Loss of job	-No insurance to cover SUD treatment, aftercare, monitoring -Expense of urine toxicology screens -Driven to return to work too soon because of financial need
Needs legal services	-Legal fees related to theft charges (re: opiate diversion) -Impact of DUI (DWI)/jail/attorney fees
Suspension of nursing license	-Loss of nursing income -Pressured to find non-nursing job (at lower income) -Increased processing fees for license reinstatement ($1,500 or more)
Lengthy investigations by BON	-Limited financial resources during investigation - Debt incurred for basic needs
Difficulty gaining a nursing position after license reinstatement	-Unable to meet family financial needs -Forced to cash in 401 K's or other retirement savings
Mandated BON work restrictions	-Day shift only with no shift differential income -Overtime prohibited: Mandated 40 hour per week maximum

Lengthy wait-time for BON decisions. Participants often waited many months for the

BON to complete investigations, decide on disciplinary actions, and reach decisions about

nursing license status. For many participants, these months of waiting necessitated finding other

jobs to sustain a livelihood until the BON made a decision. The types of jobs shared by

participants varied widely and included pet-sitting, cleaning houses, working as a nanny, nursing

141

assistant work, mental health worker, farm worker, receptionist, and restaurant worker. Some disclosed they sold their own plasma. Additionally, those participants who chose to hire an attorney shared that this was an added costly expense.

Difficulty finding nursing employment. Another external barrier to work re-entry for many participants was difficulty in finding a nursing position after SUD treatment once the nursing license was re-instated. This challenge was especially prevalent for nurses seeking positions in large healthcare systems in metropolitan areas. Some participants reported that computerized systems in human resource departments automatically eliminate applications from nurses who have had disciplinary actions from the BON and/or a past license suspension:

> Every time I called someone -- they do interviews on the phone -- and they would ask me questions like…have you ever been disciplined? Or, are you under board [of nursing] order for any reason, or something like that? I would have to say yes, and the interview would pretty much end. That would be the end of it. If that was [named] Healthcare system, then I'm blacklisted for the entire [named] Healthcare system.

Some participants shared that small agencies are more open to hiring nurses with a SUD treatment history, especially if the agency provides mental health or SUD services. However, some of those agencies who were willing to hire participants were too small to accommodate the worksite monitoring requirements and other restrictions regarding medication administration needed by nurses being monitored after SUD treatment. Several participants have successfully returned to work but could only find work in the field of mental health or SUDs, despite work experiences in highly specialized acute care areas of nursing. A participant who self-identified as a critical care nurse and now works for a mental health/SUD agency in the community stated:

142

If I were going back into [a critical care specialty area], I would feel a little bit better about that; I have some experience there. I didn't have any experience, except my own personal experience, with chemical dependency. I had no experience with mental health, and I think it's a challenging enough field anyway. That's been tough.

Returning to work before sound recovery was in place. Another external barrier in the work return experience cited by several participants was returning to work before having a solid recovery foundation in place. For some participants of this study, financial need factored into returning to work almost immediately following completion of SUD treatment if their previous job was still available or if the person could find a new position. For many of these participants, returning to work "too soon" led to relapse and an unsuccessful work re-entry experience. One participant discussed her defiance of advice given by staff at the inpatient treatment facility instructing her to take a minimum of one month off between treatment completion and work return. She stated:

I wanted to go back to work. I just wanted to get back my normal life. [The treatment staff] were not into that. I have had three relapses, so I wonder did that have something to do with it because I went back to work so soon? [Nurses I went to treatment with] that have been most successful didn't go back [so soon] and they went to [A.A.] meetings religiously. I did not.

Another participant who attributed her unsuccessful work re-entry experience to returning to work too soon offered her experience and this advice: "I had never really surrendered the idea of my career defining me. Take time, take the appropriate time to get into good recovery before re-entering the workplace." Another participant offered this advice: "…slow down and take as

much time as possible…to get to a point *before* re-entry of not identifying ourselves with our job and to get okay with us."

Drug(s) of choice. A demographic factor acting as an external barrier that contributed to work re-entry experiences for study participants was drug(s) of choice. Participants who identified alcohol as drug of choice had less contact with state BONs because alcohol is a legal substance and because nurses less frequently come to work impaired by alcohol (versus diverting and using opioids in the workplace). The exceptions to this were those participants who had "driving while intoxicated" (DWI) charges with subsequent legal consequences and corresponding financial stressors related to the charges. Some states with alternative to discipline programs allow nurses with SUDs to by-pass reporting to the BON if the nurse follows alternative program protocols and monitoring. This was the case for three participants in the study who all identified alcohol as drug of choice.

Based on participant report, opioid diversion from the worksite was viewed punitively by state BONs; often the employer filed charges of theft that led to serious legal consequences for participants who were also quickly terminated from employment. Additionally, laws and statutes in some states have become stricter with more punitive consequences for opioid diverters in recent years. This is the case in the state where the researcher resides due to the negative media attention directed at the BON in the fall of 2013. As has been discussed, state laws, BON regulations, and alternative program protocols vary significantly by state, making consensus about this issue difficult to ascertain. However, it appears that BONs and employers of nurses seem to be moving toward increasingly stricter stances toward those who participate in drug diversion from the workplace.

144

Co-morbid medical conditions or history of trauma/abuse. Nineteen (86.4%)

participants self-identified as having a pre-existing or co-existing physical or psychiatric disorder

or history of trauma and/or abuse. Several participants discussed poor management of these co-

occurring conditions as a barrier to successful work re-entry and as a factor in subsequent

relapses. SUDs, as chronic conditions, require rigorous self-management and implementation of

healthy self-care strategies. When a participant is dually diagnosed with SUD and another illness

or chronic condition, self-care management often becomes more challenging. Participants with

unsuccessful work re-entry experiences before being successful discussed struggling to manage

their co-occurring illnesses prior to treatment. One participant shared:

> I do have an anxiety disorder that was diagnosed in my late teens, and all my life [I] have
>
> been on and off medications. I believe [my anxiety] contributed to the addiction [along
>
> with] genetics and overall bad coping skills. In the medical community, if you had
>
> anxiety, let's just use pills [instead of] actually teaching you a useful way to handle it.

Internal barriers. The inter-related concepts of stigma, shame, and/or fear were

discussed frequently by participants as internal barriers to work re-entry. There is abundant

literature about stigma and shame and the impact these concepts have on individuals with SUDs.

Fear was discussed most commonly by participants in this study as a strong desire to keep their

SUD a secret from work colleagues.

Stigma. As was discussed in Chapter One, nurses often face stigma that is multi-faceted

in its negative impact. Godfrey et al. (2010) notes, "A nurse with a SUD is seen as a major

contradiction to professional standards. This dissonance creates stigma that will interfere with

the nurse's asking for or receiving proper treatment and engagement in the recovery process" (p.

1). Many participants discussed the public stigma pervasive in the profession; some also discussed self-stigma and the recovery work they have done to overcome it. Additionally, there seems to be further stigma present in the profession that is manifested in the belief that nurses with SUDs cannot return to work. One participant identified the following as the most important thing she thought she had shared in the interview: "That long term recovery is possible and that nurses are able to go back into work settings. I think there is a big stigma that we are not [able to return to work] but we are."

Shame. Shame emerged as a related concept and led the researcher back to the literature. It has been widely studied and discussed over the past several decades in conjunction with the topic of SUDs. Flanagan (2013) makes the following statements about how shame is manifested in individuals with SUD:

> I am ashamed of who I am, not simply for what I did. And it builds. An addict is someone, who like everyone else, has educational, career, and inter-personal aspirations, and he reliably fails to achieve them [because of] feelings of shame for who one is, who one has become in one's own eyes. (p. 7)

The above quote is consistent with information shared by participants in this study. Some shared the hard work done in treatment in addressing shame, especially related to the feeling that they had violated their own moral code and, for some, nursing's professional code of ethics. One participant shared this perspective about the shame she experienced:

> There's a lot of shame associated, I think, with being in a position where we're supposed to care for people and protect them and then end up in a position where we're stealing from them, where we're high when we're supposed to be helping them, so I think

accepting a part of that – that it's a part of my story that I can't change, and being okay

with it. I feel like there's a lot of responsibility that goes along with being an RN that I

took for granted. I think, in my active addiction – and part of it is the fact that I was sick

and needed help, but I think you always have this sense of guilt and shame, that [one

questions] "how could I have done something like that?"

A participant who was looking for a job at the time of the interview commented about the

shame experienced about her past actions and how her perspective differs now that she is living

in recovery:

This is what I think about going back for a job – is that you can overcome the shame for

yourself. I'm lucky I didn't kill someone; I'm very grateful for that, and I'm not in

prison. I'm sorry that this happened, but it did, and so now, as I say to people, it's my

responsibility to do something about it, which I am.

Another participant voiced the belief that it is crucial for nurses with SUD to address shame

issues prior to going back to work:

Then a huge thing for me before I went back (to work) was, I had to work through my

shame, because that was what I had the most shame about, I think, was my work, and

showing up like that for so many years. I needed to work through that before I went back

to work.

Fear. For some participants, fear was integrally tied to stigma and shame and caused

delays in getting timely help for their SUD. Evidence in the literature supports the idea that a

nurse with SUD experiences fear of being overtly stigmatized by colleagues and labeled an

addict, which delays them from seeking SUD treatment (Lillibridge et al., 2002). Fear of losing

147

one's license, job, and livelihood were other concerns voiced by several participants. One participant stated, "The fear of losing the one thing that got me out of my dysfunctional home was that nursing degree, because then I had money, I had independence." Another participant stated, "I always had a huge fear of seeking help, because I didn't want to lose my license…I used [substances] in isolation because of the fear that someone would report me to the board [of nursing]."

Another fear voiced by several participants who had experienced unsuccessful work re-entry was the fear that others in the workplace would find out about the person's SUD diagnosis and treatment; that their confidentiality would be violated. A participant stated: "Before and after, my biggest fear was people would find out at work…It was very important to me that people didn't know at that particular time [following SUD treatment] because I didn't want them to see me as incompetent." Later in the interview this same participant shared that in a later successful work re-entry experience she realized that her fears were unfounded: "I've been treated exactly the same (before and after treatment)." For this participant, her fears were primarily internally driven.

Discussion of shame or stigma was universal among all study participants. How to overcome them varied a great deal and was somewhat dependent on a participant's length of sobriety. Given that recovery is an ever-changing process, it is not surprising there would be various views and actions taken to overcome the stigma and shame that nurses with SUDs experience. Those with significant abstinence and several years of living in recovery voiced fewer fears and tended to be open and honest about their SUD with some, if not all, work colleagues.

In summary, there were many external barriers to work re-entry: lack of knowledge and education about SUDs from colleagues, financial stressors, the length of time it takes BONs to make decisions about license status, difficulty finding work after SUD treatment completion, returning to work too soon, poor management of co-occurring medical issues, and only being able to find work outside of one's specialty area in nursing. Internal barriers centered on the participants' experience and perception of stigma, shame, and fears while struggling with self-redefinition and acceptance of self as a person with SUD.

Findings related to Research Question One

What does a registered nurse (RN) experience in actualizing workplace re-entry after completion of SUD treatment?

As previously indicated, findings to this research question were not in the form of clear cut statements from participants. Findings evolved as participants discussed facilitators and barriers in research questions two and three and as these data were coded and analyzed. Recovery strategies and experiences were prominent topics in all participant stories.

Re-defining identity. Willingness to use recovery strategies supported the participants' acceptance of their SUD diagnosis and the integration of a new view of themselves as an addict, albeit living in recovery. Reconciliation of this new identity with one's professional nursing identity was challenging, but necessary. Tools to effectively address personal shame and guilt were learned in treatment and became part of the on-going recovery process for many participants who re-entered work successfully. Furthermore, through the interviews it became apparent that successful re-entry was not highly affected by external barriers but rather by the degree of internal processing by the nurse of determining "who I am" before re-entry to work.

149

This internal processing was influenced by an attitude of perseverance and engagement in ongoing recovery strategies aimed at healthy self-care.

Perseverance. Strong personal and professional nursing identity supported perseverance, which was a common theme and necessary for work re-entry success. Several participants used the term "jumping through hoops" during discussion of monitoring protocols required by the BON and state alternative programs. One participant stressed the importance of patience and perseverance:

> …I don't want to sound cliché and say like "you should never give up," but…just take it one piece at a time, and be very patient. Go work in a coffee shop. And jump through the hoops…and be patient, because if you get overwhelmed by the whole, like "Oh my God, I'll never get all the pieces of my life back together," you'll drink [or use] again.

Compliance and success with monitoring mandates supported participants in work re-entry processes by fostering positive self-esteem. Perseverance in following monitoring mandates to successful completion demonstrated to the BON and to participants themselves their readiness for work re-entry; that effective recovery strategies were in place to support a successful return to work.

Perseverance in the process of re-defining self and professional roles reaped rewards and positive changes for many participants as improved health, healed personal relationships, and successful return to work were realized. Some participants who shared their SUD diagnosis and treatment experience with work colleagues eventually gained respect at work and became a valued work resource about SUDs and SUD treatment. A participant with long-term sobriety shared her experience:

150

…at my work now everyone knows I'm an alcoholic. I find telling people that I'm in

long-term recovery sets a boundary that's important. I'm not the one you ask out for

drinks, okay? But, call me if you're going bowling. It's also made me a resource because

everyone knows—my manager knows what I do (in recovery) and will ask about

resources for patients.

Another participant talked about the impact recovery has had on her practice of nursing:

I don't think people understand how much better you're going to be as a nurse with that

sense of calm, that sense of acceptance. I don't know, I found myself being a lot more

diplomatic…and I was called into resolutions, personnel resolutions. It just comes with

recovery.

Honesty with self. Honesty with self was vital in breaking through the defense

mechanism of denial for participants and in enhancing internalization and acceptance of SUD as

a disease. Once back in the work environment, honest and open behaviors helped participants

overcome the shame and self-stigma about SUDs and supported work re-entry success. Several

participants were eventually able to disclose their status as a recovering person with SUD to

colleagues in the workplace. A participant said this about being honest and open at work:

…if you can present an aura of honesty, that is the most important thing. If you're trying

to minimize your use or hide that you're in recovery, then it's not going to work.

Employers aren't dumb; they know. They can sense insincerity in a heartbeat.

A participant with an opioid dependence and a history of diversion in the workplace prior to

treatment said this about fears of returning to drug use and keeping secrets now that she has

returned to work:

I never keep those [fears and secrets] in my head. I'll always talk about them. Even though they're small, even though they may not be that big of a deal, you know. I looked at a vial of Fentanyl, yeah okay, that doesn't really mean much. But in my head, if I let that simmer in my head, it can become something bigger. So I'm really open about fears, you know, the fear that I might have cravings. I'm always open about it. I never keep anything secret. Not anymore. They say secrets keep you sick.

Thus, honesty and openness *with* self involves practicing principles learned in recovery and being willing to talk about fears and secrets. Honesty and openness *about* self with work colleagues extended these behaviors to the workplace and became an important part of successful re-entry for many participants.

Hope. To be successful at work re-entry, hope was a significant internal element that had to grow within participants and be supported, usually by way of active recovery. It involved a reversal of negative to positive appraisal of personal and professional identity and included hope as a key feature of this change. A participant who has been back at work for several years after a lengthy struggle to get her license reinstated said: "There is life after a felony." Others stated: "I want to pass on to other people that you can get your life back; it can be done even though it's not going to be easy." "I'm evidence you can come out the other side. It doesn't mean it's going to be easy, but there's hope." "I want people to know that there is hope; that you're going to be able to be okay." A participant who has many years of abstinence in recovery and who now actively supports and sponsors other nurses in recovery provided this statement of hope:

152

I want people to know that there's help out there, that there's a better life out there, and

that if you follow some simple rules and work with a 12-step program, that your life can

be wonderful. You don't have to kiss your nursing career good bye.

Professional identity. The recognition that one's SUD could destroy individual

professional nursing careers was painfully real for many. So, too, was extreme gratitude. One

participant, a nurse in a management position, stated:

[Nursing] is in my blood. I've been in health care since I graduated from high school and

I just don't know what else I would do. I really enjoy it. It makes me get out of bed in the

morning. I feel good about what I do and when I leave at the end of the day I feel like I've

made a difference. It may have been just one person's life, whether that's my employee or

a patient. [Loss of my nursing job] would have been devastating. I don't know what I

would have done. So I'm very, very grateful.

From another participant: "I am still an effective nurse. Even with me being an addict, without

my job or without me being able to work, then I just become another statistic." Another

participant refers to nursing as her calling:

It's a spiritual thing with me. That is who I am, and I believe our profession is a calling

just like ministry is a calling. I believe who we are is a calling. It's just what we do, and

that's why I can't turn my back on who I am.

Balancing personal and professional identities. The above statements about strong

professional identity are tempered with internalization that personal identity now includes

recognition of one's self as a person with SUD. For some, finding a balance between the

identification of self as an addict with the professional nursing "self" was challenging:

153

So, we spend all of our time in recovery talking about [that] I'm an addict...and we identify ourselves with that all the time; we're saturated with it, but we can't walk back into our professional [nursing] role with that on our shoulder. We are there as a nurse to do our job as a professional, and we're not identified by our disease in our place of business. And that is a really, really difficult transition emotionally; it was for me. And I think the part of getting okay with who I am, and also not showing up as the addict to my job, was terribly important, and it was really, really hard to do, for me.

A slightly different view from another participant also speaks to the struggle of finding balance with the different aspects of identity, cautioning against identifying too strongly with professional nursing identity:

I had so much of my life where I had those [professional, advanced practice] initials behind my name…and unconsciously you tie that to yourself, and that's what makes people like me or respect me or whatever… nursing was really the only thing I knew that I was doing [that] was truly good, and I needed to get back to it because that was one of the only affirming things I had because I did it well. But, I attached way too much importance on that being the evidence I was a good person… [Don't] have your career define you.

The struggle to find a balance between identity as a nurse and the emerging/changing self-identity as a person with SUD in recovery was evident in many participants. The key feature in finding balance in the self-redefinition appeared to be a willingness to change behaviors (i.e., initiate and practice recovery) while maintaining a commitment and view of self that declares, as one participant noted, "I know I'm a good nurse." Or, as another participant succinctly described

154

the changes she has experienced since treatment completion and recovery: "The most important thing is I'm not the same person that got on that plane to [SUD] treatment."

In summary, a central theme regarding the actualization of work re-entry was not focused on responses from others in the environment but rather on internal processes within each participant. Findings from the first research question centered on integration of strong professional nursing identity with the emerging identity of self as a person with SUD. Additionally, perseverance, behaviors focused on honesty and openness, and having hope were also cited as prominent in the actualization of re-entry for participants who returned to work successfully. Also discussed were the challenges of finding balance between self and professional identity in the face of self-stigma and shame. These challenges are amplified by healthcare employment cultures that view nurses as "disposable." A participant with lengthy recovery voiced the following opinion in answering the question, "Of all the things that we've talked about today, what do you think is the most important thing for me [the researcher] to understand?"

> That the overwhelming majority of nurses do recover, and nurses aren't disposable. I think our profession needs to understand that and do everything they can to intervene with someone who's got a problem as soon as possible, and do it compassionately, lovingly, without the punishment, and without the shame.

Axial Coding Models

Conversation with experts, demographic findings, and analysis of data from the three research questions led to development of axial coding models that followed the Strauss and Corbin (1990, 1998) approach. Because constant comparative analysis is a continual back-and-

155

forth process, open coding continued as axial coding commenced. Multiple changes were made to the different components of the axial coding models as both successful and unsuccessful work re-entry were explored.

Axial Coding

Axial coding involved a process of "reassembling data" by categorizing and analyzing relationships and linkages of "fractured" data from the open coding process (Strauss & Corbin, 1998). It is a key feature of grounded theory research using the Strauss and Corbin (1990, 1998) approach and helped relate concepts to each other. The axial coding framework is composed of context, causal conditions (antecedents), phenomenon, intervening conditions, strategies/actions, and consequences. The concepts are frequently presented in diagrammatic form for clear visualization of axial coding models and their various components. The following section defines and describes the different components of the axial coding models, which are depicted diagrammatically in Figures 6 and 7.

Context. Context is defined in the early work of Strauss and Corbin (1990) as "…the location of events or incidents pertaining to a phenomenon along a dimensional range. Context represents the particular set of conditions within which the action/interactional strategies are taken" (Strauss & Corbin, 1990, p. 96). Contextual description of the research environment was discussed in Chapter Three related to the media coverage in the state where the researcher resides and the potential exposure of a large number of study participants to this contextual influence. Other factors, pertinent to *all* participants, are located in the axial coding models in Figures 6 and 7 in the box labeled "Context." The factors that comprise context are the same for both the successful and unsuccessful work re-entry axial coding models. It is the only component

156

that is the same across the two models. The components of context pertaining to healthcare work environments were perceived by participants as generally quite negative. Yet other aspects were supportive of what participants needed to provide structure for work re-entry to be actualized.

Antecedents. Antecedents, also known as causal conditions, lead to the occurrence of the phenomenon (Strauss & Corbin, 1990) and are conditions that may influence the phenomenon in some way (Corbin & Strauss, 2008). Antecedents in the axial coding model for successful work re-entry focused primarily on participants using suggested recovery and self-care management strategies and being compliant with mandated monitoring protocols. Antecedents in the axial coding model that depicts unsuccessful work re-entry found participants averse to changing work situations, resistant to suggestions about use of recovery strategies, and reluctant to comply with mandated worksite monitoring. Another possible variable could have been less commitment to nursing but this was not measured since all participants successfully returned to work at some point.

Phenomenon. The antecedents in both axial coding models influenced the development of the core phenomena: "self-redefinition" in the model depicting successful work re-entry and "lacking self-redefinition" in the model depicting unsuccessful work re-entry. The phenomenon in each model is "…the central idea, event, happening, incident about which a set of actions or interactions are directed at managing, handling, or to which the set of actions is related" (Strauss & Corbin, 1990, p. 96). In the axial coding models for this study, the phenomena relate to the participants' actions or inactions related to a change in self-identity within the context of SUD diagnosis, treatment, recovery, and work re-entry.

Strategies. Strategies are purposeful, goal-directed actions/interactions or processes that

157

Figure 6. Axial Coding Model: Successful Work Re-entry (Matthias-Anderson, 2015)

Context
- Diagnosed with substance use disorder (SUD)
- Completed SUD treatment (sometimes more than once)
- Learns about recovery strategies
- Works in a variety of nursing practice settings
- Healthcare worksite culture views nurses as "disposable," disempowering the nurse with SUD
- Board of Nursing retains legal and regulatory power
- Legal and/or financial limitations and consequences
- Healthcare providers uneducated and discriminatory about SUDs
- Healthcare environment is experienced as stigmatizing

Antecedents
- Uses recovery strategies learned in treatment
- Develops healthy relational processes and support
- Complies with BON and worksite mandates
- Adheres to an aftercare treatment plan
- Crosses paths with "turning point person(s)"
- Manages medical pre-conditions well
- Retains strong identity / connection to nursing role
- Takes adequate time to solidify recovery

Core Variable: Self-Redefinition ("I'm not the same person")

Strategies
- Acknowledges 'self as addict,' characterized by being open and honest
- Alters personal perceptions
- Integrates new coping behaviors by keeping primary focus on one's behaviors in recovery
- Maintains support system within recovery
- Re-evaluates career trajectory and re-tools for possible job change within nursing
- Gives back to others which supports normalization

Consequence/Outcomes
- Examines consequences and learns from "slips" or relapses
- Regains recovery status quickly after "slips"
- Becomes a work resource (re: SUDs)
- Maintains boundaries and accountability as mandated by BON, alternative program, or workplace
- Re-enters the work setting successfully

Intervening Conditions
- Often engages in multiple levels of treatment for ample lengths of time
- Able & willing to use a variety of recovery strategies and accept family support
- Openly shares recovery status with select work colleagues
- Finds a supportive work environment after treatment
- Faces and learns from legal consequences
- Makes decisions about work that puts recovery first

158

Figure 7. Axial Coding Model: Unsuccessful Work Re-entry (Matthias-Anderson, 2015)

Context
- Diagnosed with Substance Use Disorder (SUD)
- Completed SUD treatment (sometimes more than once)
- Taught about recovery strategies
- Works in a variety of nursing practice settings
- Healthcare worksite culture views nurses as "disposable," disempowering the nurse with SUD
- Board of Nursing retains legal and regulatory power
- Legal and/or financial limitations and consequences
- Healthcare providers uneducated and discriminatory about SUDs
- Healthcare environment is perceived as stigmatizing

Antecedents
- Resists BON and worksite mandates
- Returns to high acuity work setting (upon work re-entry)
- Minimal time between SUD treatment completion and work re-entry
- Has insufficient or ineffective relational processes and support
- Manages pre-existing medical conditions poorly
- Lacks confidence in self (personally and professionally) related to shaken view of self-identity

Phenomenon (Core Variable): Lacking Self-Redefinition ("I want to get back to my normal life")

Strategies
- Keeps SUD status a secret from many (especially at work)
- Fights to retain former view of self
- Gives minimal or no attention to recovery strategies
- Approaches work return to high stress/high acuity practice settings without examination of its effect on self

Consequence/Outcomes
- Relapses or "slips"
- Resists accountability with mandated protocols from BON, alternative program, or workplace
- Receives minimal to no support at work (often because colleagues do not knowing about SUD diagnosis)
- Unsuccessful work re-entry

Intervening Conditions
- Internalizes shame of violating personal and professional moral code
- Does not internalize need for recovery strategies
- Reluctant to share recovery status with work colleagues
- Reluctant to engage with family or environmental/recovery support systems
- Perceives healthcare environment as hostile and/or non-supportive
- Puts the need to work before personal health/maintenance of recovery

159

are evolutionary in nature and address the phenomenon (Strauss & Corbin, 1990). In the successful work re-entry axial coding model, strategies employed that influenced the core phenomenon of "self-redefinition" focused on the concept of recovery but also included a re-evaluation of one's nursing career/trajectory in order to keep recovery at the center of one's life. In the unsuccessful work re-entry axial coding model, strategies identified that influenced the phenomenon of "lacking self-redefinition" were avoidance of sound and reflective self-examination and/or actions aimed at maintenance of prior work conditions, and job status. Keeping SUD status a secret from others, including at work, was also evident.

Intervening conditions. Intervening conditions act to "…facilitate or constrain the strategies taken within a specific context" (Strauss & Corbin, 1990, p. 96). They do this by providing the "…broader structural context pertaining to the phenomenon" (Strauss & Corbin, 1990, p. 103). For successful work re-entry, the intervening conditions among participants centered on actualization of effective treatment and recovery strategies, including the willingness to be open about SUD status with select peers at work. A focus of "recovery first" is evident. For unsuccessful work re-entry, intervening conditions found participants more likely to internalize shame than to value a need for recovery. This led to reluctance in being open with others about SUD status, including in the workplace.

Consequences. The context, antecedents, phenomena, and intervening conditions all influence consequences, although consequences are most directly outcomes that emerge from strategies (actions/interactions) (Strauss & Corbin, 1990). The primary consequence was successful work re-entry when self-redefinition was actualized. It also involved healthy personal and workplace boundary setting and the ability to learn quickly from missteps in recovery. The

primary consequence was unsuccessful work re-entry when minimal change to self-identity occurred and frequently resulted in relapse, non-adherence to mandated protocols, and resistance to being honest about SUD status.

Chapter Summary

Chapter Four presented findings of this grounded theory study that explored the processes operating when a RN re-enters the workplace following completion of SUD treatment. Demographic findings of study participants were discussed. Also presented were the findings specific to the three research questions for the study. The two axial coding models were presented that represent the relationships among concepts and demonstrate the analysis and evolution of these relationships. The next chapter presents a theoretical model for both successful and unsuccessful work re-entry that depicts the interconnectedness of the core variables/phenomena with influential properties that dwell within the context of SUD treatment, recovery, regulatory mandates, and the healthcare work environment.

CHAPTER V

THEORETICAL MODELS

Introduction

Work re-entry of RNs after SUD treatment completion was examined in this grounded theory study. The purpose of the study was to explicate a substantive theory/model that describes the basic social processes (BSP) operating when a registered nurse re-enters the workplace following completion of SUD treatment. This chapter describes the theoretical models that emerged from constant comparative analysis that are reflective of higher levels of abstraction and understanding of the study findings. As with the axial coding models, two distinct theoretical models evolved: one depicts unsuccessful work re-entry and the other depicts successful work re-entry. The unsuccessful work re-entry theoretical model and its components are discussed first, as that is the order in which they were experienced by those participants who had both experiences. This is followed by discussion of the successful work re-entry theoretical model. Also included is discussion and application of the term basic social processes (BSP). The chapter concludes with a discussion of how symbolic interactionism (SI) and pragmatism guided and supported development of the theoretical models, with their various processes and contexts.

Note: As in the previous chapter, all participants discussed and referenced are denoted with female pronouns.

Theoretical Model: Unsuccessful Work Re-entry

The theoretical model for unsuccessful work re-entry emerged as a result of discussion from those study participants who experienced both unsuccessful and successful work re-entry. These eight participants (36.4%) clearly articulated the difference in the two experiences, noting new learning from the unsuccessful experience that assisted them with subsequent work re-entry success.

Description of Model Structure

The theoretical model of unsuccessful work re-entry is depicted in Figure 8. It consists of three contextual foci that form the perimeter of the model: (a) SUD treatment and recovery, (b) regulatory mandates, and (c) the healthcare work environment. These emerged from the context section of the axial coding models (see Figures 6 and 7 in Chapter Four). Within each of these perimeter sections, adjacent to the contextual foci, are the personal responses which became the properties of the core variable, "lacking self-redefinition." Double arrows depict back-and-forth movement from the properties to the core variable within each perimeter contextual focus area. Other movement or flow is not strongly evident in this model, indicating a static atmosphere where participants are resistant to change and self-redefinition as they attempt to maintain the view of self-identity that was in place prior to SUD treatment.

Core Variable: Lacking Self-Redefinition

In the grounded theory approach of Strauss and Corbin, the central or core category "…represents the main theme of the research. It is the concept that all other concepts will be related to" (Corbin & Strauss, 2008, p. 104). In this study, the term "core variable" is used as a

synonym for "core category" as the term "core variable" is found in the original work of Glaser and Strauss (1967) and in subsequent works by Glaser (1978).

The core variable that arose from constant comparative analysis in the unsuccessful work re-entry theoretical model was "lacking self-redefinition." All of the other categories and their properties are related to this phrase for the purpose of explicating its meaning. It fits the description of a core variable from the Strauss and Corbin (1998) grounded theory approach as it has the capacity to explain variations within the categories and various properties for this theoretical model.

For participants who experienced unsuccessful work re-entry, "lacking self-redefinition" was primarily an internal process, although external processes and contextual influences were evident, as illustrated by the double arrows from the properties to the core variable. Internal processes are most prevalent in the make-up of the properties in the model: (a) ineffective engagement in recovery strategies, (b) resentment and resistance to following through with mandates from the BON, alternative program, and/or employer, and (c) projection of internal responses onto the work environment, especially those related to stigma, shame, and fear.

Properties

Properties are defined by Strauss and Corbin (1998) as "…characteristics of a category, the delineation of which defines and gives it meaning" (p. 101). The core category is like any other category and must be developed in terms of its properties (Strauss & Corbin, 1990). The core variable does not exist without these properties (see Figure 8). The following discussion describes the properties that explicate the core variable in the theoretical model for unsuccessful work re-entry. Examples from findings of the study are given for each property.

Figure 8. Theoretical Model: Unsuccessful Work Re-entry (Matthias-Anderson, 2015)
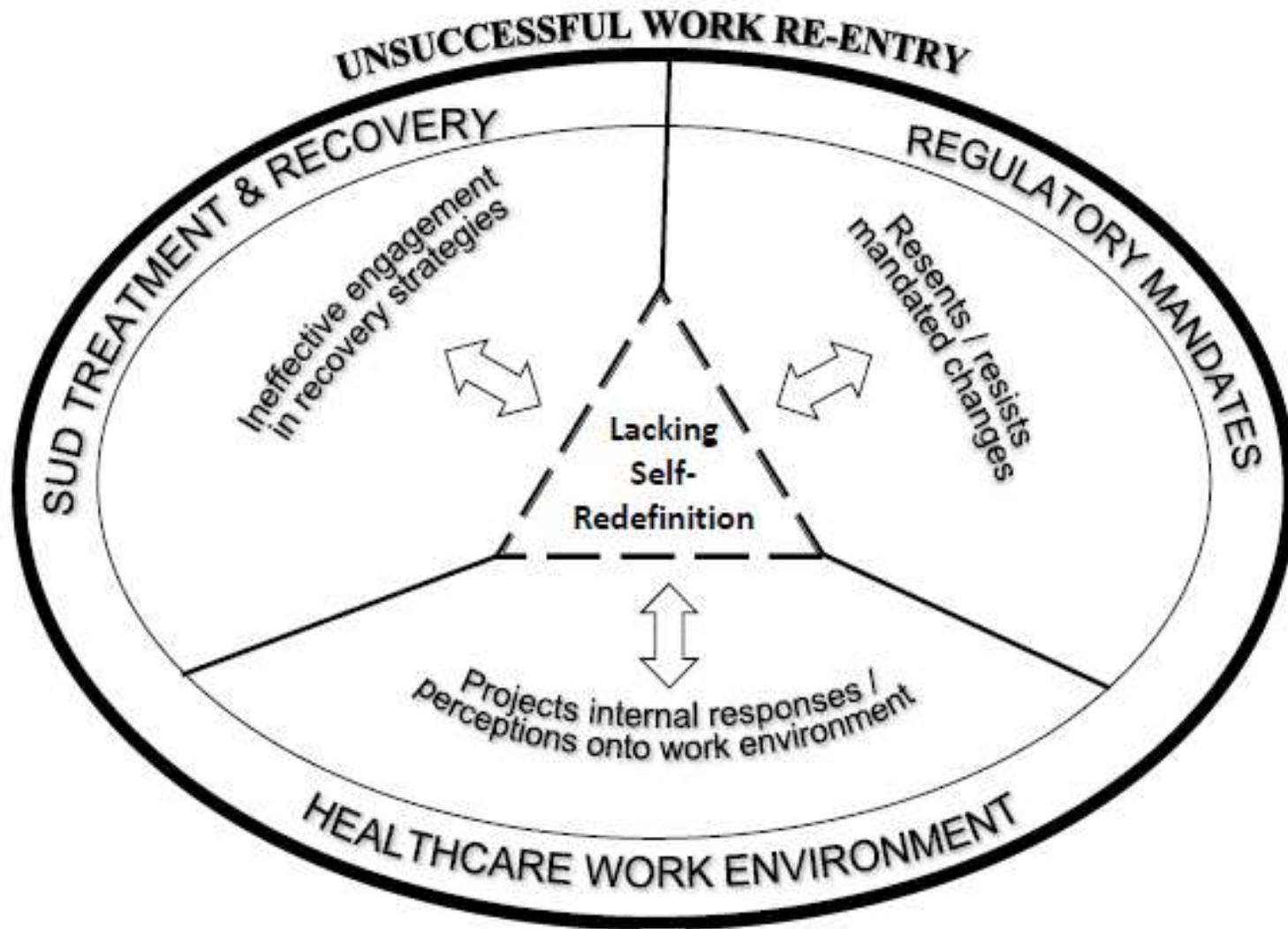
Ineffective engagement in recovery strategies. All participants in the study who experienced an episode of unsuccessful work re-entry had completed SUD treatment and, while in treatment, were taught about recovery strategies to assist with sobriety/abstinence. Recommendations from treatment center staff to participate in aftercare activities or enter sober living environments after treatment were often disregarded. Some participants who experienced unsuccessful work re-entry looked back on the experience and admitted that they had placed their primary focus on getting back to work and into what they perceived as a "normal" life rather than on maintaining sobriety/abstinence. Thus, they admitted that they had returned to work too quickly. With the primary focus on returning to work, recovery strategies were not integrated into daily life processes or internalized (see Figure 9). Therefore, there was minimal to no effect on their redefinition of self.
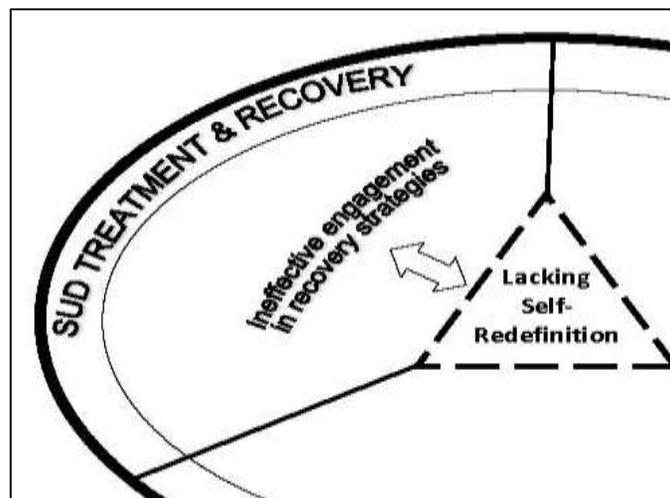

Figure 9. Ineffective Engagement in Recovery Strategies (Matthias-Anderson, 2015)

A participant reflected on two episodes of relapse and a subsequent mandatory appearance in front of the state BON as evidence of her ineffective engagement with recommended recovery activities:

What I wasn't doing was going to A.A. I wasn't doing those things. I was basically trying

to take the path of least resistance, so to speak, and I didn't have a sponsor or any of

those things. [The BON] gave me a strong talking-to, I would say … and then I had to re-

enroll in [the alternative program] again.

Now back to work successfully, the relapse and appearance before the BON was influential for

this participant to more closely examine herself and her recovery.

Another example of ineffective engagement in recovery strategies is the unwillingness to

disclose SUD status, which was discussed by a participant who had an unsuccessful work re-

entry experience prior to now being back to work successfully. This example demonstrates lack

of self-redefinition:

With the first recovery, I was so limited with who I told. In fact, I didn't even tell my

whole family that this had gone on. My parents knew, but my brothers didn't know. I

kind of had, for lack of a better word, a double life I was living. There were people [in

recovery] that I could open up to and there were people that *I wouldn't or that I couldn't*

share being me [emphasis added]. Looking back, that's definitely a barrier to somebody's

recovery, just having to be two people at the same time.

The "double life" referred to by the participant is indicative of pervasive denial that supported a

lack of redefinition of self as a person with SUD. This participant later described acceptance and

internalization of a redefined identity in the second, successful work re-entry experience (a quote

that was shared in the previous chapter):

By the second time I was much more secure in my own chemical dependency issues and

really had the firm understanding that I am chemically dependent. I wasn't just struggling

167

with that diagnosis; I got it. That made it much easier for me to be able to share that piece

of myself with somebody else.

Prior to these events, lack of attention paid to engaging in recovery strategies contributed to

failure of self-redefinition and ultimately led to relapse and an unsuccessful work re-entry

experience for this participant.

Resents/resists mandated changes. Before and after work re-entry participants faced

mandates related to their practice of nursing from the BON, the state alternative program, and/or

their employers. These were discussed in Chapter Four and include mandated requirements such

as random urine toxicology screens, work restrictions regarding medication administration,

obligatory payment of BON processing fees, required attendance at recovery meetings, etc.

When describing unsuccessful re-entry, participants recalled feelings of anger and resentment

about the mandates. A participant stated:

When I was in [SUD treatment], I was basically told I wouldn't be given a return-to-work

slip unless I contacted [the state alternative program], so I felt a little bullied into calling

[them]. I didn't really understand [the alternative program] and there wasn't a lot of

explanation about what it entailed.

A few months later this participant experienced a relapse during a time of multiple life stressors:

I was angry and upset with myself [about the relapse] and everything that was happening

in my life, kind of had that victim mentality going on, so I said [to the alternative

program staff], "I'm quitting." And that backfired, because then, even though I had

volunteered to join the [alternative program] and then opted out, it was looked at as that I

168

had failed [the alternative program], and those are the documents that went out to my

employer and to the BON.

The participant was subsequently fired by her employer and told that she could no longer

practice nursing anywhere in this large healthcare system. She also had to face the BON related

to her "failed" tenure with the alternative program. Figure 10 depicts this portion of the

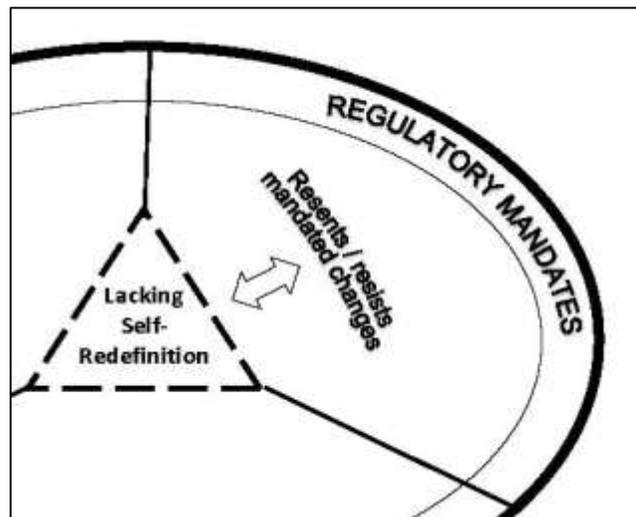unsuccessful work re-entry theoretical model.

Figure 10. Resents/Resists Mandated Changes (Matthias-Anderson, 2015)

The resistance and resentment evident in the above quote extended to legal consequences

and financial stressors that were faced by many participants. Financial stressors and

consequences were discussed in Chapter Four and were a part of the experiences of nearly all

participants. For some, financial need was amplified due to suspension of the nursing license and

an extended period of unemployment while waiting for decisions from the BON about license

reinstatement. Financial pressures for some participants contributed to a decision to return to

work quickly, often before a sound recovery program was in place.

A participant who was the sole provider for her family discussed financial hardships and the difficult learning she experienced as she dealt with a relapse after her first SUD treatment. She shared that at the end of the relapse she recalled thinking: "I am exactly in the same spot I was before I went [to SUD treatment]. I just spent $17,000 [for treatment] to get out of this situation and I am exactly in the same spot, where I did exactly the same thing." For this participant, recognition eventually occurred that she needed different ways to view regulatory mandates and more effective ways to engage in recovery, both of which contributed to self-redefinition as a person with SUD. Changing how she viewed herself and her recovery was manifested by putting sound recovery strategies into place, successfully completing mandated monitoring, and resolving financial/legal consequences of her past substance use. As a result, she was able to break the cycle of relapse and return to work successfully.

Projects internal responses/perceptions onto work environment. The final focus area in the perimeter of the unsuccessful work re-entry theoretical model is the healthcare work environment. As was explained in Chapter Four, negative bias and prejudicial attitudes exist within the nursing profession toward patients with SUDs. Study participants shared that these environmental factors were influential in internalizing self-stigma, inhibiting self-redefinition and contributing to fears about disclosing their SUD status at work. As a result, some participants approached work re-entry with the perception that the work environment would be hostile; that one's SUD status needed to be kept secret. A participant who is now successfully working in a nursing position in the field of SUDs discussed her unsuccessful work experience: "The secrecy around nurses is huge…We're kind of in a silo, that we [feel] we can't even talk about our recovery or that [SUD] happens to us, too." Avoidance of self-redefinition as a person

170

with SUD was demonstrated when returning nurses chose not to be open and honest about their

SUD status with others at work (living in dual worlds), thus projecting internalized stigma and

fear onto the work environment (see Figure 11). This created stress and, for some, resulted in

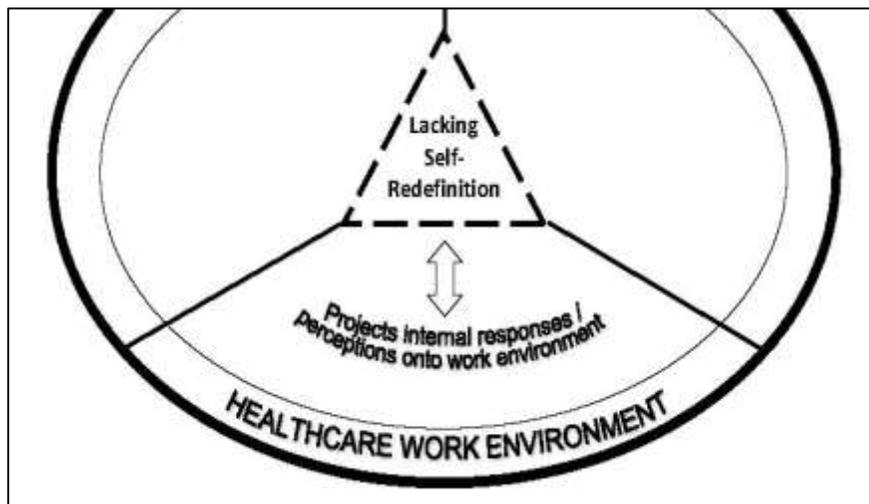relapse and unsuccessful work re-entry.

Figure 11. Projects Internal Response/Perceptions onto Work Environment (Matthias-Anderson, 2015)

Theoretical Model: Successful Work Re-entry

Description of Model Structure

The theoretical model for successful work re-entry is depicted in Figure 12. It portrays

integration of multiple changes in the life and self-identity of the RN who returns to work

successfully. The three outer contextual foci are the same as the theoretical model for

unsuccessful work re-entry in Figure 8: (a) SUD treatment and recovery, (b) regulatory

mandates, and (c) the healthcare work environment. However, participants shared significantly

different responses to each of the contextual foci compared to the previous model, thus

supporting a new core variable with its three properties. Unlike Figure 8, the theoretical model of

successful work re-entry depicted in Figure 12 has porous boundaries and back-and-forth flow

171

between all components of the model. The three properties of "redefinition" emerged from the

data and are illustrated as three inter-connected ovals all beginning with the same term

("redefines"): (a) redefines personal perceptions, values, and priorities, (b) redefines responses to

recovery processes, and (c) redefines professional relationships/processes. These properties were

essential to the development and explication of the core variable of "self-redefinition."

Core Variable: Self-Redefinition

The core variable of "self-redefinition" emerged early in the constant comparative

analysis as participants discussed life-altering experiences associated with SUD treatment,

engagement with recovery processes, and the return to work. Participants who experienced prior

unsuccessful work re-entry were especially articulate in noting the differences between the two

outcomes as they described the hard lessons learned that moved them toward internalizing,

accepting, and re-defining self as a person and a nurse with SUD. Relapse and loss of nursing

jobs after work re-entry were described as painful losses for these participants and were driving

forces that moved them to consider and accept changes in self-perceptions and behaviors.

Participants with only a successful work re-entry experience added support and clarification in

describing experiences that further elucidated the various redefinition properties as they emerged

and took shape within the model (see Figure 12).

The description of "self-redefinition" is best explicated by the statement "internalization

and acceptance of self as a person and a nurse with SUD." Significant data emerged from

participants about challenges to both self-identity and professional nursing identity when faced

with a SUD diagnosis. Acceptance of the SUD diagnosis, which was needed to sustain a healthy

lifestyle in recovery, was identified by participants as absolutely vital in forging a redefinition

172

Figure 12. Theoretical Model: Successful Work Re-entry (Matthias-Anderson, 2015)
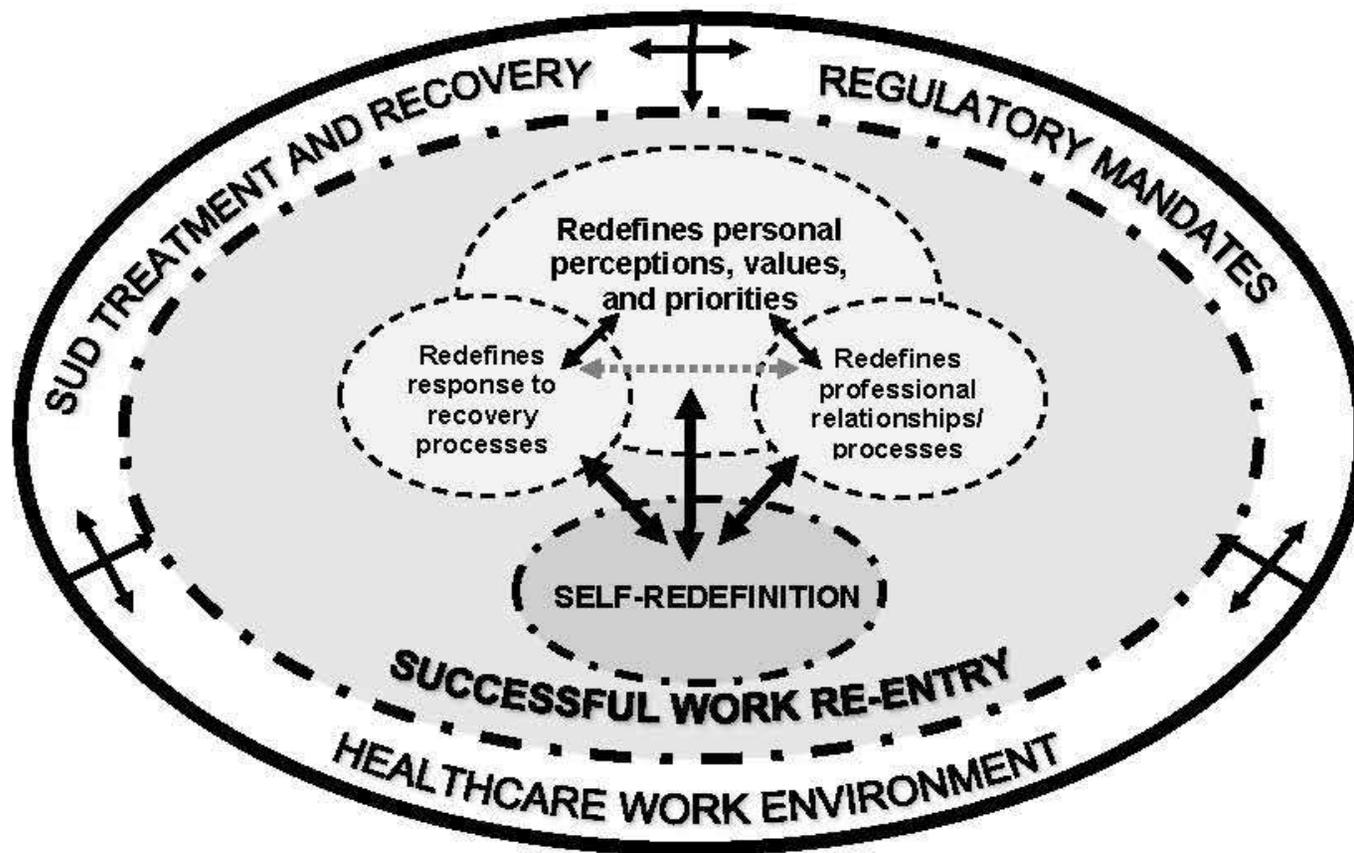
of self. Admission of one's SUD diagnosis in the face of pervasive stigma, shame, and fear

necessitated honesty, openness, and perseverance from participants when re-entering the nursing

practice work setting. The essential properties of the explication of the core variable of "self-

redefinition" are discussed below.

Properties

   Redefines personal perceptions, values, and priorities. The largest of the three

property ovals integrates features of all three perimeter contextual foci. It was identified by

participants as the most important property because it depicts foundational internal changes in

personal perceptions, values, and priorities which are vital to the core variable of self-

redefinition as a person with SUD. Originally depicted as the same size as the other property

ovals, feedback from member check interview participants clarified that the internal processes

related to changing one's self-identity within a recovery framework took precedence over the

other two properties in this theoretical model. A participant stated:

> [First you must be] accepting of yourself as who you are in the [SUD] disease
>
> process…and then deal with the professional, because the professional is not the biggest
>
> aspect; *it's who you are and whether or not you're willing to change*(emphasis added)
>
> that is going to affect the professional part. Because, *if you don't change*, [the
>
> professional nursing part] doesn't matter.

The above quote endorses the idea that a redefinition of personal perceptions, values, and

priorities allowed participants to "put recovery first," which was perceived as foundational to any

redefinition of self as a person and a nurse with SUD. Figure 13 depicts this portion of the

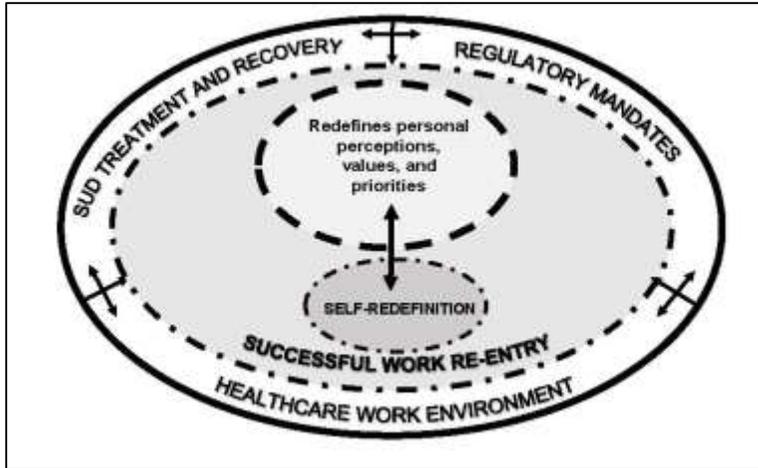successful work re-entry theoretical model.

174

Figure 13. Redefines Personal Perceptions, Values, and Priorities (Matthias-Anderson, 2015)

A firm, positive nursing identity supported perseverance for study participants after SUD treatment completion to "jump through hoops" and, for many, to do the considerably hard work of finding a nursing position given licensure and regulatory restrictions. This perseverance allowed them to continue to practice in a profession that so many stated they loved. However, it is also evident from participants that a shift was required in how one's professional nursing identity was perceived, valued, and prioritized. Internalization and acceptance of self as a person with SUD had to become a higher priority than one's professional nursing identity. As a participant advised (and was previously quoted in Chapter Four), "[Don't] have your [nursing] career define you…Take the appropriate time to get into good recovery before re-entering the workplace."

Redefines response to recovery processes. The second property supporting self-redefinition of participants with successful work re-entry was redefinition of the "response to SUD recovery processes," especially the importance of support systems. In the model, this oval is situated adjacent to the contextual focus of "SUD Treatment and Recovery" (see Figure 14). It is indicative of participant follow-through and compliance with suggested strategies

175

recommended to them during SUD treatment. Many participants discussed the importance of following recommendations to fully participate in programming while in SUD treatment and to actively engage in recommended aftercare, outpatient treatment, and recovery strategies after treatment completion, as depicted in Figure 14. For example, a participant reflected on the important role played by treatment staff in helping her prepare for work re-entry:

I would verbalize my fear about, 'How am I going to navigate this? What am I going to say to everybody [about] why I was gone [from work]?' I remember just being so scared about having to tell my boss. The people who helped me figure that out were my treatment counselors and my psychologist.
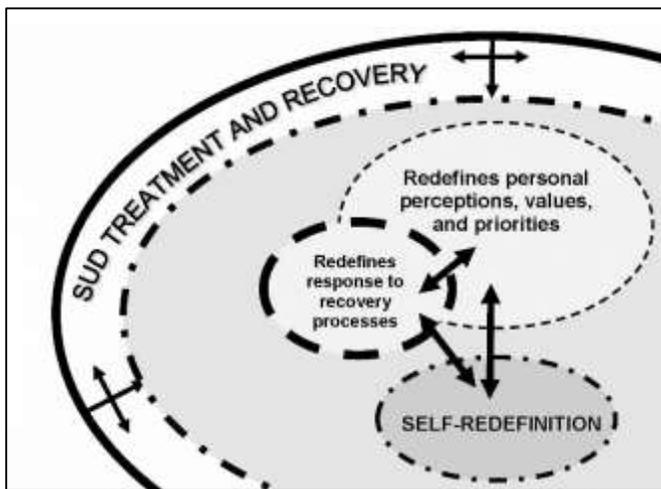
Figure 14. Redefines Response to Recovery Processes (Matthias-Anderson, 2015)

After treatment and work re-entry, a participant shared the importance of learning to recognize when she needed to engage her support systems:

I have my good days and my bad days still, and I constantly have to be vigilant about where I am at mentally and spiritually. And when I need help, I've got to go to a meeting. Because, without those meetings – it's pretty much the meetings that saved me – because

176

without those, I would be in deep [trouble]. Now I know where all [the meetings] are. So

I have meetings as safe zones. And, I'm very, very honest with my family and [my

partner] about where I am at emotionally and what is [currently] a struggle for me.

Development of healthy support systems became an integral part of the lives of

participants and a major focus of their personal self-care activities, allowing them to live

different and healthier lives. Effective use of support systems helped participants identify and

value their personal self-worth. This, in turn, helped participants deal with past guilt and shame

while developing and accepting a different view of self. Engaging in and redefining responses to

recovery processes became integral to self-redefinition.

Redefines professional relationships/processes. The third property oval (Figure 15)

depicts a redefinition of professional relationships/processes and is situated between the

perimeter contextual foci of "Regulatory Mandates" and "Healthcare Work Environment" as it is

influenced by both. When participants adhered to BON, alternative program, or employer

monitoring, it demonstrated to themselves the ability to successfully follow-through with

regulatory mandates. Successful completion of monitoring programs positively influenced self-

worth. Acceptance and resolution of the legal/financial consequences resulting from one's SUD

history were also important in this regard. Thus, compliance with monitoring mandates and

resolution of financial and/or legal consequences were not just necessary to retain the nursing

positions obtained after treatment, they were integral to solidification of self-redefinition.
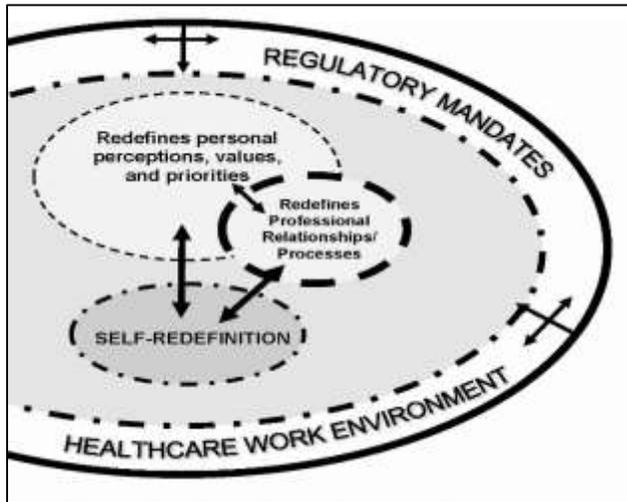
Figure 15. Redefines Professional Relationships/Processes (Matthias-Anderson, 2015)

Processes experienced within nursing were altered as participants came to internalize a new self-identity that not only included acceptance of self as a person with SUD but also acceptance of self as a *nurse* with SUD. The process of accepting one's SUD status started with practicing openness and honesty within recovery circles, and eventually led participants to being comfortable enough with themselves and their SUD status to be open and honest in the work environment. For one participant, this honesty began with telling people in her A.A. meetings that she is a nurse:

> I always tell people at A.A. that I'm a recovering nurse. Not only because it's something that I identify with, but I guess sometimes I just want other people, that I'm in the room with, to kind of know who I am and that my recovery is that important to me – that there is more attached – and maybe that's a bad thing; I don't know, but either way, I let people know.

178

Another participant discussed informing her work colleagues about the reason for her three month absence from work while in SUD treatment. She returned to work in a charge nurse position and shared the following experience:

My first day back, everyone is just like saying nothing, but I noticed they were being a little weird, and I would hear just bits and pieces [of rumors]. After some time I finally had a come-to-Jesus meeting. I said, 'OK, so everybody wants to know what it is? I'm sick of hearing the rumors. This is what it is.' I said, 'I went to treatment for drugs and alcohol. I'm sure I'm not the only one in this building who's done it and that is where I'm at. I just can't deal with not being honest.' I have had quite a lesson in brutal honesty; it's exactly that, it's brutal. It's taken me a little bit to get that.

Another participant, in long-term recovery, stated:

One of the keys to my recovery has always been that I tell people who I am; where I am. I see people in jobs hiding their recovery and I think, no, I could never do that. If I'm in a job where I have to hide my recovery, I'm in the wrong job, absolutely.

Changes in professional processes included modification of career trajectories and goals. Priorities were altered from "career first" goals with an emphasis on nursing identity to "recovery first" goals and a redefinition of personal and professional identity. The same participant who shared the quote about calling a meeting with her staff to share where she had been for three months eventually made a decision to leave that position and move across the country to the state where she had completed SUD treatment. Her decision about this was done after much personal contemplation and consultation with her A.A. sponsor. This involved notifying the BON in the new state about her recent SUD treatment and current monitoring status

179

along with making a request to the new state BON for consideration to be licensed in that state. The process of obtaining a license in this state and then procuring a job took many months, but the participant put her recovery first, valuing the stronger 12-step meetings and recovery opportunities in the state where she had completed SUD treatment. She eventually found a nursing position and at the time of the interview was licensed and being monitored by both states. Self-redefinition for this participant was actualized by significant personal and professional life changes that gave her the best opportunity to maintain sobriety/abstinence. These actions clearly demonstrate she had redefined her "self" and had internalized, valued, and accepted herself as a person and a nurse with SUD.

Summary of Theoretical Models

Based on her own nursing practice experiences where discriminatory behaviors and negative bias toward individuals with SUDs were very evident, the researcher began this research study anticipating that the external healthcare work environment would be a major obstacle to workplace re-entry for nurses returning to work after SUD treatment. This was not confirmed by study participants, as internal processes were cited as most important to the outcomes for work re-entry, both successful and unsuccessful.

Participant descriptions of the contextual (perimeter) foci of the theoretical models -- SUD treatment and recovery, regulatory mandates, and the healthcare work environment -- differed significantly depending on work re-entry outcomes. Characteristics of the major themes in the unsuccessful work re-entry model were most often predicated on internal processes within the nurse, not on outward manifestations or victimization due to discriminatory behaviors from colleagues. Discussion from participants most often centered on the following properties of the

180

core variable: (a) reluctance or unwillingness to effectively engage in recovery strategies, (b) resentments/resistance toward complying with regulatory mandates, and (c) projection of internal responses/perceptions (i.e., stigma, shame, fear) onto the work environment. When combined, these properties led to a lack of redefinition of self as a person and a nurse with SUD.

Characteristics of the properties in the successful work re-entry model were also predicated on internal processes within the nurse and not on outward manifestations or behaviors from colleagues in the nursing practice workplace. In this model, however, the internal processes for participants manifested in the following: (a) a willingness to actively engage in treatment and integrate recovery strategies into one's life, (b) adherence to and completion of regulatory mandates and resolution of financial/legal consequences, and (c) honesty and openness about SUD status with others, including in the workplace. The interaction and integration of these attitudes and behaviors supported the redefinition of one's personal values, perceptions and priorities which provided a foundation for the redefinition of responses to recovery processes and redefinition of one's professional relationships/processes. These three "redefinition" properties were essential to the emergence of the core variable of self-redefinition characterized by acceptance of self as a person and a nurse with SUD, thus supporting workplace re-entry success.

Basic Social Processes, Symbolic Interactionism, and Pragmatism: Application to the Theoretical Models of Workplace Re-entry

Basic Social Processes

The core variable in grounded theory methodology, according to Glaser (1978), is often a basic social process. This is the case in both theoretical models in this study. As defined in Chapter One, basic social processes are defined as "…pervasive [and] fundamental patterned

181

processes in the organization of social behaviors which occur over time and go on irrespective of the conditional variation of place" (Glaser, 1978, p. 100). At first glance, it would appear that "redefinition" of "self" might be solely an internal process that occurs within an individual rather than occurring within a social setting. However, according to symbolic interactionism, internal processes related to identity and self are both considered social processes (Charon, 2007; Jeon, 2004), as discussed below.

Symbolic Interactionism and Pragmatism

A primary theoretical underpinning of symbolic interactionism is the idea that individuals "…play an active role in shaping their lives by the way they handle or fail to handle the events or problems they encounter, and their action/interactions/emotional responses based…on their perceptions of those events" (Corbin & Strauss, 2008, p. 88). This idea is steeped in the philosophical tradition of pragmatism that views reality as fluid, indeterminate, and open to different and multiple interpretations; the individual is seen as active, creative, practical, and continually interpreting and finding meaning from the environment (Charmaz, 2006; Flick, 2009). Reality is an ever-changing process based on an individual's view and interpretation of it, including one's view of the "self." This is illustrated in this study by the eight participants who experienced unsuccessful work re-entry because of relapse, which led them to repeat SUD treatment and ultimately find new ways to engage in recovery and return to work successfully.

Integral to the manner in which individuals "handle or fail to handle the events or problems they encounter" (Corbin & Strauss, 2008, p. 88), are each individual's interpretation of symbols, a key concept in symbolic interactionism. Symbols, especially those related to language and words, are defined in symbolic interactionism as social objects derived from the environment

182

that act to enhance communication and meaning-making. These symbols are used intentionally by individuals in relating to the environment and other individuals (Charon, 2007; Rose, 1974). In symbolic interactionism, the terms "SUD," "self," "nurse," and "identity" may be viewed as such symbols.

Participants in this study viewed and responded to their personal interpretation of "SUD" in a variety of ways. For many nurses, interpretation of this term was influenced by feedback from and experience with nursing work environments that were negatively biased toward individuals with SUDs. Some study participants shared that their participation in discrimination and/or observation of it led to self-stigmatization and resistance to getting help when faced with their own SUD diagnosis. This also resulted in difficulties with being open and honest about it to others, especially to other nurses. Over time, however, participants came to a different meaning of SUD, viewing it as a chronic condition that can be treated and managed effectively through a process of recovery. This is congruent with the ideas in pragmatism and symbolic interactionism that each person's interpretation is unique, fluid, and ever-changing.

"Self" is also considered to be a social object in symbolic interactionism. "Identity" is the naming or labeling of "self," and is characterized by Charon (2007) as relational, social, contextual, and a motivating force for change. Identities "…become central to us over time as our interactions [with others and the environment] reconfirm them over and over" (Charon, 2007, p. 84). It is through the understanding of self and its place in the environment that an individual makes decisions about one's own behaviors and about being in relationship with others. Individuals are in continuous interaction with "self" through self-communication, self-control, and self-perception, and are all continually affected by the environment:

183

As we communicate toward self, we are able to see ourselves in the situation, to

recognize who we are in relation to others and vice versa, as well as to evaluate our own

action in the situation. We are able to develop a self-concept, judge our own selves, and

establish an identity. (Charon, 2007, p. 89)

Self-redefinition, or lack of it, is guided by the theoretical tenets of symbolic

interactionism with the emphasis on ever-changing perceptions and interpretations of reality,

identity, and social interactions. As Benzies and Allen (2001) note: "Perhaps the most important

tenet of symbolic interactionism is the idea that the individual and the context in which that

individual exists are inseparable. Truth is tentative and never absolute because meaning changes

depending on the context for the individual" (p. 544). The theoretical models that emerged from

this study illustrate that work re-entry outcomes differed depending on the interpretations and

meanings ascribed by participants to various treatment, recovery, and work re-entry experiences.

As experiences occurred and meanings changed, self-awareness was altered, affecting self-

redefinition for participants. The emergent core variables and related properties that reflect the

processes of work re-entry are thus congruent with the foundational tenets of symbolic

interactionism and pragmatism.

Chapter Summary

The theoretical models that emerged from a constant comparative analysis process

present relationships between major themes and their properties for both unsuccessful and

successful work re-entry for RNs who have completed SUD treatment. The contextual foci of

SUD treatment and recovery, regulatory mandates, and the healthcare work environment were

determined to be the same in both theoretical models but were responded to differently by

184

participants before and during re-entry to work, thus affecting the outcome of the process. The properties and their descriptors within the two models varied greatly. The core variable of "lacking self-redefinition" was identified as central to unsuccessful work re-entry for participants. This model lacked flow and connection among its properties. The model depicting successful work re-entry emerged with greater complexity and fluidity among the contextual foci, properties, and the core variable. The core variable emerged as "self-redefinition" and was characterized as internalization and acceptance of self as a person and a nurse with SUD. Self-redefinition, or lack of it, fit the definition of a basic social process as defined in the grounded theory methodological approach. Symbolic interactionism and pragmatism were discussed as guiding the development of the theoretical models, lending sound theoretical and philosophical support to the findings of the study.

The next chapter provides further discussion and implications of the findings and the summarizing conclusions to the study.

CHAPTER VI

DISCUSSION AND IMPLICATIONS OF RESEARCH FINDINGS

Introduction

The purpose of this qualitative, grounded theory study was to explicate a substantive theory/model that describes the basic social processes (BSP) operating when a registered nurse (RN) re-enters the workplace following completion of substance use disorder (SUD) treatment. This final chapter provides an overview of the study and the findings, including a brief review of the theoretical models that emerged. The research processes are summarized and limitations of the study are noted and described. Study implications, recommendations, and the need for future research on the topic of work re-entry of nurses with SUDs are also discussed.

Brief Overview of the Study

Review of Research Process

This grounded theory study examined the work re-entry experiences of 22 RNs after SUD treatment completion. Descriptions of the experiences and processes that nurses with SUDs face when returning to nursing practice after treatment are notably missing in the literature. This study was undertaken to understand the experience of work re-entry from the perspective of the nurses themselves.

The research protocol outlined in Chapter Three was followed closely. Participants for the study were recruited through recruitment ads posted at recovery focused agencies, meetings,

186

websites, and other media outlets. Snowballing referrals also assisted in recruiting participants. A mix of phone and face-to-face interviews were completed with participants who met study inclusion criteria. Interviews were audiotaped, transcribed, and coded.

The process of constant comparative analysis began at the onset of the interviews, including the pilot interviews, and continued throughout the research, including the writing process. As descriptions, categories, and themes emerged, diagrams were developed to visualize components of axial and theoretical coding and led to axial coding models and the theoretical models. Various field notes were included in data analysis, as were data from content experts and from the literature, which was consulted frequently as findings emerged.

Memos, reflexive journaling, and frequent discussion with a grounded theory methods adviser were ways to check personal biases of the researcher and to keep findings firmly grounded in the voice and experiences of study participants. Member checking by four participants helped verify data analysis and interpretation by offering feedback about emerging tables, diagrams, and models based on their personal experiences; it also helped satisfy the trustworthiness criteria of confirmability and credibility.

Triangulation occurred as the researcher shared coding tables, diagrams, and models with an expert grounded theory adviser, a nationally recognized nurse researcher on SUDs among nurses, and the participants who participated in member check interviews. Triangulation improved credibility of the study by sharing findings and interpretations with these various sources as it confirmed the accuracy of data analysis (Polit & Beck, 2012). Data to emerge from encounters with these sources became part of the overall analysis. The audit trail was systematic and multi-layered and began at the onset of the research. It was shared with a grounded theory

187

method advisor throughout the entire process. IRB protocol was followed in maintaining and storing all data that comprised the audit trail.

Discussion of Findings

Findings of the study explicate participant experiences of work re-entry after SUD treatment completion from two perspectives: unsuccessful and successful work re-entry as two separate theoretical models emerged during data analysis. All study participants eventually experienced successful work re-entry, defined as successful job retention and lack of alcohol or drug relapse. Prior to work re-entry success, over one-third of the study participants experienced unsuccessful work re-entry, defined as an alcohol or drug relapse coupled with loss of nursing employment. Characteristics of the two work re-entry experiences were strikingly different, making development of the two models necessary.

The core variable of unsuccessful work re-entry emerged as "lacking self-redefinition," an internal process of non-acknowledgement of self as a person with SUD that was reinforced for participants by stigma, shame, and fear. It was manifested during work re-entry by: (a) lack of active engagement in recovery strategies and willingness to be open and honest about SUD status with others, including at work, (b) resentment and resistance toward BON and alternative program monitoring mandates, and (c) projection of internal responses/perceptions onto the work environment (i.e., stigma, shame, fear).

The core variable of successful work re-entry emerged as "self-redefinition," characterized by internalization and acceptance of self as a person and a nurse with SUD. It was manifested in participants during work re-entry as: (a) willingness to actively engage in treatment and integrate recovery strategies into one's life, (b) adherence to and completion of

188

regulatory mandates and resolution of other financial/legal consequences, and (c) honesty and openness about SUD status with others, including with colleagues in the workplace.

The foundational property to self-redefinition was redefinition of personal values, perceptions, and priorities. Also important were processes of redefinition of responses to recovery processes and professional relationships, which were the other two properties to emerge in the model. With these redefinitions came recognition that self-care and recovery strategies were now lifelong endeavors in managing the chronic disease of SUD. These three properties support the actualization of self-redefinition for the person (nurse) with SUD.

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Similarities of Findings to Other Studies
</div>

Qualitative Studies in Nursing

Findings of the current study share similarities with two qualitative studies in the nursing literature about SUDs among nurses and are discussed briefly. Both of these studies were discussed more in-depth in Chapter Two.

"Self-integration." The grounded theory study by Hutchinson (1987) aimed to explore and describe the BSPs operating in the recovery processes of chemically dependent nurses. The emphasis of the study was on processes of recovery, not on work re-entry. The theory to emerge in the study viewed recovery as a process that moved the nurse from "self-annihilation" when using drugs and/or alcohol to "self-integration" in recovery. The term "self-integration" is not clearly defined by the author although it is stated that, "During the self-integration process the broken pieces of the self – physical, psychological, social, philosophical, spiritual – are gradually woven together. The process is internal, takes place over time, and develops in response to long-term pain and suffering" (Hutchinson, 1987, pp. 340-341). Three stages of the self-integration

process in the theory were identified as surrendering, accepting (self, disease, and reality) and committing (to new attitudes and behaviors).

Acceptance of self, the disease, and one's reality in the Hutchinson study has similarities to findings of the current study and the successful work re-entry "self-redefinition" core variable description of "acceptance of self as a person and a nurse with SUD." Another similarity is the description of the outcome of the self-integration process whereby nurses "…gradually develop and recreate themselves as new human beings" (Hutchinson, 1987, p. 342). This is comparable to the self-redefinition core variable of the successful work re-entry model in the current study. Unlike the current study, the Hutchinson study does not, however, discuss work re-entry processes or the effects that self-integration may have on professional nursing identity, a limitation of the study. The findings of the current study provide links between work re-entry processes and changes to identity which contribute to a redefinition of self as a person and a nurse with SUD.

Commitment to nursing. The study by Darbro (2005) compared nurse completers of an alternative program in New Mexico with non-completers and reported findings about nursing identity and commitment to the profession of nursing that share similarities with the findings of the current study. Nurses who completed the New Mexico alternative program were noted to be highly motivated to retain the nursing license and to possess a strong commitment to the profession of nursing. As a group, the non-completers voiced less commitment to nursing and were considering leaving nursing or combining nursing with another area of employment.

Strong professional nursing identity of participants of the current study were discussed in Chapter Four as an important concept contributing to the emergence of the core variable of self-

redefinition in the successful work re-entry theoretical model. Commitment to the nursing profession and having hope to one day re-enter the nursing workplace were deemed valuable in helping participants persevere during times of unemployment and while waiting for BON decisions regarding license status. Strong commitment to the nursing profession also helped support participants as they complied with and completed mandated requirements from the BON, alternative program, and/or the workplace.

In summary, the findings of the current study share similarities with two past qualitative studies done by nurse researchers. Changes to "self" that occurs for nurses in recovery after SUD treatment were defined by Hutchinson (1987) as "self-integration;" the current study finds changes related to redefinition of the identity of self. Similar findings with the Hutchinson study were also noted related to acceptance of self and the disease of SUD. These similarities provide support that recovery is a life-altering, ever-changing process as they pertain to one's view of self, providing a solid link back to basic tenents of symbolic interactionism. The current study also shares similarities with the study by Darbro (2005) in that both found nurses with strong professional nursing identities fare better with alternative program completion and, in the case of the current study, successful work re-entry outcomes.

Self-identity and Recovery

As findings about self-redefinition emerged during constant comparative analysis, the literature about identity and SUD recovery was explored. Much of it comes from studies done in Europe. All but one of the studies explored the influence of a 12-step approach to recovery, a perspective that has not changed significantly since its inception. Discussed first are four studies that explore the link of A.A. and 12-step program involvement to identity change. It is followed

191

by a discussion of two studies published more recently that focused on future orientation as a critical component to recovery and identity transformation.

12-step programs and identity change. Cain (1991) found that identity change in alcoholics who attended A.A. was mediated through the formation of an A.A. personal story, helping to transform an alcoholic identity to one of a sober, recovering "A.A. alcoholic" identity (p. 221). Kellogg (1993) examined successful 12-step recovery processes through the theoretical lens of identity theory finding that identity restructuring occurs through social connection and the supportive environment offered by 12-step communities. Kellogg found that identity is transformed from one that is addictive based, to one that is recovery-oriented and emphasizes the component of service, where one alcoholic assists others to undergo similar identity changes.

In a study from Finland, Koski-Jännes (2002) explored long-term changes to personal and social identity in recovering individuals with a variety of addictive disorders (tobacco, drugs, alcohol, and eating disorders). Findings reported 12-step recovery organizations facilitated changes to social identities by modeling recovery success, offering social support, and providing a safe environment to repeatedly share one's story. Weegman and Piwowoz-Hjort (2009) conducted a study in the United Kingdom with nine recovering individuals who regularly attended A.A. and/or Narcotics Anonymous (N.A.) meetings. Findings showed that 12-step recovery programs provide a model for narrative ("story") development by which new recovery-based identities can be known and changes considered. The study found that the opportunity to formulate and share such narratives helped redefinition of self be realized.

The findings of these four studies have similarities with the current study and the core variable of self-redefinition that emerged with successful work re-entry. The idea of sharing

192

one's "story" was mentioned by participants in the current study as a way to be honest and open about experiences; sharing was also verbalized as a way to possibly educate others about recovery and successful work re-entry experiences. It was also a way for participants to find meaning in their experiences, a theoretical and philosophical link back to symbolic interactionism and pragmatism. The four studies discussed above reported that recovery groups and organizations contribute to identity change for individuals with SUD by offering a milieu for social support, effectively modeling recovery strategies used by others, and story sharing. The findings of these four studies are consistent with the findings of the current study, which validated that integration of recovery processes influenced the self-redefinition which participants experienced within the context of their lives, their careers, and their recoveries.

Future orientation and identity change. Findings from two additional studies focused on the importance of future orientation and share similarities with findings of the current study. A study by Hughes (2007) of "ex/users of heroin" (p. 673) in the United Kingdom reported findings about the importance of developing skills to project one's future identity as a non-user; to believe in one's ability to achieve sobriety. Identity transformation was viewed as a process of pursuing a new trajectory toward recovery as well as making purposeful behavioral decisions within the social context offered by the support of recovery groups and healthcare services.

The second study, a qualitative study by McIntosh and McKeganey (2001) of recovering drug addicts in Scotland, focused on how decisions were made to give up using drugs and how changes to personal identity occurred once drug use was stopped. Participants who were successful in recovery demonstrated a future orientation typified by the belief that one's identity can change and a sober lifestyle was possible. Internal motivating processes of the recovery

193

process were deemed to be as important as external support systems and were exemplified by changes in personal values and goals. The importance of future orientation described in these two studies is similar to the findings of the current study where self-redefinition is strongly based on a shift in personal perceptions, values, and priorities, supporting redefinition of self and is characterized by internalization and acceptance of ("belief in") self as a person and a nurse with SUD who is able to return to work successfully.

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Limitations of the Study

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Limitations based on research methodology were discussed in Chapter Three. The following discussion relates to limitations of the current study based on design and findings.

Homogeneity of Participants

Geographic area. A majority of participants (81.8%, $n = 18$) were licensed in one region of the country, thereby limiting maximum variation that could be realized had this study been conducted on a broader, national level. Participants from states and regions outside of the Upper Midwest were added late in the data gathering process and added to the maximum variation of the sample related to geographic region. They also increased the diversity among participants. The addition of the latter participants validated that the findings of the study were consistent and could be applied to nurses in recovery from different regions around the nation, thus tempering this limitation.

Co-Morbid Conditions. There was homogeneity among study participants related to self-reported co-occurring medical conditions (physical and/or psychiatric) and history of trauma or abuse. All but three participants (13.6%) reported a co-morbid condition or trauma/abuse history, in addition to their diagnosed SUD. The high percentage (86.4%) of participants affected

by a co-morbid conditions and history of trauma/abuse may have implications for treatment facilities and the nursing profession requiring further investigation. A study with a larger sample that includes a greater number of individuals with no reported co-morbid conditions might identify differences between the participants in this study and nurses who may use/abuse substances for reasons not potentially associated with co-morbid conditions.

All Participants had Completed Treatment and had Experienced Work Re-entry

An inclusion criterion of the study was that only nurses with SUD treatment completion and a work re-entry experience in nursing were studied, which provided a boundary to the study around participant selection. Different perspectives and results would be noted with the inclusion of nurses who have chosen to leave nursing or who have failed to achieve and/or sustain sobriety/abstinence after SUD treatment. Extension of this research could include participants representing these two groups and is discussed later in this chapter as suggested future research.

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Study Implications

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Today's complex nursing practice settings are frequently experienced by nurses as stressful. As participants in this study shared, there is pervasive stigma about SUDs within the professional culture of nursing, contributing to workplace stress due to concern about how they will be treated upon a return to work after treatment. Yet, as Brown (2012) notes, there are many benefits to an organization to rehire or retain a nurse in recovery: (a) there is less expense to the healthcare system compared to having to hire and orient a replacement nurse; (b) it demonstrates to other employees that the organization supports its employees; and (c) it demonstrates that the organization believes SUDs are treatable diseases, which may encourage others within the organization to seek help for concerns with substance use.

It is ultimately up to the returning nurse to decide how much to disclose about his/her history. Findings of this study found greater work re-entry success when participants could be open and honest about their SUD status with others at work, yet overcoming fears and concerns about nursing workplace stigma toward SUDs was challenging for most. Cultural change within nursing to decrease and eliminate stigma about SUDs will take time and must be predicated on greater efforts to expand education about SUDs as chronic, manageable conditions that affect an estimated ten percent of the population, including nurses (Monroe et al., 2013). Discussion of the implications of this study begins, therefore, with the critical needs related to education. A synopsis of this discussion is depicted in Table 12. This is followed by a discussion of recommendations identified to assist nurses during the critical time periods of early recovery. Issues and recommendations related to nursing regulation and policy are discussed. The section concludes with a discussion of the unique SUD treatment services needed for nurses by virtue of their education and the work settings where nursing is practiced.

Education

Nurse managers/worksite monitors. Participants reported variability in their experiences with nurse managers upon work re-entry but a consistent finding of the study was the perception that nurse managers are poorly educated or informed about managing and/or monitoring nurses with SUDs. Nursing organizations in some states have recently developed training modules about worksite monitoring of a nurse with SUD upon work re-entry and have made these modules available nationally. The Fit to Perform training (Cadiz et al., 2012) discussed in Chapter Two is an example of one such training program. An online course for nursing worksite monitors has also been developed by the South Dakota Health Professionals

196

Assistance Program (South Dakota Board of Nursing, 2015). Both of these training programs include evidence-based information about SUDs in general as well as information about SUDs among nurses. It is recommended that all worksites that employ nurses after SUD treatment incorporate such training for nurse managers and/or nurses assigned to be worksite monitors. Additionally, evaluation of the effectiveness of these worksite monitoring training programs is recommended; national dissemination in the nursing literature is also needed.

Staff nurses and healthcare colleagues in nursing practice settings. The literature validates that education about SUDs decreases stigma and may positively change nursing and healthcare cultures where discriminatory behaviors and stigmatization toward individuals with SUDs are prevalent. It is recommended that regularly scheduled continuing education on this topic be instituted in healthcare settings to counteract knowledge deficits among nurses and members of other healthcare disciplines. Also needed are encounters within the healthcare culture for nurses to engage with recovering nurses who have successfully returned to nursing practice after SUD treatment. Such "cultural encounters" (Campinha-Bacote, 2002) may raise awareness and knowledge about SUDs among nurses, thereby decreasing stigma. Many states have nursing peer assistance groups which may provide an opportunity for encounters with recovering nurses (New York State Nurses Association Statewide Peer Assistance for Nurses, 2014). One aim of nursing peer support groups is providing education to other nurses about the topic of SUDs and recovery among members of the nursing profession.

On a broader healthcare systems level, it is currently difficult to ascertain from the literature what types of specific educational strategies and guidelines are available for continuing education on the topic of SUDs or how widely they are implemented. There is a need to

197

Table 12. *Education Needs Based on Study Results*

Study Findings	Targeted Group	Educational Strategies Needed	Who to Develop / Implement / Oversee

Worksite monitors are poorly educated on how to assist nurses with SUDs	• Nursing administration
	• Nurse managers
	• Worksite Monitors
		Training programs to educate managers about SUDs, conducting interventions, best practices related to monitoring and work re-entry. Examples:
		• Fit to Perform (Oregon)
		• Course for Nursing Worksite Monitors (South Dakota Health Professionals Assistance Program)
			• State alternative programs
			• Other state nursing organizations:
			  o Peer assistance groups
			  o State nurses association
			• Healthcare organizations
			• State BONs

Discriminatory culture in nursing work environments toward patients and nurses with SUD	• Staff nurses • Other healthcare professionals	Strategies to influence cultural change: • Cultural competence theory by Campinha-Bacote (2002) • "Just Culture" strategies (Frankel, Leonard, & Denham, 2006). • Analysis of healthcare cultures; strategy development based on analysis	Healthcare systems with inclusion / assistance from BON, alternative programs, and the following: • Nursing and healthcare administration • Human resource departments • Employee Assistance Programs • Nurse researchers (PhD and DNP)

Minimal to no exposure / content on topic of SUDs among nurses in nursing education departments (in healthcare organizations) and academic settings	• Nursing administration
	• Staff nurses
	• Nurse educators
	• Nursing students
		Curriculum development, dissemination, and evaluation for:
		• Professional development courses in healthcare organizations
		• College and university course in nursing (pre-licensure and graduate programs)
			• Clinical educators in healthcare systems
			• Nurse educators with support from:
			  o NCSBN (for inclusion in NCLEX)
			  o AACN or NLN to include in "Essential" curricular content documents

Lack of clarity about successful SUD treatment strategies typically used for nurses re: work re-entry	SUD Treatment Providers	• Identification of unique needs of nurses in preparing for work re-entry while in treatment • Separation of nurses from physicians and other healthcare professionals and use of focused treatment strategies for nurses • Examination and evaluation of current strategies for improved outcomes	• Dissemination of research by nurse researchers related to work re-entry of nurses to assist SUD treatment providers • Treatment centers to collaborate with nurse researchers and other researchers to produce evidence supporting focused SUD treatment for nurses
Need to more effectively assist nurses as they move through regulatory and alternative program monitoring processes	BON members and alternative program staff	Education and training programs about SUDs among nurses for those taking on a regulatory role (BON) or monitoring role (alternative program staff): • Needs of nurses with SUDs as they go through these processes • Facilitation of mandates in a timely manner	• NCSBN – for a national approach to orient new members to state BONs • NOAP (National Organization of Alternative Programs) for alternative program staff training • Nursing peer support groups and networks

determine what is being done within healthcare settings related to continuing education on this topic, how program effectiveness is measured, and whether any such continuing education programs have been published and disseminated nationally. It is also difficult to determine how nursing peer assistance groups provide education and support as it appears there is variance around the country in how these groups are structured and operate, again making evaluation of the impact of such groups from a national perspective difficult.

Nurse educators and students in the academic setting. Several participants shared that they did not recall receiving information about the topic of SUDs among nurses during their nursing education. It is recommended that curricula about SUDs among nurses be developed for use in all types of nursing education programs in academic settings. The main components of the curriculum should address: (a) risks; (b) common drug(s) of choice; (c) attitudes, including presence of stigma and discriminatory behaviors within the culture and work settings of professional nursing; (d) signs and symptoms of drug/alcohol use; (e) consequences to patient safety and the health and career of the affected nurse; (f) regulatory issues: BON discipline and monitoring versus state alternative program monitoring; (g) ethical mandates of reporting colleagues with probable SUD; and (h) workplace re-entry processes and outcomes.

Once developed, implemented, and evaluated, effort must be made to disseminate the curriculum nationally. In this regard, it is recommended that partnerships with prominent nursing education organizations such as the American Association of Colleges of Nursing (AACN) and the National League for Nursing (NLN) be initiated to support this national effort. The example set by the American Association of Nurse Anesthetists (AANA) with Certified Registered Nurse Anesthesia educational programs that have instituted curriculum about the topic of SUDs among

CRNAs could provide a model for such curriculum development and implementation in other nursing educational preparation programs.

        Inclusion of topic of SUD among nurses on NCLEX® licensure exams. Nursing schools are responsible for preparing safe practitioners of nursing who are also able to pass the NCLEX® licensure exam. The NCSBN is responsible for developing the national NCLEX® licensure exams for nurses that are consistent with current nursing practice (NCSBN, 2015). To date, the NCLEX® exams do not include content related to the issue of SUDs among nurses. Addition of such content to the national NCLEX® nursing licensure exams by the NCSBN would compel nurse educators from across the country to include evidence-based content about SUDs among nurses in pre-licensure nursing program curricula. Incorporation of the topic of SUD among nurses into a school's nursing curriculum would provide nursing students with early exposure of this topic prior to being licensed and entering the profession. It is recommended that the NCSBN include content about SUDs in nurses to the NCLEX® test plans and exams.

Strategies to Assist Nurses during Early Recovery

        For newly abstinent/sober individuals, early recovery is a time of relapse risk, with evidence in the literature noting that the first two years of recovery being the time of highest risk (NCSBN, 2011). Study participants shared that there were many challenges experienced during early recovery, as were noted in Chapter Four in the discussion of findings about barriers to workplace re-entry. The period immediately after treatment completion was a time when many awaited decisions from the BON regarding license status or were getting established in alternative program or BON monitoring. This was also a time when job searches began for those who had lost their previous nursing position. Based on the findings of the current study, table 13

outlines participant identified needs and recommended strategies to assist nurses with the

numerous challenges during early recovery.

Table 13. *Identified Needs of and Recommended Strategies for Nurses in Early Recovery*

Category	Need	Recommended Strategy	Who to Operational Strategy
Legal	Accessing legal aid	List of lawyers experienced in providing legal assistance to nurses with SUD	• State board of nursing • State alternative programs • Nursing peer support groups • Professional nursing organizations
	Paying for lawyer services	List of lawyers willing to work *pro bono* or on sliding fee scale	
Financial	Low interest loans or other financial assistance	List of agencies willing to provide loans / financial assistance to nurses in early recovery	• State alternative programs • Nursing peer support groups • Professional nursing organizations
	Employment (non-nursing, health-related) while waiting for license re-instatement	List of employment opportunities to earn income while waiting for return to nursing position (Examples: child care services, personal care attendant, insurance positions, etc.)	
Employment	Employment options after license re-instatement	List of organizations and employment positions for nurses in recovery after SUD treatment	• Nursing peer support groups • Professional nursing organizations • Collaborative healthcare groups/agencies who support hiring nurses after SUD treatment
	Job search considerations	Tips and advice in developing resumes, job interview tips in light of SUD history	

Nursing Regulation and Policy

      Nursing regulation. The role played by the state BON in the lives and experiences of

study participants who returned to work was significant. Participants of this study voiced

understanding of the regulatory role of the state BON in enforcing protocols regarding SUDs.

Several participants shared that their encounters with BON staff were professional and, in some

cases, supportive. Regulatory mandates from BONs regarding monitoring after treatment were viewed by some participants as a way to strengthen individual accountability. Yet, decisions by BONs took more time to be made than participants hoped or were prepared for, increasing financial stressors that were prevalent for so many. Over one-third of study participants cited this lengthy wait to be an external barrier to work re-entry. It was not uncommon for participants to report waiting six month to a year or longer for a decision to be made by the BON about the status of the nursing license.

Frustration about the perceived drawn-out amount of time it takes BONs to act was not unique to just a few BON jurisdictions. It was voiced by nurses from over half of the states represented in the study. Based on this finding, it is recommended that state BONs assess their processes related to investigations and decision-making in order to identify ways to decrease the time between receiving a complaint, investigating it, and making a decision about status of the nursing license.

Policy and position statements. Several well-known, influential national and international nursing organizations have produced position statements about SUDs among nurses. Some examples are the American Association of Colleges of nursing (1998), the International Nurses Society on Addictions (Monroe, Vandoren, & Smith, 2011), the American Nurses' Association (2002), and the Canadian Nurses Association (2009). Common to all of the positions statements are the following assumptions and beliefs: (a) SUDs are treatable medical conditions; (b) early identification of SUDs in nurses helps insure patient/public safety and promotes recovery success for the affected nurse; (c) professional codes of ethics mandate reporting by colleagues, managers, and employers of unsafe nursing practice of a nurse with a

possible SUD; (d) SUD treatment assistance and monitoring by alternative programs is preferred over BON disciplinary actions; and (e) work re-entry of the nurse is encouraged and supported.

It is unclear how the above-mentioned position statements have influenced nursing policies at the national, state, or healthcare system levels. A review of policies and position statements by Monroe et al. (2011) found gaps across policies and position statements related primarily to communication between sources, principally nursing administration, healthcare system administrators, and regulatory and monitoring agencies. As was discussed earlier, policies and regulations of state BONs and alternative programs vary greatly. The way state alternative programs interact with the state BON also differs among states. These differences make it very difficult to understand common concerns, issues, and strategies from a national perspective. This is an obvious disadvantage for reaching conclusions about the effectiveness of policies, treatment modalities, and monitoring strategies enacted in individual states that could be shared and applied nationally. Congruent and streamlined policies and greater communication among state BONs, alternative programs, professional nursing organizations, and healthcare systems would promote greater capacity in doing regional and/or national research on the topic of SUD among nurses.

SUD Treatment Services

Nurses comprise a unique group among the population of individuals with SUDs. Access to addictive substances in the workplace, coupled with nursing knowledge that endorses the therapeutic use of pharmacologic agents, puts nurses at risk for abuse of these substances. Stressful work environments and a workplace culture that stigmatizes SUDs among patients too often results in nurses hiding their own issues related to SUDs and not getting timely help.

Return to work issues are also challenging for nurses, especially since work return often occurs when the nurse is early in recovery. Drug and alcohol treatment facilities that treat nurses for SUDs must recognize these unique contextual circumstances for nurses when providing treatment for them.

Specialized treatment tracks for healthcare professionals exist in some drug and alcohol treatment facilities around the country. A select few have specialized nurses tracks within these healthcare professionals programs. What remains unclear, however, is whether the scientific evidence on which SUD treatment of nurses is based was developed from rigorous research studies done with nurses as study participants. Given the unique environments where nursing is practiced, sound evidence about what is most effective for SUD treatment, recovery, and work re-entry for nurses is greatly needed. It is very difficult to ascertain from the current literature whether specific studies have been conducted specific to nurses. Much of the research literature appears to be based on studies done with physicians as study participants.

Future Research Needs

The current study has raised many questions about the complex topic of work re-entry for nurses after SUD treatment. Significant gaps in knowledge remain that call for additional research across various aspects of the profession of nursing, including regulation, policy, and education. Future research is needed to expand knowledge about work re-entry issues for nurses with SUD. The following list outlines several areas that warrant further investigation.

- Explore the decision-making processes by nurses with SUD who do not attempt work re-entry or who attempt work re-entry, are unsuccessful, and leave the profession. The current study sought only nurses with work re-entry experiences; there are nurses who

204

don't attempt re-entry and very little literature exists as to how or why decisions to leave nursing are made. Recruitment of participants may be difficult for such a study but national organizations, recovery settings, internet recovery blogs, and state peer support groups may be possible sources from which to recruit this population. These nurses are lost to the profession. Ascertaining reasons as to why they don't pursue work re-entry would add valuable data to the knowledge base about this topic and could positively affect retention of these nurses.

- An in-depth examination is recommended of the experiences that nurses with SUD have with BONs and alternative programs and the impact these experiences have on work re-entry and recovery processes. The current study touched on these issues but a more in-depth survey of participant experiences with these regulatory and monitoring agencies would add to the knowledge base. This could provide valuable assessment and evaluation information to these agencies for purposes of improving/revising policies and procedures.

- Broaden the current research study about work re-entry experiences to include other regions of the country, which would incorporate more state BONs and alternative programs. It could be accomplished by expanding recruitment strategies that were used successfully for this study, particularly use of websites and blogs targeting nurses with SUDs. The same research questions, interview guide, and consent form could be used. Expansion of sampling to include licensed practical nurses (LPNs) may also add important data to the nursing literature about SUDs among nurses.

- Investigate the link between co-morbid conditions and SUD development and outcomes. Findings of this study showed a high rate of co-morbid conditions among participants.

Expansion of the study to include greater numbers of nurses with SUDs who have no co-morbid conditions would make clearer how these differences compare/relate. Findings of such studies may lead to recommendations about screening prior to licensure and/or hiring in order to develop adequate support resources to retain nurses.

- Further explore any correlation between length of time off from work (after SUD treatment) and work re-entry success. This was an interesting finding of the current study that warrants additional investigation to strengthen work re-entry guidelines for state BONs, alternative programs, and healthcare systems.

- Investigate the consequences that drug diversion by a nurse have on the staff of a nursing unit, including the challenges and features faced in the nursing management of such a unit. How is this situation experienced by staff nurses and nurse administrators and/or managers? What impact does a drug diversion episode have on unit morale and the individual attitudes of the nursing staff? What opportunities for staff education result?

- Evaluate curriculum about SUDs among nurses used in healthcare systems and in all levels of nursing education in academic settings.

- Conduct quantitative, qualitative, or mixed methods research to explore issues and experiences of nurses with SUDs related specifically to the concepts of stigma, shame, resilience, self-care, social support, or self-efficacy. Each of these concepts are related, directly or indirectly, to the findings of this study. A literature search found descriptions and/or examples of survey instruments available for quantitative measurements of several of these concepts, including stigma (Brown, 2011; Luoma, O'Hair, Kohlenberg, Hayes, & Fletcher, 2010), shame (Cook, 1987; Rüsch et al., 2007), resilience (Connor &

206

Davidson, 2003; Windle, Bennett, & Noyes, 2011), self-care (Henry & Holzemer, 1997), social support (Gottlieb & Bergen, 2010; Hardan-Khalil & Mayo, 2015), and self-efficacy (McKiernan et al., 2011; Phillips & Rosenberg, 2008; Scherbaum, Cohen-Charash, & Kern, 2006). Mixed methods studies that would explore connections between participant experiences with work re-entry and the above-listed concepts would add valuable data to the body of literature on this topic.

- Investigate further the development and characteristics of professional nursing identity and its role in recovery practices and work re-entry experiences for nurses with SUDs. Findings of this study and the research by Darbro (2005) were similar in uncovering a link between strong identity to nursing and a commitment to retain one's nursing license in order to return to work. There is a substantial body of nursing literature on professional identity formation, although most from a nursing practice perspective. Symbolic interactionism is a commonly identified theoretical framework for this body of literature (Becker, 2013). A grounded theory study with the purpose of explicating the basic social processes of professional identity transformation in the face of substance use, SUD treatment, and work re-entry would add valuable data to both of these topics in the nursing literature.

- Conduct a national survey of all drug treatment facilities that operate a specialized SUD treatment track for healthcare professionals to answer the following questions:

    (a) What research evidence is being applied that supports the SUD treatment strategies used for nurses in treatment?

(b) Are nurses being offered individualized SUD treatment, different from treatment strategies used for other healthcare professionals, based on nurses' unique knowledge, experiences, and work situations?

(c) If nurses are receiving specialized SUD treatment, what evaluations are being done on such treatment strategies and are findings being disseminated nationally?

- Investigate existing training programs or supportive services used by healthcare systems which may support re-entry to work by employees after SUD treatment. Questions to consider would be:

(a) Have any healthcare systems developed programs to assist employees, including nurses, return to work after SUD treatment?

(b) How are such programs designed and implemented?

(c) How are outcomes measured or effectiveness of such programs evaluated?

(d) What disciplines/departments are involved in implementing these programs (e.g., human resources, employee assistance/employee health, nursing administration, etc.)?

(e) Have any of the models of programs for work re-entry used by healthcare systems been published and/or disseminated nationally?

Chapter Summary

This chapter provided a brief overview of the current study, including a summary of research processes and findings. Similar findings from previous nursing research studies and literature from other fields were discussed. Limitations were explored. Study implications were discussed related to education needs, nursing regulation and policy, and SUD treatment services.

Several future research ideas were proposed for knowledge expansion on the topic of work re-entry of nurses after SUD treatment.

Study Conclusions

The topic of work re-entry for nurses with SUD who complete treatment has been under researched. The large number of retirements looming for nurses and changes to healthcare related to the Affordable Care Act have led to predictions of a significant potential shortage of nurses in the U.S. within the next few years (AACN, 2014). When the nursing profession loses an experienced nurse because of SUD it is a loss not only to the profession but also for the nurse. Findings of this study conclude that processes that influence work re-entry for nurses with SUD after treatment are complex and consist of many internal and external facilitators and barriers.

Nurses can successfully re-enter the nursing workplace after SUD treatment, as the 22 participants of this study confirmed. Self-redefinition occurs, defined as internalization and acceptance of self as a person and a nurse with SUD, and was the core variable to emerge in the successful work re-entry theoretical model. Self-redefinition is a complex process that requires the presence of three properties: a) the person reflect on and redefine personal perceptions values, and priorities; b) redefinition of one's response to recovery processes; and c) redefinition of one's response to professional relationships. For some participants, an unsuccessful work re-entry experience preceded successful work re-entry and was noted with the core variable of "lacking self-redefinition," supporting the development of a separate, distinct theoretical model.

Participants in this study shared examples of the pervasive nature of SUD and how all aspects of a person's life are affected, including one's practice of nursing in today's challenging workplaces. Experiences shared by study participants validate that a holistic approach to living

one's life helps regain balance in order to live fully as a person in recovery, which changes self-identity. Attention to the emotional, physical, and spiritual aspects of health involves learning healthy self-care practices and making recovery one's main priority in life. When participants "put recovery first," they shared an awareness that this made them more effective nurses.

Additional investigation into the numerous corollary issues that emerged in this study is recommended in order to elucidate additional strategies that may influence and support work re-entry for nurses who have completed SUD treatment. Professional nursing organizations are urged to take a leadership role in facilitating expansion of research efforts on the topic of SUDs among nurses, including further studies aimed at understanding the intrinsic and extrinsic forces that impact the lives and careers of nurses with SUD who desire to return to work. The 22 study participants have reclaimed their health and preserved their nursing careers. As findings of this study indicate, there is much more to be done by the profession of nursing and healthcare systems to educate nurses and support nurses with SUDs who wish to return to the nursing workplace after treatment.

CONSENT FORM
The Process of Workplace Re-entry for Nurses after Substance Use Disorder Treatment: A Grounded Theory Study

You are invited to participate in a research study being conducted by Deborah Matthias-Anderson, PhD-c, RN, CNE, a doctoral student at the University of North Dakota, College of Nursing. The purpose of this study is to explore the lived experiences of a nurse returning to the nursing workplace following completion of substance dependence (SUD) treatment. The researcher is specifically interested in hearing your perspective about a) what acted as barriers to your return to the workplace after completion of SUD treatment and b) what helped you return to the workplace after completion of SUD treatment.

If you agree to participate in the study, you will be asked to share demographic data about your contact information, age and marital status, race/ethnicity, type of nursing education and degree, length of time spent working as a nurse, work setting, length of time back at work, type and number of substance dependence treatment(s), drug/substance of choice, number of relapses, any involvement with the state board of nursing or alternative program (e.g., HPSP), recovery involvement and/or strategies, and how you found out about the study. This will take approximately 15 to 20 minutes to complete at the beginning of the interview.

In addition, you will participate in an interview with the researcher in which you will be asked to share your experiences about returning to work after completion of substance dependence treatment. It is estimated that the interview will take 60 to 90 minutes. The interviews may be conducted face-to-face, by telephone, or using Skype, depending on the preference of the participant. The interviews will be at a time and private location that works best and is most comfortable for you. During the interview, you are free to discuss issues and answer questions to the extent that you feel comfortable doing so. You may choose not to answer any question that you are not comfortable with. There is the possibility of a second conversation with the researcher by phone, Skype, or in person to clarify responses from the first interview. The second conversation/interview would take place within one to six months of the first interview. If this is needed, you will be asked if you are willing to complete a second interview, and the consent will be read again.

Upon completion of each interview, you will receive a $25 debit card in appreciation for your willingness to participate in the study and share your experiences. The only costs to you for participation will be your time spent in the interviews.

The interviews will be audio-recorded. The tapes of the interviews will be sent to a professional _confidential_ transcription service and transcribed into a written text. Thus, transcribers will have access to the data to complete the transcription. However, all names and identifying information will be removed from the transcript, in order to insure that the information you share will be anonymous. You will be assigned a code and that code will be used to mark your interview

transcript. Your identity and all information that is obtained in connection with the study, whether in person or over the telephone, will be kept confidential. The study data and the code associated with study participant's contact information will be retained in separate locked files in the researcher's home office. These files will only be accessible to the researcher. The files will be kept for a minimum of three years following completion of the study, at which time they will be destroyed by shredding. All audio-tapes of the interviews will be destroyed upon completion of the study. Only the researcher, the researcher's advisors, a research assistant, and people who audit Institutional Review Board procedures, will have access to the data. In any type of reports or manuscripts generated as a result of the study, demographic data will be reported in the aggregate and there will not be any information that would make it possible to identify you. Direct quotes may be used in writing the findings of the study, but all identifying information will be removed from the quotation. Upon request to the researcher, you may receive a copy of the findings of this study.

There are no physical risks with participation in this study. A potential risk is that you might experience some emotional discomfort or stress during the interview, because of the sensitive nature of the topic of sharing your experiences with substance use, treatment and work re-entry. The researcher is an experienced psychiatric nurse and will be available to assist you with dealing with any discomfort and stress that occurs. The researcher also reserves the right to end the interview at any time without penalties to you if it is believed that the interview is causing you undue stress and anxiety. You may choose to stop the interview or withdraw from the study at any time. The researcher will incur no cost from any assistance you seek after the interview. This is your responsibility.

There are no known individual benefits to participation in the study. A potential benefit is that you might experience a reflective process during the interviews, which could contribute to your own understanding of your experiences. Another potential benefit of this research is that you will be able to inform the discipline of nursing about how best to facilitate and support work re-entry for nurses with substance use disorders after completing treatment. This is knowledge that is currently undeveloped and lacking in the nursing literature. In addition, by sharing your experiences and perspectives, your contributions may improve the experience of work re-entry of other nurses with substance dependence after completion of treatment.

At the end of the interview the researcher may request your permission to contact you at a later date for any clarification that may be needed for content not well understood. The second contact may be brief and will not necessarily involve a face-to-face interview. At the end of the interview you will be asked how you wish this contact to be made.

Your participation in this study is voluntary, and your decision whether or not to participate will not change your future relations with the University of North Dakota or the researcher. If you decide to participate, you are free to discontinue participation at any time, without penalty, by contacting the researcher.

If you have questions regarding your rights as a research subject, you may contact The University of North Dakota Institutional Review Board at **(701) 777-4279.**

- You may also call this number about any problems, complaints, or concerns you have about this research study.
- You may also call this number if you cannot reach research staff, or you wish to talk with someone who is independent of the research team.
- General information about being a research subject can be found by clicking "Information for Research participants" on the web site: http://und.edu/research/resources/human-subjects/research-participants.cfm

If you have questions about the research, please feel free to ask them at any time, or you may call me, Deborah Matthias-Anderson, PhD-c, RN, CNE, at 651-247-9036. If you have any other questions or concerns, you may also call my advisors, Dr. Glenda Lindseth and Dr. Eleanor Yurkovich at 701-777-4506; or the University of North Dakota Office of Research Development and Compliance at 701-777-4279.

You will be offered a copy of this consent form for future reference.

Appendix B

Demographic Information Interview Process and Questions

1) <u>At beginning of interview</u>: Have participant read consent form and ask,
   a) Do you have any questions about the consent?
   b) Do you give verbal consent to discuss your work re-entry experiences with me as outlined in the consent?
   c) Do I have your permission to tape this interview?
   d) You realize that you can terminate the interview at any time?
   e) If there are any questions that are difficult for you, please tell me and we will move on.
2) Demographic information question probes:
   a) What are your age and marital status?
   b) What race/ethnicity do you consider yourself to be?
   c) What is the highest degree you hold in nursing? (If advanced practice degree, do you have prescriptive authority?)
   d) How long have you been a nurse?
   e) Are you currently employed in a nursing position? If yes,
      i) Is this the same position (and site) you worked before treatment?
      ii) How many hours do you work per week?
      iii) Do you ever work overtime? If so, how much?
      iv) Do you ever float off your main work site?
      v) In what (specialty) area of nursing do you currently work?
      vi) What other areas in nursing have you worked in the past?
   f) How long have you been back at work since completing SUD treatment?
   g) How much time elapsed between completing SUD treatment and your return to work?
   h) How many SUD treatments have you had and what type of treatment were they? (e.g., inpatient, outpatient, specific to healthcare professionals?)
   i) What do you consider your drug/drugs of choice?
   j) Have you ever had a slip or relapse? If so, how many?
   k) Have you ever been involved with or monitored by the state alternative program (in MN: HPSP) or the state BON?
   l) What recovery strategies do you currently use to maintain sobriety/abstinence?
   m) How did you find out about this study?
   n) *(Added after pilot interviews):* Besides your substance use disorder, do you have any other diagnosed medical or psychiatric conditions or do you have a personal or family history of trauma and/or abuse?
3) <u>At conclusion of interview</u>: If re-contact of participant is needed to clarify any information,
   a) Will you allow me to contact you again?
   b) (If yes,) what is the best way to do that?

Appendix C

Semi-Structured Interview Guide

<u>Focus of interview</u>: The experience of substance dependent registered nurses who return to nursing practice after successful completion of substance use disorder (SUD) treatment.
<u>Questions</u>:
1. Tell me about your experience of returning to work following substance dependence treatment.
    <u>Probes</u>:
    - What things at work were most significant to your return to work?
    - What was your life like at that time? (Family life, job situation, emotional status, etc.)
    - How is this different from before treatment?
2. What factors acted as barriers (hindered you) in your return to work?
    <u>Probes</u>:
    - What things at work, if any, do you see as barriers?
    - What are the hardest things you have faced since your return to work?
    - Which of these do you still face?
    - How often have you / do you still face them?
    - Who, if anyone, has made it difficult to return to work?
    - Who, if anyone, has made it difficult *at* work? (I am not asking for names, just positions will be adequate, example, nurse administrators, etc.)
3. What things / factors helped you to successfully return to work?
    <u>Probes</u>:
    - What things at work, if any, helped you in your return to work?
    - What was the best thing(s) about returning to work?
    - Which of these positive things are still present?
    - How often have you / do you still experience them?
    - What strategies have/had you put in place in your life that helped you in the process of returning to work?
    - Who, if anyone, has helped you in your return to work?
    - Who, if anyone, <u>at work</u> has helped you in your return to work? (I am not asking for names, just positions will be adequate, example, nurse administrators, etc.)
4. What advice would you give to other nurses who return to work after treatment?
5. What else would you like to tell me?
6. Tell me about what motivated you to join this study.
7. Of all the things that we've talked about today, what do you think is the most important for me to understand?
8. (At conclusion, ask permission to re-contact participant if clarification needed; ask about the best way to make that contact. See last item on Appendix B, Demographic Information Interview Process and Questions).

Appendix D

Recruitment Advertisement

Research Study is Seeking REGISTERED NURSE Participants

A doctoral student in nursing is seeking interested Registered Nurse participants for her research dissertation study. The purpose of the research is to explore how RNs with substance use disorders (SUD) experience returning to work after completion of SUD treatment.

I invite you to contact me if you meet the following criteria:

- are currently licensed as a RN;

- competed at least 1 substance dependence treatment;

- returned to work in a job requiring a RN license (although you do not need to be currently working in a RN position), and

- are interested in meeting for a 60-90 minute interview to discuss your experience.

Deborah Matthias-Anderson, RN, PhD (c), Doctoral Student, University of North Dakota, at (651) 247-9036 (in the Twin Cities) or email at deborah.matthiasande@my.und.edu

A $25 gift card will be given in appreciation for your time.

Appendix E

Crisis Phone Numbers
Twin Cities, Minnesota, National

<u>Twin Cities</u>:

- Crisis Connection:
  - o 612-379-6363
- Hennepin County Medical Center Acute Psychiatric Services:
  - o 612-873-2222
- Urgent Care for Adult Mental Health (St. Paul)
  - o 651-266-7900
- Walk-In Counseling Center:
  2421 Chicago Ave. S., MPLS
  - 612-870-0565
- Behavioral & Substance Abuse Emergency Center, U of MN / Fairview
  - o 612-672-6600

<u>Statewide (Minnesota)</u>:

- Crisis Connection:
  - o 1-866-379-6363
- Behavioral & Substance Abuse Emergency Center, U of MN / Fairview
  - o 1-800-233-7503

<u>National Services</u>:

- National Suicide Lifeline:
  - o 1-800-273-TALK
- SAMHSA's National Helpline:
  - o 1-800-662-HELP (4357)

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INSTITUTIONAL REVIEW BOARD
c/o RESEARCH DEVELOPMENT AND COMPLIANCE
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TWAMLEY HALL ROOM 106
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(701) 777-4279
FAX (701) 777-6708

October 21, 2013

Deborah Matthias-Anderson
1359 Palisade Path
Woodbury, MN 55129

Dear Ms. Matthias-Anderson:

We are pleased to inform you that your project titled, "The Process of Work Re-entry for Nurses after Substance Use Disorder Treatment: A Grounded Theory Study" (IRB-201310-1131), has been reviewed and approved by the University of North Dakota Institutional Review Board (IRB). The expiration date of this approval is October 16, 2014. Your project cannot continue beyond this date without an approved Research Project Review and Progress Report.

As principal investigator for a study involving human participants, you assume certain responsibilities to the University of North Dakota and the UND IRB. Specifically, an unanticipated problem or adverse event occurring in the course of the research project must be reported within 5 days to the IRB Chairperson or the IRB office by submitting an Unanticipated Problem/Adverse Event Form. Any changes to or departures from the Protocol or Consent Forms must receive IRB approval prior to being implemented (except where necessary to eliminate apparent immediate hazards to the subjects or others.)

All Full Board and Expedited proposals must be reviewed at least once a year. Approximately ten months from your initial review date, you will receive a letter stating that approval of your project is about to expire. If a complete Research Project Review and Progress Report is not received as scheduled, your project will be terminated, and you must stop all research procedures, recruitment, enrollment, interventions, data collection, and data analysis. The IRB will not accept future research projects from you until research is current. In order to avoid a discontinuation of IRB approval and possible suspension of your research, the Research Project Review and Progress Report must be returned to the IRB office at least six weeks before the expiration date listed above. If your research, including data analysis, is completed before the expiration date, you must submit a Research Project Termination form to the IRB office so your file can be closed. The required forms are available on the IRB website.

If you have any questions or concerns, please feel free to call me at (701) 777-4279 or e-mail michelle.bowles@research.und.edu.

Sincerely,

Michelle L. Bowles, M.P.A., CIP
IRB Coordinator

MLB/jie

Enclosures

218

REPORT OF ACTION: PROTOCOL CHANGE
University of North Dakota Institutional Review Board

Date: 6/2/2014   Project Number: IRB-201310-131

Principal Investigator: Matthias-Anderson, Deborah

Department: Nursing

Project Title: The Process of Work Re-entry for Nurses after Substance Use Disorder Treatment: A Grounded Theory Study

The above referenced project was reviewed by a Designated Member for the University's Institutional Review Board on **JUN 16 2014** and the following action was taken:

☑ Protocol Change approved. **Expedited Review** Category No. 6/7
Next scheduled review must be before: **OCT 16 2014**

☐ Copies of the attached consent form with the IRB approval stamp dated _____
must be used in obtaining consent for this study.

☐ Protocol Change approved. **Exempt Review** Category No. _____
This approval is valid until _____ as long as approved procedures are followed.
No periodic review scheduled unless so stated in the Remarks Section.

☐ Copies of the attached consent form with the IRB approval stamp dated _____
must be used in obtaining consent for this study.

☐ Minor modifications required. The required corrections/additions must be submitted to RDC for review and approval. **This study may NOT be started UNTIL final IRB approval has been received.**
(See Remarks Section for further information.)

☐ Protocol Change approval **deferred. This study may not be started until final IRB approval has been received.**
(See Remarks Section for further information.)

☐ Protocol Change **disapproved. This study may not be started until final IRB approval has been received.**

REMARKS: Any unanticipated problem or adverse occurrence in the course of the research project must be reported within 5 days to the IRB Chairperson or RDC by submitting an Unanticipated Problem/Adverse Event Form.

Any changes to the Protocol or Consent Forms must receive IRB approval prior to being implemented (except where necessary to eliminate apparent immediate hazards to the subjects or others).

PLEASE NOTE: Requested revisions for student proposals MUST include adviser's signature. All revisions MUST be highlighted and submitted to the IRB within 90 days of the above review date.

☑ Education Requirements Completed. (Project cannot be started until IRB education requirements are met.)

cc: Dr. Glenda Lindseth

Signature of Designated IRB Member
UND's Institutional Review Board

6-16-14
Date

219

REFERENCES

Alcoholics Anonymous World Services. (1952). *Twelve steps and twelve traditions.* New York, NY: Alcoholics Anonymous World Services.

Aluni-Kinkle, S. & Rundio, A. (2015). *Peer assistance and opioid dependency* [PowerPoint slides]. Retrieved from http://pcss-o.org/event/peer-assistance-and-opioid-dependency/

American Association of Colleges of Nursing. (1998). *Substance abuse statement: Policy and guidelines for prevention and management of substance abuse in the nursing education community*. Retrieved from http://www.aacn.nche.edu/publications/position/substance-abuse-policy-and-guidelines

American Association of Colleges of Nursing. (2014). *Nursing shortage fact sheet.* Retrieved from http://www.aacn.nche.edu/media-relations/NrsgShortageFS.pdf

American Nurses Association. (2002). *Action: The profession's response to the problem of addictions and psychiatric disorders in nursing.* Retrieved from http://www.nursingworld.org/MainMenuCategories/WorkplaceSafety/Healthy-Work-Environment/Work-Environment/ImpairedNurse/Response.pdf

American Nurses Association. (2013). *What is nursing?* Retrieved from http://www.nursingworld.org/EspeciallyForYou/What-is-Nursing

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: American Psychiatric Publishing.

Anda, R.F., Brown, D.W., Felitti, V.J., Dube, S.R., & Giles, W.H. (2008). Adverse childhood experiences and prescription drug use in a cohort study of adult HMO patients. *BMC Public Health, 8*, 198-206. doi:10.1186/1472-2458-8-198

Angres, D.H., & Bettinardi-Angres, K. (2008). The disease of addiction: Origins, treatment, and recovery. *Disease-a-Month, 54*, 696-721. doi:10.1016/j.disamonth.2008.07.002

Angres, D.H., Bettinardi-Angres, K., & Cross, W. (2010). Nurses with chemical dependency: Promoting successful treatment and reentry. *Journal of Nursing Regulation, 1*(1), 16-20.

Back, S.E., Payne, R.L., Simpson, A.N., & Brady, K.T. (2010). Gender and prescription opioids: Findings from the National Survey on Drug Use and Health. *Addictive Behaviors, 35*, 1001-1007. doi:10.1016/j.addbeh.2010.06.018

Back, S.E., Payne, R.L., Wahlquist, A.H., Carter, R.E., Stroud, Z., Haynes, L.,…Ling, W. (2011). Comparative profiles of men and women with opioid dependence: Results from a national multisite effectiveness trial. *American Journal of Drug and Alcohol Abuse, 37*, 313-323. doi:10.3109/00952990.2011.596982

Baldisseri, M.R. (2007). Impaired healthcare professional. *Critical Care Medicine, 35*, S106-S116. doi:10.1097/01.CCM.0000252918.87746.96

Becker, B. (2013). *The lived experience of professional identity in master nursing academics* (Doctoral dissertation). Retrieved from ProQuest Dissertations & Theses A&I: Health & Medicine. (3588988)

Benoliel, J.Q. (1996). Grounded theory and nursing knowledge. *Qualitative Health Research, 6,* 406-428. doi:10.1177/104973239600600308

Benzies, M. K., & Allen, M.N. (2001). Symbolic interactionism as a theoretical perspective for

multiple method research. *Journal of Advanced Nursing, 33*, 541-547.

doi:10.1046/j.1365-2648.2001.01680.x

Bettinardi-Angres, K., & Angres, D.H. (2010). Understanding the disease of addiction. *Journal

of Nursing Regulation, 1*(2), 31-37.

Bettinardi -Angres, K., & Angres, D.H. (2011). Understanding the disease of addiction. *Missouri

State Board of Nursing Newsletter, May-June,* 7-8.

Bettinardi-Angres, K., & Garcia, R. (2015). A consistent approach to treatment and reenty for

CRNAs with substance use disorder. *Journal of Nursing Regulation, 6*(2), 47-51.

Bettinardi-Angres, K., Pickett, J., & Patrick, D. (2012). Substance use disorders and accessing

alternative-to-discipline programs. *Journal of Nursing Regulation, 3*(2), 16-23.

Betty Ford Institute Consensus Panel. (2007). What is recovery? A working definition from the

Betty Ford Institute. *Journal of Substance Abuse Treatment, 33,* 221-228.

doi:10.1016/j.jsat.2007.06.001

Bissel, L., & Haberman, P.W. (1984). *Alcoholism in the professions.* New York, NY: Oxford

University Press.

Bissel, L., & Jones, R.W. (1981). The alcoholic nurse. *Nursing Outlook, February*, 96-101.

Blazer, L.K., & Mansfield, P.K. (1995). A comparison of substance use rates among female

nurses, clerical workers and blue-collar workers. *Journal of Advanced Nursing, 21*, 305-

313. doi:10.1111/j.1365-2648.1995.tb02527.x

Blumer, H. (1969). *Symbolic interactionism: Perspective and method.* Berkeley, CA: University

of California Press.

Bowen, M.K., Taylor, K.P., Marcus-Aiyeku, U., Krause-Parello, C.A. (2012). An examination of

stress, coping, and adaptation in nurses in a recovery and monitoring program. *Journal of*

Addictions Nursing, 23, 159-166. doi: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.

Breyer, J.L, Lee, S., Winters, K.C., August, G.J, & Realmuto, G.M. (2014). A longitudinal study

of childhood ADHD and substance dependence disorders in early adulthood. *Psychology*

of Addictive Behaviors, 28, 238-246. doi:10.1037/a0035664

Brown, J.G., Trinkoff, A., & Smith, L. (2003). Nurses in recovery: The burden of life problems

and confidence to resist relapse. *Journal of Addictions Nursing, 14,* 133-137.

doi:10.1080/10884600390245712

Brown, L. (2012, January, February, March). Supporting a nurse's re-entry to practice after

treatment for addiction. *South Carolina Nurse,* 11.

Brown, S. (2011). Standardized measures for substance abuse stigma. *Drug and Alcohol*

Dependence, 116, 137-141. doi:10.1016/j.drugalcdep.2010.12.005

Bryant, A., & Charmaz, K. (2007). Introduction to grounded theory research: Methods and

practices. In A. Bryant & K. Charmaz (Eds.), *The SAGE handbook of grounded theory*

(pp. 1-28). Los Angeles, CA: SAGE.

Burbank, P.M., & Martins, D.C. (2009). Symbolic interactionism and critical perspective:

Divergent or synergistic? *Nursing philosophy, 11*, 25-41. doi:10.1111/j.1466-

769X.2009.00421.x

Cadiz, D.M., O'Neill, C., Schroeder, S., & Gelatt, V. (2015). Online education for nurse

      supervisors managing nurses enrolled in alternative-to-discipline programs. *Journal of*

      Nursing Regulation, 6(1), 25-32.

Cadiz, D.M., Truxillo, D., & O'Neill, C. (2012). Evaluation of a training program for nurse

      supervisors who monitor nurses in an alternative-to-discipline program. *Advances in*

      Nursing Science, 35, 135-144. doi:10.1097/ANS.0b013e31824fe6e0

Cain, C. (1991). Personal stories: Identity acquisition and self-understanding in Alcoholics

      Anonymous. *Ethos, 19*, 210-253. Retrieved from http://www.jstor.org/stable/640431

Campinha-Bacote, J. (2002). The process of cultural competence in the delivery of healthcare

      services: A model of care. *Journal of Transcultural Nursing, 13*, 181-184.

      doi:10.1177/10459602013003003

Canadian Nurses Association. (2009). Position statement: Problematic substance use by nurses.

      Retrieved from http://www.cna-aiic.ca/~/media/cna/page-content/pdf-

      fr/problem_substance_abuse_fs_e.pdf?la=en

Center for Substance Abuse Treatment. (2005). *A national review of state alcohol and drug*

      treatment programs and certification standards for substance abuse counselors and

      prevention professionals. Retrieved from

      http://www.hhs.gov/partnerships/resources/fbci_counselor_standards.pdf

Centers for Disease Control and Prevention. (2013). Prescription painkiller overdoses: A

      growing epidemic, especially among women. *CDC Vital Signs (July).* Retrieved from

      www.cdc.gov/vitalsigns/PrescriptionPainkillerOverdoses/

Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis.* Lost Angeles, CA: SAGE.

Charon, J.M. (2007). *Symbolic interactionism: An introduction, an interpretation, an integration.* Upper Saddle River, NJ: Pearson Prentice Hall.

Chenitz, W.C., & Swanson, J.M. (1986). *From practice to grounded theory: Qualitative research in nursing.* Menlo Park, CA: Addison-Wesley Publishing Company.

Clark, C., & Farnsworth, J. (2006). Program for recovering nurses: An evaluation. *MEDSURG Nursing, 15*, 223-230.

Connor, K.M., & Davidson, J.R.T. (2003). Development of a new resilience scale: The Connor-Davidson Resilience scale (CD-RISC). *Depression and Anxiety, 18*, 76-82. doi:10.1022/da.10113

Cook, D.R. (1988). Measuring shame: The internalized shame scale. *Alcoholism Treatment Quarterly, 4* (2), 197-215. doi:10.1300/J020v04n02_12

Cook, L.M. (2013). Can nurses trust nurses in recovery reentering the workplace? *Nursing 2013, 43*(3), 21-4. doi:10.1097/01.NURSE.0000427092.87990.86

Copp, M.A.B. (2009, April 1). Drug addiction among nurses: Confronting a quiet epidemic. *Modern Medicine.* Retrieved from http://www.modernmedicine.com/modern-medicine/news/modernmedicine/modern-medicine-features-articles/drug-addiction-among-nurses-con?id=&date=&%0A%09%09%09&pageID=4

Corbin, J., & Strauss, A. (2008). *Basics of qualitative research* (3rd ed.). Los Angeles, CA: SAGE Publications.

Corrigan, P. (2004). How stigma interferes with mental health care. *American Psychologist, 59*, 614-625. doi:10.1037/0003-066X.59.7.614

Creswell, J.W. (2003). *Research design: Qualitative, quantitative, and mixed methods approaches* (2nd ed.). Thousand Oaks, CA: SAGE Publications.

Creswell, J.W. (2007). *Qualitative inquiry and research design: Choosing among five approaches* (2nd ed.). Thousand Oaks, CA: SAGE Publications.

Darbro, N. (2005). Alternative diversion programs for nurses with impaired practice: Completers and non-completers. *Journal of Addictions Nursing, 16,* 169-185. doi:10.1080/108860050032815

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,* 24-33. doi:10.1080/10884600802693256

Davis, K., Powers, C., Vuk, J., & Kennedy, R. (2014). Predictors of substance use recidivism among Arkansas nurses. *Journal of Nursing Regulation, 5*(2), 39-44. doi:10.1016/S2155-8256(15)30075-2

Dittman, P.W. (2008). Male nurses and chemical dependency. *Nursing Administration Quarterly, 32*, 324-330. doi:10.1097/01.NAQ.0000336731.64878.66

Dube, S.R., Anda, R.F., Felitti, V.J., Edwards, V.J., & Croft, J.B. (2002). Adverse childhood experiences and personal alcohol abuse as an adult. *Addictive Behaviors, 27*, 713-725. doi:10.1016/S0306-4603(01)00204-0

Dunn, D. (2005). Substance abuse among nurses: Defining the issue. *AORN Journal, 82*, 573-

596. Retrieved from http://dx.doi.org.ezproxy.undmedlibrary.org/10.1016/S0001-

2092(06)60028-8

Falkowski, C. (2015). *Drug abuse trends in Minneapolis/St. Paul, Minnesota: April 2015.*

Retrieved from http://www.mnprc.org/sites/default/files/downloads/report-2015-

drugtrendsfinal.pdf

Flanagan, O. (2013). The shame of addiction. *Frontiers in Psychiatry, 4*(120), 1-11. Retrieved

from http://dx.doi.org/10.3389/fpsyt.2013.00120

Fletcher, C.E., & Ronis, D.L. (2005). Satisfaction of impaired health care professionals with

mandatory treatment and monitoring. *Journal of Addictive Diseases, 24*, 61-75.

doi:10.1300/J069v24n03_05

Flick, U. (2009). *An introduction to qualitative research.* Los Angeles, CA: SAGE Publications.

Fogger, S.A., & McGuinness, T. (2009). Alabama's nurse monitoring programs: The nurse's

experience of being monitored. *Journal of Addictions Nursing, 20*, 142-149.

doi:10.1080/10884600903078928

Frankel, A.S., Leonard, M.W., & Denham, C.R. (2006). Fair and just culture, team behavior, and

leadership engagement: The tools to achieve high reliability. *Health Services Research,

41*, 1690-1709. doi:10.1111/j.1475-6773.2006.00572.x

Gallup (2014). *Americans rate nurses highest on honesty, ethical standards*. Retrieved from

http://www.gallup.com/poll/180260/americans-rate-nurses-highest-honesty-ethical-

standards.aspx

Girimont, T.M. (2011). Colleague connection: Recognizing and assisting the impaired anesthesia

provider. *Journal of the Association of Occupational Health Professionals in Healthcare,*
31(2), 23-27.

Gitlow, S. (2015). An understanding of addictive disease and drug testing: Implications and

recommendations. *Journal of Nursing Regulation, 6*(2), 30-35. Retrieved from

http://www.journalofnursingregulation.com/

Glaser, B.G. (1978). *Theoretical sensitivity.* Mill Valley, CA: The Sociology Press.

Glaser, B.G. (1992). *Basics of grounded theory analysis.* Mill Valley, CA: The Sociology Press.

Glaser, B.G., & Strauss, A.L. (1967). *The discovery of grounded theory: Strategies for*

qualitative research. New York, NY: Aldine de Gruyter.

Godfrey, G., Harmon, T., Roberts, A., Spurgeon, H., McNelis, A.M., Horton-Deutsch, S., &

O'Haver Day, P. (2010). Substance abuse among nurses. Retrieved from

http://indiananurses.org/isnapsite/documents/2010GodfreyetalfinalcopyforBulletin_1_.pd

f

Gottlieb, B.H., & Bergen, A.E. (2010). Social support concepts and measures. *Journal of*

Psychosomatic Research, 69, 511-520. doi:10.1016/j.jpsychores.2009.10.001

Graham, K., Bernards, S., Knibbe, R., Kairouz, S., Kuntsche, S., Wilsnack, S.C.,…Gmel, G.

(2011). Alcohol-related negative consequences among drinkers around the world.

Addiction, 106, 1391-1405. doi:10.1111/j.1360-0443.2011.03425.x

Griffith, J. (1999). Substance abuse disorders in nurses. *Nursing Forum, 34*(4), 19-28. Retrieved

from http://onlinelibrary.wiley.com/journal/10.1111/(ISSN)1744-6198

Haack, M.R., & Harford, T.C. (1984). Drinking patterns among student nurses. *The International Journal of the Addictions, 19*, 577-583. doi:10.3109/10826088409057205

Haack, M.R., & Yocom, C.J. (2002). State policies and nurses with substance use disorders. *Journal of Nursing Scholarship, 34*, 89-94. doi:10.1111/j.1547-5069.2002.00089.x

Hamza, H., & Monroe, T. (2011). Reentry and recidivism for certified registered nurse anesthetists. *Journal of Nursing Regulation, 2*(1), 17-22.

Hardan-Khalil, K., & Mayo, A.M. (2015). Psychometric properties of the multidimensional scale of perceived social support. *Clinical Nurse Specialist, 29*, 258-261. doi:10.1097/NUR.0000000000000148

Health Professionals Services Program. (2015). *State of Minnesota: Health Professionals Services Program (HPSP).* Retrieved from http://mn.gov/health-licensing-boards/hpsp/

Health Resources and Services Administration. (2013). *The U.S. nursing workforce: Trends in supply and education*. Retrieved from http://bhpr.hrsa.gov/healthworkforce/reports/nursingworkforce/nursingworkforcefullreport.pdf

HealthyPeople.gov. (2013). *Substance Abuse*. Retrieved from http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=40

Heath, H., & Cowley, S. (2004). Developing a grounded theory approach: A comparison of Glaser and Strauss. *International Journal of Nursing Studies, 41,* 141-150. doi:10.1016/S0020-7489(03)00113-5

Heise, B. (2003). The historical context of addiction in the nursing profession: 1850-1982. *Journal of Addictions Nursing, 14,* 117-124. doi:10.1080/jan.14.3.117.124

Hendrix, M.J., Sabritt, D., McDaniel, A., & Field, B. (1987). Perceptions and attitudes toward

    nursing impairment. *Research in Nursing and Health, 10,* 323-333.

    doi:10.1002/nur.4770100506

Henry, S.B., & Holzemer, W.L. (1997). Achievement of appropriate self-care: Does care

    delivery system make a difference? *Medical Care, 35*, NS33-NS40

Hernandez, C.A. (2010). Getting grounded: Using Glaserian grounded theory to conduct nursing

    research. *Canadian Journal of Nursing Research, 42*(1), 150-163.

Horton-Deutsch, S., McNelis, A., & O'Haver Day, P. (2011). Enhancing mutual accountability

    to promote quality, safety, and nurses' recovery from substance use disorders. *Archives of*

    Psychiatric Nursing, 25, 445-455. doi:10.1016/j.apnu.2011.02.002

Hudson, S. (1998). Reentry using naltrexone: One anesthesia department's experience. *Journal*

    of the American Association of Nurse Anesthetists, 66, 360-364.

Hughes, K. (2007). Migrating identities: The relationship constitution of drug use and addiction.

    Sociology of Health and Illness, 29, 673-691. doi:10.1111/j.1467-9566.2007.01018.x

Hughes, T.L., Howard, M.J., & Henry, D. (2002). Nurses' use of alcohol and other drugs:

    Findings from a national probability sample. *Substance Use and Misuse, 37*, 1423-1440.

    doi:10.1081/JA-120014085

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. doi:10.3109/10884609809041782

Hunter, A., Murphy, K., Grealish, A., Casey, D., & Keady, J. (2011). Navigating the grounded

theory terrain: Part 1. *Nurse Researcher, 18*(4), 6-10.

doi:10.7748/nr2011.07.18.4.6.c8636

Hutchinson, S. (1986). Chemically dependent nurses: The trajectory toward self-annihilation.

Nursing Research, 35, 196-201.

Hutchinson, S.A. (1987). Toward self-integration: The recovery process of chemically dependent

nurses. *Nursing Research, 36*, 339-343.

Indiana State Nurses Association. (2009, May). Guidelines for managers of impaired nurses.

ISNA Bulletin, 8-12. Retrieved from

www.nursingald.com/uploads/publication/pdf/578/IN5_09.pdf

Jeon, Y.H. (2004). The application of grounded theory and symbolic interactionism.

Scandinavian Journal of Caring Science, 18, 249-256. doi:10.1111/j.1471-

6712.2004.00287.x

Kalivas, P.W., & Volkow, N.D. (2005). The neural basis of addiction: A pathology of motivation

and choice. *American Journal of Psychiatry, 162*, 1403-1413.

Kaplan, L., Skillman, S.M., Fordyce, M.A., McMeniman, P.D., & Doescher, M.P. (2012).

Understanding APRN distribution in the United States using NPI data. *The Journal for

Nurse Practitioners, 8*, 626-635. doi:10.1016/j.nurpra.2012.05.022

Kellogg, S. (1993). Identity and recovery. *Psychotherapy, 30*, 235-243.

Kelly, J.F., & Westerhoff, C.M. (2010). Does it matter how we refer to individuals with

substance-related conditions? A randomized study of two commonly used terms.

International Journal of Drug Policy, 21, 201-207. doi:10.1016/j.drugpo.2009.10.010

Koski- Jännes, A. (2002). Social and personal identity projects in the recovery from addictive behaviors. *Addiction Research and Theory, 20*, 183-202. doi:10.1080/16066350290017266

Lachicotte, J.L., & Alexander, J.W. (1990). Management attitudes and nursing impairment. *Nursing Management, 21*(9), 102-114.

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. doi:0.1046/j.1365-2648.2002.02268.x

Lincoln, Y.S., & Guba, E.G. (1985). *Naturalistic inquiry.* Newbury Park, CA: SAGE Publications.

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. doi:10.5172/conu.2009.33.2.166

Luck, S., & Hedrick, J. (2004). The alarming trend of substance abuse in anesthesia providers. *Journal of PeriAnesthesia Nursing, 19*, 308-311. doi:10.1016/j.jopan.2004.06.002

Luoma, J.B., O'Hair, A.K., Kohlenberg, B.S., Hayes, S.C., & Fletcher, L. (2010). The development and psychometric properties of a new measure of perceived stigma toward substance users. *Substance Use and Misuse, 45,* 47-57. doi:10.3109/10826080902864712

Luoma, J.B., Twohig, M.P., Waltz, T., Hayes, S.C., Roget, N., Padilla, M., & Fisher, G. (2007). An investigation of stigma in individuals receiving treatment for substance abuse. *Addictive Behaviors, 32*, 1331-1346. doi:10.1016/j.addbeh.2006.09.008

McClanahan, R.P., & Sullivan, E.J. (1995). Content analysis of alcohol- and drug-dependent

    nurses' perceptions of the process of their dependency and recovery. *Substance Abuse,*

    16, 183-193.

McIntosh, J., & McKeganey, N. (2001). Identity and recovery from dependent drug use: The

    addict's perspective. *Drugs, Education, Prevention and Policy, 8*, 47-59.

    doi:10.1080/09687630124064

McKiernan, P., Cloud, R., Patterson, D.A., Wolf, S., Golder, S., & Besel, K. (2011).

    Development of a brief abstinence self-efficacy measure. *Journal of Social Work*

    Practice in the Addictions, 11, 245-253. doi:10.1080/1533256X.2011.593445

McKay, J.R., & Hiller-Sturmhöfel, S. (2011). Treating alcoholism as a chronic disease. *Alcohol*

    Research & Health, 33, 356-370.

McLellan, A.T., Lewis, D.C., O'Brien, C.P., & Kleber, H.D. (2000). Drug dependence, a chronic

    medical illness: Implications for treatment, insurance, and outcomes evaluation. *JAMA,*

    284, 1689-1695. doi:10.1001/jama.284.13.1689

McNelis, A.M., Horton- Deutsch, S., O'Haver Day, P., Gavardinas, T., Outlaw, C., Palmer, R.,

    & Schroeder, M. (2011). Indiana State Nurses Assistance Program: Identifying gender

    differences in substance use disorders. *Perspectives in Psychiatric Care, 48,* 41-46.

    doi:10.1111/j.1744-6163.2010.00300.x

Monroe, T.B., Kenaga, H., Dietrich, M.S., Carter, M.A., & Cowan, R.L. (2013). The prevalence

    of employed nurses identified or enrolled in substance use monitoring programs. *Nursing*

    Research, 62(1), 10-15. doi:10.1097/NNR.0b013e31826ba3ca

Monroe, T., Pearson, F., & Kenaga, H. (2008). Procedure for handling cases of substance abuse

among nurses: A comparison of disciplinary and alternative programs. *Journal of*

Addictions Nursing, 19, 156-161. doi:10.1080/10884600802306024

Monroe, T., Vandoren, M., & Smith, L. (2011). Nurses recovering from substance use disorders:

A review of policies and position statements. *Journal of Nursing Administration, 41*, 415-

421. doi:10.1097/NNA.0b013e31822edd5f

Morse, J.M. (2001). Situating grounded theory within qualitative inquiry. In R.S. Schreiber &

P.N. Stern (Eds.), *Using grounded theory in nursing* (pp. 1-15). New York, NY: Springer

Publishing Company.

Morse, J.M. (2007). Strategies of intraproject sampling. In P.L. Munhall (Ed.), *Nursing*

research: A qualitative perspective (4th ed.) (pp. 529-539). Boston, MA: Jones and

Bartlett Publishers.

Morse, J.M. (2010). Sampling in grounded theory. In A. Bryant & K. Charmaz (Eds.), *The*

SAGE handbook of grounded theory (pp. 229-244). Los Angeles, CA: SAGE.

Mynatt, S. (1996). The model of contributing risk factors to chemical dependency in nurses.

Journal of Psychosocial Nursing and Mental Health Services, 34(7), 13-22.

Naegle, M.A. (2003). An overview of the American Nurses' Association's action on impaired

practice with suggestions for future directions. *Journal of Addictions Nursing, 14*, 145-

147. doi:10.1080/10884600390245730

National Alliance of Advocates for Buprenorphine Treatment. (2015). *Opiates/Opioids.*

Retrieved from https://www.naabt.org/education/opiates_opioids.cfm

National Council on State Boards of Nursing. (2010). NCSBN glossary. *Business Book: NCSBN 2010 Annual Meeting, 313-335.* Retrieved from:

https://www.ncsbn.org/BB_2010_Section_II.pdf

National Council on State Boards of Nursing. (2011). *Substance use disorder in nursing: A resource manual and guidelines for alternative and disciplinary monitoring programs.* Retrieved from https://www.ncsbn.org/SUDN_11.pdf

National Council on State Boards of Nursing. (2012). *NCLEX-RN® examination: Detailed test plan for the National Council Licensure Examination for Registered Nurses.* Retrieved from https://www.ncsbn.org/2013_NCLEX_RN_Detailed_Test_Plan_Educator.pdf

National Institute on Drug Abuse. (2010). *Addiction is a chronic disease.* Retrieved from

http://archives.drugabuse.gov/about/welcome/aboutdrugabuse/chronicdisease/

National Institutes on Drug Abuse. (2015a). *Emerging trends.* Retrieved from

http://www.drugabuse.gov/drugs-abuse/emerging-trends

National Institute on Drug Abuse. (2015b). *Trends and statistics: Costs of substance abuse.* Retrieved from http://www.drugabuse.gov/related-topics/trends-statistics

New York State Nurses Association Statewide Peer Assistance for Nurses. (2014). The adverse childhood experiences study. *"SPAN"ing New York State, 12*(1), 2-3. Retrieved from https://salsa4.salsalabs.com/o/50772/images/SPANingNYSpring14_vol12no1.pdf

Ohlmeier, M.D., Peters, K., TeWildt, B.T., Zedler, M., Ziegenbein, M., Wiese, B.,…Schneider, U. (2008). Comorbidity of alcohol and substance dependence with attention-deficit/hyperactivity disorder (ADHD). *Alcohol & Alcoholism, 43,* 300-304. doi:10.1093/alcalc/agn014

Phillips, K.T., & Rosenberg, H. (2008). The development and evaluation of the harm reduction
    self-efficacy questionnaire. *Psychology of Addictive Behaviors, 22*(1), 36-46.
    doi:10.1037/0893-164X.22.1.36

Polit, D.F., & Beck, C.T. (2012). *Nursing research: Generating and assessing evidence for
    nursing practice* (9th ed.). Philadelphia, PA: Wolters Kluwer/Lippincott Williams &
    Wilkins.

Quinlan, D. (2003). Impaired nursing practice: A national perspective on peer assistance in the
    U.S. *Journal of Addictions Nursing, 14*, 149-155. doi:10.1080/10884600390245749

Quinlan, D. (2009). Peer assistance reaches its 25th year. *AANA Journal, 77*, 254-258.

Randall, D.M., Huo, Y.P., & Pawelk, P. (1993). Social desirability bias in cross-cultural ethics
    research. *The International Journal of Organizational Analysis, 1*, 185-202.
    doi:10.1108/eb028788

Rose, A.M. (1974). A systematic summary of symbolic interaction theory. In J.P. Riehl & C.
    Roy (Eds.), *Conceptual models for nursing practice* (pp. 34-46). New York, NY:
    Appleton-Century-Crofts.

Rüsch, N., Corrigan, P.W., Bohus, M., Jacob, G.A., Brueck, R., & Lieb, K. (2007). Measuring
    shame and guilt by self-report questionnaires: A validation study. *Psychiatry Research,
    150*, 313-325. http://dx.doi.org/10.1016/j.psychres.2006.04.018

Russell, K.A. (2012). Nurse practice acts guide and govern nursing practice. *Journal of Nursing
    Regulation, 3*(3), 36-42.

Sandelowski, M. (1993). Rigor or rigor mortis: The problem of rigor in qualitative research
    revisited. *Advances in Nursing Science, 16*(2), 1-8.

Scherbaum, C.A., Cohen-Charash, Y., & Kern, M.J. (2006). Measuring general self-efficacy: A comparison of three measures using item response theory. *Educational and Psychological Measurement, 66*, 1047-1063. doi:10.1177/0013164406288171

Shaffer, S. (1988). Attitudes and perceptions held by impaired nurses. *Nursing Management, 19*(4), 46-50.

Smith, G.B. (1992). Attitudes of nurse managers and assistant nurse managers toward chemically impaired colleagues. *IMAGE: Journal of Nursing Scholarship, 24*, 295-300. doi:10.1111/j.1547-5069.1992.tb00736.x

Snow, D., & Hughes, T. (2003). Prevalence of alcohol and other drug use and abuse among nurses. *Journal of Addictions Nursing, 14,* 165-167. doi:10/1080/10884600390245802

South Dakota Board of Nursing. (2015). *Course for nursing worksite monitors.* Retrieved from https://doh.sd.gov/boards/nursing/assets/FullCourse.htm

Stefanik-Campisi, C., & Marion, T.R. (1987). Case management and follow-up of a chemically impaired nurse. *Perspectives in Psychiatric Care, 24*, 114-119. doi:10.1111/j.1744-6163.1987.tb00292.x

Storr, C.L., Trinkoff, A.M., & Hughes, P. (2000). Similarities of substance use between medical and nursing specialties. *Substance Use and Misuse, 35*, 1443-1469. doi:10.3109/10826080009148225

Strauss, A., & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques.* Newbury Park, CA: SAGE Publications.

Strauss, A., & Corbin, J. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory.* Thousand Oaks, CA: SAGE Publications.

Substance Abuse and Mental Health Services Administration. (2013). *National expenditures for mental health services and substance abuse treatment, 1986-2009.* HHS Publication No. SMA-13-4740. Rockville, MD: Substance Abuse and Mental Health Services Administration. Retrieved from https://store.samhsa.gov/shin/content/SMA13-4740/SMA13-4740.pdf

Substance Abuse and Mental Health Services Administration. (2014). *Results from the 2013 national survey on drug use and health: Summary of national findings*, NSDUH Series H-48, HHS Publication No. (SMA) 14-4863. Rockville, MD: Substance Abuse and Mental Health Services Administration. Retrieved from http://www.samhsa.gov/data/sites/default/files/NSDUHresultsPDFWHTML2013/Web/NSDUHresults2013.pdf

Sullivan, E.J. (1987). Comparison of chemically dependent and nondependent nurses on familial, personal and professional characteristics. *Journal of Studies on Alcohol, 48*, 563-568. doi:10.15288/jsa.1987.48.563

Thomas, C.M., & Siela, D. (2011). The impaired nurse: Would you know what to do if you suspected substance abuse? *American Nurse Today, 6*(8), 1-5. Retrieved from http://www.americannursetoday.com/the-impaired-nurse-would-you-know-what-to-do-if-you-suspected-substance-abuse/

Trinkoff, A.M., Eaton, W.W., & Anthony, J.C. (1991). The prevalence of substance abuse among registered nurses. *Nursing Research, 40*, 172-175.

Trinkoff, A.M. & Storr, C.L. (1998). Substance use among nurses: Differences between

    specialties. *American Journal of Public Health, 88*, 581-585.

    doi:10.3109/10884609809041784

Trinkoff, A.M., Zhou, Q., Storr, C.L., & Soeken, K.L. (2000). Workplace access, negative

    proscriptions, job strain, and substance use in registered nurses. *Nursing Research, 49*,

    83-90.

Trossman, S. (2003). Nurses' addictions. *AJN, 103*(9), 27-28.

Tuckett, A.G. (2005). Part II. Rigour in qualitative research: Complexities and solutions. *Nurse*

    Researcher, 13(1), 29-42.

U.S. Department of Labor, Bureau of Labor Statistic. (2014). *Occupational employment and*

    wages, May 2014, registered nurses. Retrieved from:

    http://www.bls.gov/iag/tgs/iag62.htm#workforce

U.S. Department of Labor, Bureau of Labor Statistic. (2015). *Labor force statistics from current*

    population study. Retrieved from http://www.bls.gov/cps/cpsaat11.htm

Veatch, D. (1987). When is the recovering impaired nurse ready to work? A job interview guide.

    Journal of Nursing Administration, 17(2), 14-16.

Weegman, M., & Piwowoz-Hjort, E. (2009). 'Naught but a story': Narratives of successful A.A.

    recovery. *Health Sociology Review, 18*, 273-283. doi:10.5172/hesr.2009.18.3.273

Wennerstrom, P.A., & Rooda, L.A. (1996). Attitudes and perceptions of nursing students toward

    chemically impaired nurses: Implications for nursing education. *Journal of Nursing*

    Education, 35, 237-239.

West, M.M. (2003). A kaleidoscopic review of literature about substance abuse impairment in

      nursing: Progress toward identification of early risk indicators? *Journal of Addictions*

      Nursing, 14, 139-144. doi:10.1080/10884600390245721

White, W.L. (2008). Recovery management and recovery-oriented systems of care: Scientific

      rationale and promising practices. *Northeast Addiction Technology Transfer Center and*

      the Great Lakes Addiction Technology Transfer Center, 1-26. Retrieved from

      http://www.naadac.org/assets/1959/whitewl2008_recovery_management_and_recovery-

      oriented_systems_of_care.pdf

Wilens, T.E., Biederman, J., & Mick, E. (1998). Does ADHD affect the course of substance

      abuse?: Findings from a sample of adults with and without ADHD. *American Academy of*

      Addictions Psychiatry, 7, 156-163. doi:10.1111/j.1521-0391.1998.tb00330.x

Wilsnack, R.W., & Wilsnack, S.C. (2013). Gender and alcohol: Consumption and consequences.

      In P. Boyle, P. Boffetta, A.B. Lowenfels, H. Burns, O. Brawley, W. Zatonski, & J. Rehm

      (Eds.), *Alcohol: Science, policy, and public health* (pp. 153-159). Oxford: Oxford

      University Press.

Wilson, H., & Compton, M. (2009). Reentry of the addicted certified registered nurse anesthetist:

      A review of the literature. *Journal of Addictions Nursing, 20,* 177-184.

      doi:10.3109/10884600903078951

Windle, G., Bennett, K.M., & Noyes, J. (2011). A methodological review of resilience

      measurement scales. *Health and Quality of Life Outcomes, 9*(8), 1-18. doi:10.1186/1477-

      7525-9-8

Windle, P.E., & Wintersgill, C.L. (1994). The chemically impaired nurse's reentry to practice:

    The nurse manager's role. *AORN Journal, 59*, 1266-1273. doi:10.1016/S0001-

    2092(07)64891-1

World Health Organization. (n.d.) *Lexicon of alcohol and drug terms published by the World*

    Health Organization. Retrieved from

    http://www.who.int/substance_abuse/terminology/who_lexicon/en/

Wright, E.L, McGuiness, T., Moneyham, L.D., Schumacher, J.E., Zwerling, A., & Stullenbarger,

    N.E.N. (2012). Opioid abuse among nurse anesthetists and anesthesiologists. *AANA*

    Journal, 80, 120-128.

Wuest, J. (2007). Grounded theory: The method. In P.L. Munhall (Ed.), *Nursing research: A*

    qualitative perspective (4th ed.) (pp. 241-271). Boston, MA: Jones and Bartlett

    Publishers.

Young, L.J. (2008). Education for worksite monitors of impaired nurses. *Nursing Administration*

    Quarterly, 32, 331-337. doi:10.1097/01.NAQ.0000336732.02996.f7