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The Lived Experience of Nurses Working in a Modified Therapeutic Community

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THE LIVED EXPERIENCE OF NURSES WORKING IN A SECURE
MODIFIED THERAPEUTIC COMMUNITY

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of the requirements for the

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ABSTRACT

Today over one million U. S. prisoners are being held in federal and state systems for substance use-related crimes. The financial, social, and emotional costs have turned policymakers' attention to rehabilitation rather than incarceration. In an attempt to meet the challenge of recovery from addiction, prison systems around the nation have explored various options, including residential treatment programs. One such form of residential treatment is the modified therapeutic community (MTC) where inmates participate in a nine-month, cognitive-based treatment program. This model focuses on incarcerated individuals, addicted to substances, to assist them in developing behaviors to reduce antisocial peer associations and replace criminal thinking with prosocial alternatives. In the MTC, inmates, counselors, physicians, and nurses work closely together to form a very structured environment for treatment. Though this treatment has demonstrated positive outcomes for reducing addiction, studies do report nurses working in this environment suffer a high burnout rate. Nurses play a significant role in the MTC; however, previous studies indicate that nurses lack the knowledge and skills for this role. Based on an extensive literature review, little or no information exists on the effect this lack of knowledge might have on the nursing population.

This research undertakes a phenomenological inquiry to describe, interpret, and gain a deeper understanding of the nurses' lived experiences while working with prisoners that are rehabilitating from substance use disorders in a secure MTC. The research data was analyzed using Max van Manen's six research activities of hermeneutic phenomenology and Colaizzi's seven-step method of data analysis which operationalizes van Manen's approach. The question guiding this study is: What is the meaning and

significance of the lived experience of a nurse working in a secure modified therapeutic community?

Ten nurses from three MTCs participated in the study. The findings from the interview data analysis led to the development of a model depicting the fundamental structure of the overall essence of a MTC-A Pathway to Professional Identity which includes three major themes and a total of twelve subthemes. The information gathered in this study will be useful for nurses who are preparing to engage in work at a secure MTC and for nursing directors and administrators who will be supporting them.

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TABLE OF CONTENTS

ABSTRACT.....	iii
ACKNOWLEDGEMENT.....	v
CHAPTER I INTRODUCTION.....	1
Background and Significance.....	1
Definitions of Substance Use and Treatment Programs.....	2
Definitions of Participants.....	3
Problem Statement.....	3
Purpose of the Study.....	4
Research Question.....	4
Chapter Summary.....	4
CHAPTER II REVIEW OF RELATED LITERATURE.....	5
Prisoners and Substance Abuse.....	5
Modified Therapeutic Community.....	9
Brain-related Changes with Substance Abuse.....	13
Nurses Attitudes and Substance Abuse.....	16
Chapter Summary.....	18
CHAPTER III METHOD OF INQUIRY: GENERAL.....	20
Historical Foundations of Phenomenology.....	20
Max van Manen’s Approach to the Lived Experience.....	22
Phenomenological Activities Related to this Study.....	23
Research Plan.....	25
Participant Selection.....	25
Data Generation Methods.....	25
Data Analysis Methods.....	26
Ensuring Trustworthiness.....	27
Chapter Summary.....	28
CHAPTER IV METHOD OF INQUIRY: APPLIED.....	29
Participant Recruitment and Selection.....	29
Gaining Access.....	30
Privacy and Confidentiality.....	31
Informed Consent.....	32
Data Generation and Analysis Procedures.....	33
Data Generation.....	33
Data Analysis.....	34
Ensuring Trustworthiness and Authenticity.....	35
Chapter Summary.....	36
CHAPTER V FINDINGS.....	37
Description of Participants.....	37

Data Collection.....	38
Data Analysis.....	40
Overall Essence, Themes, and Subthemes.....	43
Essence of a MTC, A Pathway to Professional Identity.....	44
Chapter Summary.....	76
Cross-Case Analysis of Themes across All Participants.....	77
CHAPTER VI DISCUSSION AND INTERPRETATIONS.....	78
Findings as they Relate to Current Literature.....	78
Implications for Nursing.....	83
Limitations.....	86
Recommendations for Further Research.....	87
Chapter Summary.....	87
Conclusion.....	88
APPENDIX A	89
APPENDIX B	90
APPENDIX C	94
APPENDIX D	95
APPENDIX E	96
REFERENCES.....	97
CURRICULUM VITAE	103

CHAPTER I

INTRODUCTION

Background and Significance

Today over one million prisoners are being held in federal and state systems for substance related crimes (Federal Bureau of Prisons [FBP], 2012). The financial, social, and emotional costs have turned policymakers' attention to rehabilitation within the prison system rather than mere incarceration (FBP, 2012). Treating addiction requires attention to both biological and psychosocial aspects of the disease (FBP, 2012). Even when addressing these two areas, the path is not straightforward, and treatment outcomes vary among individuals. To further complicate the issue, medical, psychosocial, psychiatric, social, cultural, moral, and religious views of addiction have clouded the conceptualization of the phenomenon of rehabilitation. Relapse is also common, and it is not unusual for substance abusers to make several attempts to completely give up drugs before they succeed (FBP, 2012). From a medical perspective, once the person has reached detoxification, he or she is no longer addicted. Unfortunately, remaining free of substances is a complex journey. For this reason the underlying root of the addiction needs to be resolved so as to prevent relapse.

In an attempt to meet the challenge of addiction and recovery, prison systems around the nation began to explore alternative options for treatment (Chandler, Fletcher, & Volkow, 2009). One such option was the creation of residential treatment programs or therapeutic communities for substance use disorders (Chandler, Fletcher, & Volkow, 2009). Under the milieu of the modified therapeutic community (MTC), inmates participate in a 9-month cognitive-based treatment program. This model focuses on

prisoners learning behaviors to reduce antisocial peer associations, promoting positive relationships, increasing self-control, and replacing criminal thinking with prosocial alternatives. In the therapeutic community, inmates, counselors, physicians, and nurses all work closely together to form a very structured environment for treatment. Though this treatment has demonstrated positive outcomes for reducing addiction in prisoners, the literature suggests that nurses working in this environment suffer a high burnout rate (Knudson, Abraham, Roman, & Studts, 2011). With few trained nurses, it is not uncommon for these treatment programs to have lengthy vacated periods, creating a gap in the therapeutic community's ability to provide adequate coverage (Knudson, et.al, 2011). Since nurses play a significant role in the MTC, it is important to understand their experience of working with prisoners with substance use disorders when using this treatment approach.

Definitions of Substance Use and Treatment Programs

The following definitions of substance use disorder were used throughout this study:

Modified therapeutic community (MTC): an intensive, comprehensive, inpatient, residential treatment model developed to treat substance use disorders (Perfas, 2012).

The concept behind the MTC is to teach individuals how to function within society while living a sober lifestyle.

Substance use disorder: criteria of "substance use disorder" include repeated drug use in nonhazardous situations or recurrent occupational, educational, legal, or social problems caused by use of illicit drugs (Bureau of Justice Statistics, 2006).

Family member in a MTC: an individual who enters the MTC to rehabilitate from substance use disorder.

Definitions of Participants

The following definitions of participant groups were used in this study:

Nursing staff: registered nurses (RNs) with a full- or part-time position at a facility that uses MTC to treat substance use disorders.

Nursing director: an RN with a full-time position who directs nursing staff using MTC to treat substance use disorders.

Problem Statement

In an attempt to rehabilitate prisoners from substance use disorders while incarcerated, the MTC, a type of inpatient residential treatment program, was developed and has demonstrated good success (Chandler, Fletcher, & Volkow, 2009). This residential treatment program is nine months long and focuses on promoting a more holistic lifestyle, enhancing social, psychological, and emotional patterns of behavior. Nurses play a significant role in the treatment of individuals in this type of program. Unfortunately, there is a high turnover rate for nurses working in substance use programs, and a lengthy vacancy rate (Knudsen et.al, 2011). Given the importance of nurses in the MTC environments, it is important to explore the meanings and experiences of nurses as they have prepared for and moved into this unique profession of nursing. Little information or research has been done on nurses' professional experiences of working in a secure MTC. An in-depth inquiry into the nursing perspectives of working with prisoners in a secure MTC is needed to address the knowledge gap.

Purpose of the Study

The purpose of this phenomenological inquiry is to describe, interpret, and gain a deeper understanding of the experiences nurses have while working with prisoners who are rehabilitating from substance use disorders in a secure MTC. Treating prisoners with addiction using inpatient residential treatment methods, such as the secure MTC, is becoming a popular alternative to address the correctional needs of this specialized population. These facilities employ nurses to administer pharmacotherapies as well as physical and mental health care. Knudsen, Abraham, Roman, and Studts's (2011) documented study indicates high burnout for nurses working in this area. However, there is no documented research that analyzes the phenomenon from the nursing perspective. Since nurses play key roles in delivering these services, this qualitative research contributes to the science of nursing by providing better understanding of the meaning and significance of the lived experiences of nurses working in a secure MTC for substance use disorders.

Research Question

The main question used to guide this study is: What is the meaning and significance of the lived experience of a nurse working in a secure MTC?

Chapter Summary

This chapter provides a brief background for this research. Included is the purpose of the study along with the research question that guides this phenomenological inquiry from the perspective of a nurse working in a secure MTC. The operational definitions of key concepts were also included.

CHAPTER II

REVIEW OF THE RELATED LITERATURE

The review of literature provides previously conducted studies related to the purpose of this study. Specifically, the following areas will be addressed: prisoners and substance abuse, brain-related changes, MTC, and nurses' attitudes towards substance abuse. Sources accessed for this literature review include the electronic databases of Academic Search Premier, ProQuest, ERIC, and CINAHL.

Prisoners and Substance Abuse

The 1960s marked an era where drugs became the symbol of youthful rebellion and political dissent. Drug use skyrocketed and so did drug-related crime. In June 1971, President Nixon declared a "war on drugs". The Nixon administration strengthened its efforts against the sale, distribution, and consumption of any illegal drug (Moore & Elkavich, 2008). The unprecedented expansion of the "war on drugs," with the Ronald Reagan administration, marked the beginning of the extreme rates of incarceration (Moore & Elkavich, 2008). The "Just Say No" campaign set the stage for zero-tolerance policies on the use and sale of illegal drugs. Since 1972, the number of people incarcerated has increased five-fold without a comparable decrease in drug use or crime (Moore & Elkavich).

According to the National Institute of Justice, presently over one million prisoners are being held in federal or state systems (*FBP*, 2012). Of these one million, nearly three quarters are serving time for nonviolent offenses (Moore & Elkavich, 2008). According to the Bureau of Justice Statistics (2006) report from the Criminal Justice Data Improvement Program, nearly half of offenders in these federal and state prisons meet the

criteria for recent substance use disorder. The criterion of “substance use disorder” includes repeated drug use in hazardous situations or recurrent occupational, education, legal or social problems caused by use of illicit substances (CJDIP, 2006). The repercussions of years in the prison system are substantial. Incarcerated men and women who serve sentences for drug offenses are left with little or no social support when released. Many find it difficult to find legitimate employment because of their felony record and lack of social and life skills (Moore & Elkavich, 2008). Meanwhile, the cost of incarceration has skyrocketed. The estimated taxpayer cost for each offender is \$20,000 to \$30,000 annually (Danzer, 2012).

Since offenders have increased likelihood of substance use disorders, treatment of these individuals provides a great opportunity to decrease repeated offenses and their impacts. The magnitude of the financial, social, and emotional costs of drug-related crimes has led policy makers to pursue a number of strategies in response to this escalating situation. Chandler, Fletcher, and Volkow (2009) assert the failure to treat offenders who are addicted to drugs is a missed opportunity to simultaneously improve both public health and safety.

However, transitioning to healthier and more effective treatment methods has proved difficult. Prior to the 1970s, there was an ideology based on previous studies that rehabilitation in prisons would not work (Marks, 2002). Attempts to reintroduce drug treatment programs in prison were crushed again in the 1980’s “tough on crime” political environment and by a dominant belief of ‘punishment’ rather than ‘treating’ (Marks, 2002).

Beginning in the 1990s, attitudes began to change in Europe and in the United States, allowing a new drug policy to emerge due to the mass numbers of drug-related crimes (Marks, 2002). Another contributing factor was the successful results of the treatment programs in Canada that challenged the “nothing works” mentality (Marks, 2002). As a result, the number of inmates in drug treatment programs has steadily risen since 1997 (Center for Substance Abuse Treatment, 2005).

Various studies have repeatedly demonstrated the benefits of these treatment programs. Substance use disorder treatment in prison has shown to greatly reduce the risk of recidivism among offenders with drug abuse histories (Anglin & Hser, 1990; Hubbard et al., 1984; Wexler et al., 1988; Wisdom, 1999). Twenty years ago, the Federal Bureau of Prisons (FBOP) came on board by implementing its current drug abuse strategy that offered substance abuse treatment and drug-abuse education in each of the 117 FBOP institutions (*FBP*, 2012). All inmates with drug-related charges are minimally required to take a drug abuse education course (*FBP*, 2012). Therefore, a referral to the drug abuse treatment program is made for all inmates identified to have a drug use problem (*FBP*, 2012).

In 2011, the Office of National Drug Control Policy (ONDCP), added a new action item to improve the treatment of substance use disorder in prisons (*FBP*, 2012). One such improvement was to increase inmate participation in residential drug abuse treatment programs. The Residential Drug Abuse Treatment Program (RDAP) was originally developed in 1989 based on evidence of that time. There are presently sixty-two FBOP institutions that operate RDAP (*FBP*, 2012). These programs include staffing by a doctoral-level psychologist who can supervise the treatment team. The ratio of drug

abuse treatment staff to inmates is 1 to 24 (*FBP*, 2012). Treatment is provided for a minimum of 500 hours over nine to 13 months based on research that indicates efficacy of treatment length (*FBP*, 2012). Also, inmates are housed separately from other inmates who are not participating in the residential program. The FBOP has established a unified process for inclusion in the RDAP. Inmates meeting the criteria for a substance use disorder may voluntarily sign an agreement to participate. Participants are informed of the behaviors and expectations expected of them for successful completion of the RDAP. Treatment staff emphasizes the program's primary purpose is to treat the drug abuse, not to provide an early release from the prison system (*FBP*, 2012).

The premise of the RDAP is based on Cognitive Behavior Therapy (CBT) which focuses on learning behaviors to reduce anti-social peer associations, promote positive relationships, increase self-control and self-management, improve problem-solving skills, end drug use, and replace lying and aggression with pro-social alternatives (*FBP*, 2012). The units themselves operate under a therapeutic community creating mini-societies where attitudes and behaviors, thoughts, and feelings, connectedness and alienation are viewed as if under a magnifying glass (*FBP*, 2012). Each person in the mini-society is everyone else's mirror so that participants are able to view themselves from other perspectives, which are usually very different from the behaviors that led to incarceration.

Chandler et al. (2009) report individuals who participate in prison-based treatment are seven times more likely to be drug free and three times less likely to be arrested for criminal behavior than those who do not receive treatment. Offenders in treatment use far

less drugs, work more and effectively pay more tax dollars, and commit fewer crimes (Marks, 2002).

As a result, some states are responding to the methamphetamine epidemic with the creation of “meth prisons” designed after RDAPs. These prisons are dedicated exclusively to inmates addicted to methamphetamine. The Montana Department of Corrections operates two “meth prisons”: an 80-inmate unit for men and a 40-inmate unit for women (Campo-Flores & Skipp, 2006). Illinois also has two “meth” facilities housing 200 inmates each. These facilities demonstrate a 50% decrease in recidivism rates from graduates compared to that of groups in the regular prisons (Campo-Flores & Skipp, 2006). The theory behind these intensive programs is to isolate participants from non-participating convicts in hopes of decreasing behaviors that feed into the addiction, such as criminal thinking. The treatment includes group counseling, individual therapy, seminars, and family and life skills. Drug treatment has proven to be significantly more effective at reducing drug-related crime, demand for drugs, and the demand of public resources (Hohman, 2000).

Modified Therapeutic Community

One example of the RDAP is the concept-based MTC, a model for treating clients with addictions and personality disorders. The MTC model began in Britain during the Second World War to treat traumatized and mentally ill British soldiers. This movement came to North America in the 1950s and was known as the Synanon Movement. This theoretical treatment of drugs and alcohol was the first of its kind and debunked previous beliefs that addicts were not able to rehabilitate. The concept-based MTC gradually

evolved and was adopted by the criminal justice system. Today, many prison systems are using an MTC to treat the multifaceted issues of addiction.

The purpose of an MTC is to form a community of current drug abusers who help each other recover and remain abstinent from drugs. This compelling form of treatment relies on the power of the group or community for healing and support. Much of its theoretical underpinnings are borrowed from Bandura's (1986) notion of reciprocal determinism. The three factors governing the theory are the person's characteristics, behaviors, and how the environment impacts human learning within his or her social context. The goal of the MTC is to help the addicted person quit drugs, develop a drug-free lifestyle, and mature as an individual (Perfas, 2012). Unlike programs of the past, the client does not have to rely solely on the therapist as treatment provider. The evolved approach promotes self-help among the members who are called "residents" or "family members" and members of the therapeutic team. This approach requires the member to develop a dual-role as participant and therapist. The formation of the MTC is distinct from the operations of most communities in the outside world. The success is based on its selection of members, established standards for hierarchy, and strict rules and regulations. Members of this society are drug-addicted individuals, many of whom spent years learning how to navigate the social structure of the prison system. Criminal drug offenders' are constantly challenged by the MTC's strict adherence to morality and accountability to encourage responsible concerns toward their peers. The ultimate goal is to inoculate a moral sensibility and to increase the capacity for empathy and the feeling of guilt resulting in the development of a socially accepted pattern of behavior and value system.

Often the staff working in the MTC is under scrutiny by the family members. Teamwork and mutual respect are two important values that underlie the working relationship between the members and staff. Unlike the multidisciplinary model, nurses functioning in this role are not limited to dispensing medication, but they may be called upon to facilitate a meeting or help implement clinical interventions (Perfas, 2012). Staff members of the MTC must be willing to give and receive feedback in group meetings and participate in the life and activities of the MTC (Perfas, 2012). To achieve a sense of community cohesiveness, the MTC generally holds a daily meeting that all members, including nurses, attend to deliver and accept affirmations (Perfas, 2012).

The physical environment, even in a prison-based MTC, creates a feeling of home that is absent in a traditional correctional environment. The goal is to remove all semblance of the prison experience and set a standard of behavior that is family oriented. This highly structured environment is a result of adherence to a daily schedule. Each family member has a specific role and responsibility similar to most families: chores, laundry, and homework. The structure provides predictability and purpose, with the intention to help participants delay their impulse for immediate gratification. The most fundamental key to success is establishing small successes by accomplishing the tasks established in this highly structured setting (Perfas, 2012). The rules are meant to help guide the family member. Any violation of the rule is meant to be addressed first by the members of the community and next by the staff, possibly resulting in termination from the program and, thus, a return to prison. In the MTC, inappropriate behavior is addressed by peers through an accountability-promoting concept called the learning experience (LE). For example, if a family member continually fails to make his bed, he

or she may be asked to provide orientation to a new family member on how to properly make a bed. Should the newcomer fail to make the bed as expected, both the family member and the newcomer will be held responsible. To acknowledge the inappropriate behavior, violations range from additional chores to having to stand up in front of the other family members and admit his or her wrongdoing. This is sometimes the first time the person has taken accountability for his or her own actions. Even though violations must be recognized and addressed when they occur, much of the program's emphasis is rewarding positive behavior by earning a privilege. Examples of a privilege include walking around the facility without an escort, making a phone call, purchasing items from the community store, and being able to wear street clothes.

The MTC is a process that involves developing increased self-awareness about the issues that have influenced the user's history of drug abuse. The program's creators recognized this and therefore developed phases for recovery. Each phase has its own set of objectives and tasks to be demonstrated before the participant can officially move into the next phase. The literature supports the phasing system as an important component of this highly structured program. An Australian study of 225 ex-residents of a MTC found that the amount of progress made during the program was a greater indicator of success than the length of time spent in treatment (Toumbourou et al., 1998).

Several studies have examined the effectiveness of the MTC on prisoner recidivism. Most studies have examined the effectiveness and outcomes of MTC by examining the numbers of dropouts and program graduates with a control group. Indiardi et al. (2004) reported that offenders are 15–20 times more likely to remain drug free than those who did not participate in an MTC. One longitudinal study reported that

participants from an MTC are four times more likely to have remained drug free for 60 months after prison release (Indiardi et al., 2004).

Because of increased numbers in drug-related crimes, the Kentucky Department of Corrections expanded its treatment program to include an MTC in each of its institutional settings (Stanton-Tindall, McNeese, Leukefeld, Walker, Thompson, Pangburn, & Oser, 2009). The state of Kentucky initiated an outcome study to evaluate the treatment plan's effectiveness. Findings indicate the percentage of the 700 participants of prison treatment who reported any substance use following prison release plummeted from the baseline of 94.1% to 43.9% after the establishment of the MTC. (Stanton-Tindall et al., 2009). Another longitudinal study also supports the MTC mode, Wexler, Melnick, Lowe, and Peters (1999) examined the Amity TC program at a California-based prison and found an increase in sobriety 36 months following release from prison.

Brain-related Changes with Substance Abuse

A great challenge faced during treatment is the high correlation of substance use disorder and co-occurring mental illness. Le Fauve (2005) reports that four million adults in the U.S. have a serious mental illness coupled with a substance use disorder. Specifically, 20% of those with any substance use disorders have at least one mood disorder, 18% have at least one anxiety disorder, 29% of individuals have a current alcohol use disorder, and 48% of those with a drug use disorder have at least one personality disorder (LeFauve, 2005). Findings indicate illicit drug use is more than twice as high among persons with a serious mental illness as those without (LeFauve, 2005). Women tend to have even greater challenges; compared with incarcerated men,

women inmates are more likely to have co-occurring psychiatric disorders, higher levels of emotional disturbance, more psychological problems, lower self-esteem, more severe substance-abuse histories, and a higher likelihood of taking prescribed medications for psychological problems (Mosher & Phillips, 2006).

Addiction is composed of biological, psychological, and social components requiring multifaceted treatment. These addictive substances cause cravings and physical symptoms of withdrawal in their absence. Drug usage creates a feeling of euphoria and provides refuge from various psychological emotions. Not all drugs lead to physical dependence; however, they all have similar potential for causing uncontrollable, continued use because of their ability to alter the neurobiological process of the brain.

Addiction to methamphetamine is one such example of this process.

Approximately one quarter of incarcerated inmates claim to have been under the influence of methamphetamine during their crimes (BJS-Meth, 2006).

Methamphetamine use leads to a high level of the chemical dopamine in the brain. The increased release and blocking of dopamine reuptake is a common mechanism of action for most drugs that are abused. This ability to release dopamine quickly to the brain's cortical levels produces the intense "euphoria" that leads to its highly addictive nature. An emerging body of literature reflects how methamphetamine use interacts with the chemistry and structure of specific regions in the brain. Thompson et al. (2004) revealed several anatomical changes related to chronic methamphetamine abuse. Specifically, their analysis of magnetic resonance imaging (MRI) revealed significant atrophy and structural abnormalities throughout the cingulate gyrus and the right anterior cingulate.

This specific area of the cingulate cortex had the most robust deficits and contributes to emotional function, depression, anxiety, and cravings (Thompson et al., 2004).

When evaluating the brain MRIs of chronic methamphetamine abusers, London et al. (2004) found a neurobiological base accounting for mood disturbances in methamphetamine abusers. This evaluation confirmed that anatomical changes are present in the anterior cingulate, middle and posterior cingulate, and the orbitofrontal cortex positively correlating with high levels of self-reported depression and anxiety (London et al., 2004).

Recently, Yin et al. (2012) demonstrated increased activation to the anterior cingulate cortex and prefrontal lobes when addicts watched methamphetamine-cue images. Participants also indicated having increased cravings concurrently. Yin et al. (2012) stated these cravings create a powerful motivational state that drives users to seek continued use of methamphetamine. Newton, De La Garza, Kalechstein, Tziortzis, and Jacobsen (2009) reveal cravings and “pleasure-seeking” behavior as the two biggest reasons for relapse. Findings also indicate these responses are heightened during periods of stress (Newton et al., 2009).

Due to the compulsive nature of the drug, its use becomes the organized principle of its users, often rendering them dysfunctional in their social and psychological functioning. The changes to the brain are varied but will hamper the user’s abilities to process information to develop cognitively. Drug offenders often present a set of attitudes, beliefs, and mentality referred to as “criminal thinking.” This type of thinking leads to a sense of entitlement and is often driven by antisocial thinking. This often provides the justification to deny any personal responsibility. A strong belief that he or

she was treated unfairly drives his or her identification as a “victim” and rules out in advance a defiant and adversarial stance with other members of society.

Nurses Attitudes and Substance Abuse

Illicit drug users rely heavily on healthcare but can be a challenge for nurses to care for. Ford, Bammer, and Becker (2008) examined the therapeutic attitude of generalist nurses in Australia towards patients using illicit drugs. This cross-sectional survey of 1,605 general nurses indicates that nurses are struggling to complete their professional obligations to care for patients using illicit drugs. Most of the nurses recognized their role of caring as legitimate, but 25% noted a lack of education as the reason for not fulfilling this professional obligation. It was also reported that as disapproval of illicit drugs increased, therapeutic attitude decreased (Ford, Bammer, & Becker, 2008).

Monks, Topping, and Newell’s (2012) qualitative, grounded theory study explored the dissonant care management of drug users by nurses in an acute care setting. Data collection used 41 semi-structured interviews from medical-surgical nurses at nine medical wards in England. By analyzing data using constant comparative analysis, two subcategories emerged: “Lack of knowledge to care” and “distrust and detachment” together forming the core category of “dissonant care” (Monks et al., 2012). Challenges nurses face when working with patients with known substance abuse include a potential to interpret patient reports of discomfort as drug seeking therefore tending ignore patient requests for treatment (Monks et al., 2012). Studies conducted on nurses’ attitudes toward drug users (Carroll, 1995; Carroll, 1996; Chan et. al. 2008) have focused on determining the inherent contradictions in attitudes held by the nurse but did not address

how this could factor into the therapeutic community for patients seeking addiction treatment. The results of Monks et al.'s (2012) grounded theory suggest a lack of educational preparation, aggression, untrustworthiness, attitudes and experience of conflict will negatively impact the nurse–patient relationship in an acute-care setting. Nurses discussed a feeling of distrust when interacting with patients and reported limiting the amount of time and interactions with the patients who used drugs compared with the non-using, acute-care patients (Monks et al., 2012). Nurses also stated that a lack of knowledge about illicit drugs caused them to avoid discussions about any other drug-related issues not directly involved with the admitting diagnosis to the hospital (Monks et al., 2012). In contrast, three of the subjects disclosed having a personal experience with a friend or family member who had used illicit drugs. These RNs viewed their drug-using patients as people, as opposed to offenders, tending to display an empathetic behavior toward them. It reported the relationships between the nurses and their patients appeared to be less dissonant and more congruent with the ideology of caring in the profession of nursing (Monks et al., 2012).

Nurses working in an MTC must be knowledgeable of issues related to substance use disorder treatment. Nurses must have updated information regarding human behavior and addiction and be competent in evidence-based practices. A complete knowledge of co-occurring disorders and pharmacological and non-pharmacological treatment options is also essential. The training, though, needs to extend further for nurses working with family members from the prison system. These clients with more serious psychological problems often suffer from various mental health issues. The users' history and involvement in a criminal lifestyle, insufficient family income, or limited employment

history require that a different skill set be utilized when working with these individuals. Perfas (2012) stated knowledge of the core functions of substance abuse treatment and knowledge of the treatment needs of the criminal drug offender are the basic requirements health care professionals should have to work within this environment. Proficiency in criminal thinking, relapse prevention, trauma and substance abuse, co-occurring mental disorders, motivational interviewing, stages and processes of change, assessment and treatment planning, cognitive-behavioral interventions, and gender issues is highly recommended (Perfas, 2012).

There is little research regarding the nature of the nurse's roles in the MTC however; Knudsen, Abraham, Roman, and Studts's (2011) exploratory study examined the nurse turnover within substance use programs. Interviews with treatment program administrators reported a voluntary turnover rate was greater than 15%. The majority of the administrators stated difficulty in filling this vacant position: the average time was greater than 2 months. Despite the importance of nurses in the delivery of substance use disorder treatment, little has been published about the lived experience of the nurse in the treatment workforce.

Chapter Summary

New treatment options are emerging due to the increase in drug-related incarcerations. Left untreated, these highly addictive drugs result in high incidences of relapse and recidivism for those abusing them. The effects on the individual's brain and emotional development create challenges for successful recovery. MTCs address the cognitive delays of the individuals as well as the biological and psychological components of drug addiction. Nurses play a significant role in an MTC; however,

previous studies indicated that nurses lack the knowledge and skills for this role. Nursing turnover in substance use facilities is high, but few studies have investigated the lived experience of working in this environment.

CHAPTER III

METHOD OF INQUIRY: GENERAL

Phenomenology is the study of the lifeworld (how one lives and experiences) and aims to gain a deeper understanding of the nature or meaning of our everyday experiences (van Manen, 1990). Using the phenomenological approach of Max van Manen, this study explored the meanings of the lived experiences of nurses working in an MTC with prisoners recovering from methamphetamine and other substance use disorders. Nursing is a practice discipline based on caring, and the insights gained through the use of van Manen's (1990) stance and approach can help uncover the internal meaning of lived experiences. Phenomenology is based on the philosophical premise that it is possible to capture the meaning of the experience and create a better understanding of a phenomenon or experience. This method is useful for interpreting empirical evidence on nursing practices that supports and enhances the ways patients respond to the many challenges in their health care setting (Houser, 2012).

Historical Foundations of Phenomenology

Since Galileo, the preferred methods to study natural science have been detached observation, controlled experiments, and quantitative analysis. In contrast, self-reflection, critical analysis, and description are the preferred methods to study human science. The phenomenological movement began around the first decade of the 20th century and consisted of three phases: Preparatory, German, and French. The preparatory phase, dominated by Franz Brentano (1838–1917) and Carl Stumpf (1848–1936), worked to establish the concept of *intentionality*. “Intentionality means that consciousness is always consciousness of something” (Streubert & Carpenter, 2011, p. 75). The second

phase, the German movement, was led by Edmund Husserl (1857–1938) and Martin Heidegger (1889–1976). Husserl believed that philosophy should become a rigorous science claiming a foundation of phenomenology that would restore contact with deeper human concerns. Husserl emphasized the importance of describing the structure of the lifeworld and sought to find concepts to best describe human experiences. Three major concepts, *essence*, *intuiting*, and *phenomenological reduction*, were developed during this phase.

Essences are the concepts that give common understanding to the phenomenon under investigation and can emerge by themselves or in relationship to one another. The essences provide meaning of actions by different individuals in the same setting or by the same act in different settings. This can be demonstrated in the nursing literature by Schwarz's (2003) study that explored how nurses experience and respond to terminal patients' request for assistance in dying. The same setting resulted in a continuum of experiences from nurses' refusal to providing varying types of direct aid. *Intuiting* is the accurate interpretation of the meaning of the description of the phenomenon under study (Streubert & Carpenter, 2011). This concept requires the researcher to imaginatively vary the data until a common understanding of the phenomenon emerges. The concept of *phenomenological reduction* is the process of "bracketing" one's preconceptions to experience the "essence" of the phenomenon in its pure form (Cohen, 1987). Heidegger closely followed the workings of Husserl to lay the hallmark of the hermeneutic perspective which established the importance of interpreting the underlying meaning.

The phenomenological movement entered its third phase in the early 1900s in France (Cohen, 1987). The work of Husserl and Heidegger was continued by the French

philosophers Merleau-Ponty (1905–1980), Marcel (1889–1973) and Sartre (1905–1980), which then evolved into phenomenological existentialism (Streubert & Carpenter, 2011). During this phase of the phenomenological movement, the concept of “being in the world” or embodiment through the individual’s perspective was added (Streubert & Carpenter, 2011). Four existential lifeworlds to facilitate inquiry, writing, and reflection were added by Merleau-Ponty. This addition evolved this pure philosophy into the phenomenological method (Cohen, 1987).

Max van Manen’s Approach to the Lived Experience

“Perhaps the best answer to the question of what is involved in a hermeneutic phenomenological human science research method is ‘scholarship’” (van Manen, 1990, p.29). van Manen (1990) considers hermeneutic phenomenology to be a descriptive and interpretive form of human science. According to van Manen, an advantage of his approach is the possibility of being in more direct contact with the world and gaining plausible insight by uncovering and describing a structure of the phenomenon in its truest essence (van Manen, 1990). Each experience is both descriptive and interpretive; however the essence of interpretation is inherent in the process of symbolically capturing the phenomenon. If the description is sufficiently described in language that captures the essence, it will “reawaken or show us the lived quality and significance of the lived experience in a fuller and deeper manner” (van Manen, 1990, p.10). The aim of phenomenology is to start with the lived experience, transform it into a textual expression of essence, and end at phenomenological research. If the textual expression is written in such a way that the effect is reflexive, the reader will powerfully animate something meaningful in his or her own lived experience (van Manen, 1990).

The concept of reflexivity is significant in that phenomenological research is a self-critical human science that continually examines its own methods of evaluating the structures of meaning of the lived human world (van Manen, 1990). It is the researcher's responsibility to formulate questions which create reflection from the collected information. Hermeneutic phenomenological research is the search for the fullness of living with its highest aim to "become more fully who we are" (van Manen, 1990, p.12).

van Manen claims the pursuit of becoming fully aware is systematic (van Manen, 1990). He considers the hermeneutic phenomenological method to be the interplay among six activities: (a) turning to a phenomenon that seriously interest us; (b) investigating experiences as we live it rather than as we conceptualize it; (c) reflecting on the essential themes; (d) describing the phenomenon through the art of writing; (e) maintaining a strong pedagogical relation to the phenomenon: and (f) balancing the research context by considering parts and the whole (van Manen, 1990, pp. 30–31).

Phenomenological Activities Related to this Study

van Manen's six activities, the basis of the hermeneutic phenomenological method, were employed in the study of the experiences of nurses working in a therapeutic community for substance use rehabilitation. Phenomenological reduction is a process developed by Merleau-Ponty. This process of awakening the senses of wonder about the phenomenon will begin this research process. Next the researcher will reflect on potential expectations that may prevent the phenomenon from truly emerging. Third, conceptions from science and other theories will be abandoned to gain the spontaneous surge of the lifeworld. Fourth and finally, complete reduction will occur whereby the researcher will see beyond this lived experience to gain universal essence "returning to the world as lived

in an enriched and deepened fashion” (van Manen, 1990, p. 185). van Manen is clear to point out that complete phenomenological reduction not possible but encourages researchers to come to terms with the assumptions rather than attempting to forget the known. Open-ended questions utilized in the research study are designed to encourage the participants to share thoughts freely. Thus hoping to capture reflections on essential themes of the nurses’ lived experience of working with substance abuse in the therapeutic community. The researcher strived to capture what makes this different than working in other types of nursing environments.

The lived world as experienced in everyday relations becomes the exploration of the structure of the human lifeworld, the premise of the phenomenological research method. To guide in this reflection, van Manen offers four fundamental lifeworld existential (a) “spatiality” or lived space; (b) “corporeality” or lived body; (c) “temporality” or lived time; and (d) “relationality” or lived human relations (van Manen, 1990, p. 101). Spatiality may be considered “perceived space” describing the ways we experience our daily existence and feelings about space (van Manen, 1990). Corporeality refers to the physical or bodily presence in the world (van Manen, 1990). Temporality refers to our relationship to the world and subjective time (van Manen, 1990). Relationality refers to how interpersonal interactions with human are maintained within the confines of human space (van Manen, 1990). Although each fundamental lifeworld existential has its differentiation, they cannot be separated.

In order to be convincing and powerful, the final activities are an integral part to van Manen’s method. The phenomenological text must be oriented, rich, deep, and strong (van Manen, 1990). The goal is not to oversimplify but to maintain a strong

orientation to evoke a response from the reader. According to van Manen, artful writing will reveal “action-sensitive” knowledge leading to tactful thoughtfulness that helps nurses understand themselves (van Manen, 1990). The researcher will include quotes from nurse participants and detailed anecdotes to display emotions and feelings.

Finding balance between the parts and the whole is the final activity in van Manen’s hermeneutic phenomenological method. This procedure is not specifically outlined, however van Manen (1990) suggests researchers periodically step back to assess the big picture and work with data from a thematic perspective.

Research Plan

Participant Selection

The guiding principle of sample selection in the phenomenological method is that all participants must have experienced the phenomenon (Polit & Beck, 2008). Because the participants must also be able to articulate the lived experience, researchers employ a criterion sampling method, when selecting the sample. It is not uncommon for the sample size to be small however; collection continued until saturation was achieved.

Phenomenologists tend to rely on a very small sample of participants- typically 10 or fewer (Polit & Beck, 2008). In order to gain perspective of the lived experience, nurses from three similar facilities two male and one male and female, were asked to participate.

Data Generation Methods

The researcher used hermeneutic interview for data generation. In this method the researcher is the primary instrument for collecting data (Houser, 2012). van Manen (1990) suggests developing a conversational relationship with the participant about the meaning of the experience when using hermeneutic interviews. Beginning questions with

“what is it like” was suggested by van Manen (1990) as a way to gather data and develop relationships. van Manen (1990) encourages researchers to use probes such as “Can you think of a time?” to elicit personal stories and anecdotes from the participants. “There is less concern with the facts of the experience than for the meaning these facts hold for the people experiencing them” (Houser, 2012, p. 434). A general interview guide using suggested van Manen probes was developed for data collection, but the process of the interviews was guided by the nurses who have experienced the phenomenon of working in a therapeutic environment.

Data Analysis Methods

Hermeneutic phenomenology research involves constant comparative analysis and multiple iterations. This involves the researcher moving in and out of the data collection and analysis process. The process begins with the researcher asking a question or series of questions designed to lead to the essence of the lived experience. The process continues until the researcher reaches saturation at which time there are no new ideas and insights emerging from the data. Instead, the researcher sees strong repetition in the themes he or she has already observed and articulated. The process of analyzing the data involves three levels or types of coding. The first is open coding where the researcher begins to segment or divide the data into similar groupings and forms preliminary categories of information about the phenomenon being examined. Second is axial coding, when the researcher begins to bring together the categories she has identified into groupings. These groupings resemble themes and are generally new ways of seeing and understanding the phenomenon under study. Last is selective coding, when the

researcher organizes and integrates the categories and themes in a way that articulates a coherent understanding of the phenomenon of study (Streubert & Carpenter, 2011).

Data collection, analysis, and interpretation occurred simultaneously, in keeping with phenomenology methodology. After each recorded interview, the transcript was manually transcribed onto a personal computer, providing an opportunity for identifying themes as the tape was transcribed. Following transcription, a printout was obtained and the tape replayed making notes onto the transcripts. Memoing included making comments about tone of voice, recurrent themes, and the researcher's own initial thoughts and feelings about the nature and significance of the data. The transcripts were reread and codes assigned to recurrent themes using the constant comparative method, first for open codes, then axial codes, then selective codes. The final step was to return to the participants for an interview to validate the findings with any new themes integrated into the final product.

Ensuring Trustworthiness

Every attempt was made to analyze the study and present findings based on the standards established by Guba and Lincoln (2000). The recommended criteria to establish reliability and validity are credibility, dependability, confirmability, and transferability (Guba & Lincoln, 2000). To ensure credibility, the researcher spent a prolonged engagement with the participants to support an in-depth analysis, test interpretations, and analyze results for misinformation or misinterpretations. The purpose of combining the data collection methods is to provide a more holistic and improved understanding of the phenomenon under study (Streubert & Carpenter, 2011). Peer debriefing was also be utilized as an external validity check by reviewing the researcher's

results with her advisor and committee members. The measure of dependability was validated using simple agreement from the subject that, in fact, the essence and meaning have been captured. An inquiry audit was used to assess both dependability and confirmability of the analysis. The researcher provided thick descriptions of the setting and process during the study to allow judgment about the context of the data to demonstrate transferability.

Chapter Summary

This chapter provided an overview of the historical foundations of phenomenology. Max van Manen's hermeneutic approach to phenomenology was then discussed, followed by an explanation of the method that guided this study. The chapter continued with a description of the methodological considerations of data collection and analysis. The researcher also discussed the theoretical underpinnings and description of ensuring trustworthiness and authenticity.

CHAPTER IV

METHOD OF INQUIRY: APPLIED

Participant Recruitment and Selection

After Institutional Review Board (IRB) approval, purposive sampling was used to recruit participants from treatment programs using the modified therapeutic treatment approach in a Rocky Mountain Region. According to Polit and Beck (2008), purposive sampling is intended to recruit a sample that will benefit the study the most.

Phenomenologists tend to rely on samples of 10 or fewer; (Streubert & Carpenter, 2011) so the researcher had set an initial goal of recruiting at least 10 participants. However, interviewing nurses who hold the range of experience in the MTC and reaching saturation was considered more important than the predetermined number of participants for this study.

The inclusion criteria that were used for the sample selection include (a) Registered nurses (RNs); (b) currently working full- or part-time in an MTC; and/or (c) nursing director of a facility using an MTC approach. Licensed practical nurses were the only excluding criteria for this study.

The selection of the institutions with experienced nurses working in MTCs was designed to promote rich descriptions from participants who have the knowledge and experience. Participants were recruited from three institutions to include two all-male and one mixed gender facility to provide a broad spectrum of the nurses' experiences. The current staff at these facilities included thirteen RNs, however; three nurses were out on medical leave. The inclusion criteria of "currently working" is consistent with van Manen's (1990) intent to gain insightful hermeneutic interpretations requires

retrospective reflection of the current experience. Nurses currently working in this environment were able to provide detailed descriptions of what it is like to work in the environment rather than relying on memory of the experience.

Gaining Access

Protection of Human Subjects. The researcher obtained approval from the IRB of the University of Nevada, Las Vegas and received written permission from the appropriate administrator at each of the facilities from which participants were recruited. The participants signed written consent to participate.

Recruitment. Using online search engines, the researcher identified institutions in this Rocky Mountain State which utilize the MTC. The researcher reviewed the websites and identified three rehabilitation programs in the state where RNs are employed and actively engage in the MTC. The researcher contacted the administrators of the institutions and used a snowball sampling technique to initially identify any other treatment facilities in the state. All programs identified were already on the researchers list of three.

As a first step in the recruitment process, the researcher sent a letter and e-mail about the study to the program administrators. The body of the message explained the purpose of the study, the eligibility criteria, an offer to answer questions relating to the study, details of the study, and researcher's contact information. A recruitment flyer was also included as an electronic attachment and hard copy sent via the United States Postal Service. Administrators were asked to share this information with all RNs and nursing directors currently employed in their facility. According to Houser (2013), this is known as a "hidden" population because random selection is not likely for this sampling frame.

This sample, however, represents a substantial part of the healthcare delivery system and Houser (2013) states there are few statistical differences in outcomes between samples recruited through a carefully planned purposive sampling method versus a random method. “Although true randomized sampling remains more likely to result in a representative sample, when dealing with hidden populations or difficult-to-recruit samples, a thoughtful, carefully-executed purposive sample may generate results that are transferable” (Houser, 2013, pg.195). With logistics, travel, and financial considerations in mind, the researcher made contacts by region and continued until saturation was achieved. All of the participants agreed to participate in the study and were contacted via phone to answer questions about the study procedures, verify eligibility, and arrange a time for the face-to-face interview. The participants were also asked to complete a consent form prior to this interview.

Privacy and Confidentiality

After obtaining written consent, the semi-structured face-to-face interviews were conducted using a digital tape recorder at a mutually accepted, comfortable and private location. Each setting had a closed door with only the researcher and participant in the room. The researcher had a second digital tape recorder activated as a back-up in the event mechanical malfunction occurred. Both recorders were in plain view of the researcher and participant.

The consent forms were carried in a secured accordion-style portfolio, and the recorders were transported in a small box with a locked closure devise. All items were stored in a bag kept close to the researcher while she was traveling from institution to home via private vehicle during the interview process. All electronic information was

stored on a password-protected private computer, and any printed data was kept in a locked cabinet in a locked office. After the digital audio file was uploaded to the computer, the original file was erased from the tape recorder. The audio recordings were transcribed by the researcher in a private room while wearing headphones. After data analysis all documents will be kept at UNLV for the three-year storage time and will be destroyed in compliance with the UNLV IRB requirement.

Participant responses were coded on the demographic questionnaire, recordings, transcriptions, and field notes by the researcher. The participants and facilities were given pseudonyms in the written analysis, and no references have been made that could lead to participant identification.

Informed Consent

The researcher obtained written informed consent for participation in the audio-taped interview prior to the interviews. The researcher ensured that the Health Insurance Portability and Accountability Act of 1996 (HIPAA) were followed and that participants' rights were protected at all times during the study. No patient, participant, or facility names are mentioned in this study. All names were redacted in the transcripts. If the description is very clear in the quotes, some of the descriptors have been changed (like the crime or drug used) to protect anonymity. All participants were informed that participation is strictly voluntary and that no repercussions for nonparticipation would be employed. Confidentiality was maintained at every phase of the study. The participants were notified that they have the right to refuse to answer any question on the demographic questionnaire or any posed in the interview process. Participants were informed that they could withdraw from the study at any time.

Data Generation and Analysis Procedures

Data Generation

After written informed consent was obtained, the participants were asked to complete a demographic questionnaire. There were five items intended to provide the researcher with an overall demographic depiction of the each participant: gender, age, ethnicity, years of nursing and in what areas, and educational level. Other questions regarding experience working in an MTC were also asked to obtain a snapshot about the participant's lifeworld in the context of the study. Because relationality with drug users was addressed in the interviews, the researcher is interested in knowing whether the participants have also worked in areas that do not use MTCs. The participants had the opportunity to ask the researcher for clarification of any items.

After completion of the questionnaire, the researcher verified that the participants were ready for the interview to begin. The researcher used two audio-recorders which were turned on after receiving participant verification of readiness. The researcher began the interview using questions that guided the study as well as probes when needed. The researcher mainly focused on listening, acknowledging, and noting verbal and nonverbal cues while making field notes when needed about the behavior and demeanor of the interviewee. At the conclusion of the interview, the researcher reiterated there would be a follow-up contact to validate the accuracy of the interpretations and descriptions of the interviews to enhance credibility. Field notes and journaling were also used to reconstruct body language, demeanor, and observations of the researcher that cannot be discerned from the recorded transcript. The notes and transcripts formed an "audit trail" for this phenomenological inquiry.

Data Analysis

van Manen's (1990) philosophical approach combined with Colaizzi's (1978) application method of phenomenological analysis was used to strengthen the process of data analysis. All interview recordings were transcribed verbatim by the researcher during the data collection process. Data analysis and data collection in the phenomenological method occurred simultaneously to identify when data saturation had been achieved. The transcripts were analyzed using the following procedures:

Reading all descriptions. The researcher first read all of the transcripts to gain a general feeling for them. The researcher then read the participants' narratives multiple times to obtain a sense and understanding of the participants' ideas. This step encouraged the researcher to immerse herself in the data. The researcher kept a journal of thoughts, feelings, and ideas that transpired during the reading of the transcripts.

Extracting significant statements. In accordance with Colaizzi's (1978) method, the researcher then extracted significant statements from the participants' narratives that directly pertained to the nurses' experiences working in a MTC. Repetitious statements in the manuscript were noted. All of this was hand coded as the researcher is a novice to qualitative research. Data was then reread completely, statements were circled, and categories were highlighted from the transcripts to extract meaning of the experience.

Formulating statement meanings. In this stage, the researcher studied each individual word, sentence, and phrase to discern meaning from the participants' statements regarding their experiences in working in a MTC. The researcher looked for commonalities and differences in the transcribed statements and field notes.

Organizing formulated meanings into theme clusters. According to van Manen (1990), words and phrases that are similar to all of the transcript constitute a theme. Clusters of themes were formulated into meanings after verifying completeness of the original transcripts. The researcher looked for any discrepancies or gaps in the themes.

Formulating a description of the fundamental structures of the phenomenon. The researcher identified the fundamental structure of the phenomenon by clustering individual essences into a cumulative level. This was done by formulating exhaustive description of the phenomenon under study.

Validating finding with participants. The researcher then contacted the participants to ask them to validate the findings. As the final validation stage of data analysis, the researcher returned to the participants for one last interview to extract views on the essential structure of the phenomenon under study. The transcribed interview was also distributed to each participant via e-mail for verification of content and meaning. Each participant was contacted by phone to inquire if they wish to provide any corrections to the text or to clarify any misinterpretations.

Ensuring Trustworthiness and Authenticity

To enhance the rigor of the study, Colaizzi's (1978) methods were used to ensure trustworthiness and authenticity. The researcher used the following methods to enhance these qualities of the study.

Credibility. The researcher manually transcribed the interviews and used member checking with the interviewees after transcription. The researcher also dialoged with the dissertation committee chair regarding the analysis during the study.

Dependability. The researcher kept a written audit trail of all records to include locations, times, dates, and observations made during the study. The audio recordings were kept as digital files to provide documentation of accuracy of the transcripts throughout the study. The transcripts were also sent to the interviewees for their review.

Transferability. The researcher used thick and detailed descriptions as well as a purposive sampling method to enhance transferability of the results.

Confirmability. The researcher used an audit trail to carefully document how the researcher arrived at her conclusion.

Authenticity. Through the use of purposive sampling, obtaining informed consent, and honoring the guidelines established by the UNLV IRB, authenticity was enhanced. The interview probes encouraged participants to share both the positives and challenges of working in a MTC. Truthful participants, accurate recall of events, and the ability to deeply reflect are the assumptions of the study.

Chapter Summary

This chapter presented the methods for protection of human subjects, privacy, confidentiality, and recruitment for the study. The approach to data generation, collection, and analysis using van Manen's and Colaizzi's methods were also discussed. Explanations of methods to enhance trustworthiness and authenticity were also explained.

CHAPER V

FINDINGS

The purpose of this hermeneutic phenomenological study was to describe, interpret, and offer insight into the meanings of the lived experiences of nurses in MTCs across several facilities in a Rocky Mountain region. The research question that guided the study was the following: What is the meaning and significance of the lived experience a nurse working in a secure modified therapeutic community? This chapter will describe characteristics of the nurse participants and the data collection and analysis procedures through which the findings were revealed. The overall essence, themes, and subthemes of the participants' experiences are captured from the nurse narratives and presented in a diagrammatic representation.

Description of Participants

A total of 10 RNs participated in the study. The participants worked in one of three secure MTCs from a western region in the continental U.S. Nine of the participants were female, and one was male. The age of the participants ranged from 20 to 59 years. Three were in the 20 to 29 age range, four were in the 30 to 39 age range, two were in the 40 to 49 age range, and one was in the 50 to 59 age range. The length of time the participants have been nurses ranged from one year to 29 years, with an average of 7.4 years in nursing. Six participants held bachelor's degrees in nursing, and four of the participants held associate's degrees in nursing. The total number of years of experience in working in a secure MTC ranged from one year to nine years. The participants had an average of 2.5 years of experience in a secure MTC. All but one nurse had previous

nursing experience elsewhere, primarily on acute care. Individual participant profiles are included in Appendix F.

Data Collection

The interviews were conducted in June and July of 2015. Each participant chose a private setting for the interview, and the location choices included four participants' offices at the facilities, five at the researcher's office, and one at the researcher's home. The follow-up phone interviews were conducted from the researcher's private home with no one else present.

Each of the participant's choice of location was private and appropriate for the interview. The furniture varied across the settings, with some having a table and several chairs, some having a desk and two chairs, and one having a kitchen table and several chairs. The venues ranged in size from a small office that was approximately eight feet in both length and width to a large kitchen estimated by the researcher to be 24 feet by 20 feet. The researcher and participant sat facing or diagonally from each other at the tables and desks with the two digital recorders placed centrally. No significant distractions occurred during the interviews, and the researcher turned off the ringer on her cellular telephone. One participant had to briefly stop to speak with a staff member at the facility, but this did not disrupt the flow of the interview.

The administrator of two of the facilities provided me with seven participant numbers after giving them the study flyer and agreeing to provide me with their contact information. One nurse director provided me with four contact numbers at one of the facility sites after she spoke directly to them and obtained permission to provide me with the contact information. The researcher contacted each potential participant directly via

the phone to discuss the purpose of the study, the method, the consent process, and to decide on a time and place to conduct the initial interview. After agreeing to be in the study, the researcher emailed each participant the consent to read prior to the interview date. One of the potential participants was willing to participate but elected not to because she was going on medical leave. Interview time and place was mutually decided upon, and written consent was obtained prior to starting the data collection. Participants' consent occurred in the following manner: Each participant was given the consent form and allowed five minutes to read it privately. The researcher then asked if there were any questions and answered any questions the participant might have after reading the consent form. The participant was reminded that the study was voluntary and that he/she could withdraw from the study at any time without penalty. The consent form was then signed with a copy provided for each participant.

Each participant completed a demographic questionnaire that took an average of three minutes to finish. The researcher explained that participants' disclosure of answers was voluntary and that they could decline to answer any or all of the questions. All of the participants chose to complete the questionnaire in its entirety. None of the participants asked clarifying questions about any of the demographic questionnaire items. After participant completion, both the consent form and the questionnaire were placed into the accordion file, and the closure was secured and placed back in the researchers' tote bag.

In order to build a rapport and put the participant at ease, an open dialogue about their summer and family was held prior to the start of the interview. This usually lasted between 5 to 10 minutes. The researcher asked each participant if he or she was ready to begin the interview. When he/she acknowledged "yes," the recorders were turned on and

the researcher stated, “We are now recording.” To establish rapport, provide context, and serve as an ice-breaker, the researcher initiated the interview by asking each participant what it means to them to be a nurse in a secure MTC. To answer the question that guided the study, the researcher then proceeded to use open-ended questions and probes to explore the meanings and feelings associated with the experience of being a nurse in a secure MTC (Appendix E). Prior to ending each interview, the researcher asked, “Is there anything else you would like to share about your experience?” Once the participant offered that he/she was finished with his/her thoughts, the researcher stated, “This concludes this interview,” and the recorder was turned off.

Follow-up meetings were conducted in July 2015. These communications were performed through phone conversations based on scheduling and availability of both the participant and the researcher. These follow-up meetings and communications were used to clarify any errors of the verbatim transcription, allowed participants an opportunity to add any additional thoughts and rectify and misinterpretations of the researcher regarding the themes. All 10 participants who started the study completed the study.

Data Analysis

Each of the interviews was transcribed personally by the researcher onto a Microsoft Word document. The researcher’s data analysis procedure was guided by Colaizzi’s (1978) method for phenomenological inquiries. van Manen’s (1990) four lifeworlds guided the researcher’s theme reflection throughout data analysis.

Creating initial impressions. The researcher listened to each tape recording and wrote down her initial thoughts and reactions into the field note journal. The researcher then created a verbatim transcription while listening to each recording a second time.

Once transcribed, the transcription was read while listening to the audiotapes to verify the accuracy of the transcript. The researcher read the narratives multiple times to obtain a sense of ideas and to gain an understanding of each participant's story. This step helped the researcher to become immersed in the data. Once again, thoughts, feelings, and ideas that occurred during the reading of the transcript were logged into the researcher's journal.

Extracting significant statements. The researcher reread each transcript while manually highlighting key statements, passages, or paragraphs. Each of the 10 interviews produced between four to 16 pages of single-spaced transcription. For each significant word, statement, or phrase, the researcher formulated meanings. Statements from expressed feelings, passages that characterized relationships and anecdotes from participants' stories that captured the essences of the nurses' lived experience were used as examples and therefore marked for inclusion in this analysis.

Formulating meanings. The researcher reread the highlighted areas of text that had been extracted and made manual notations in the margins about possible underlying, broad meanings of the statements or narrations. For example, when one participant said, "On acute care we can treat their pain on what they tell us; here we can't" the researcher interpreted the meaning of the statement as "dissonance of care." The researcher diligently avoided imposing causality or theory and instead remained focused on formulating meanings that had connections to the data. The broad meaning interpretations were manually compiled as a list for each protocol. Every effort was made to ensure that each formulated interpretation remained connected to the participants' original statements.

Creating theme clusters. The researcher then reviewed each list of meaning interpretations to identify emerging common themes. Each transcript protocol was reread in its entirety, and, during this step, the collective formulated meanings were organized for likenesses; through this process, clusters of themes were developed. During this review, the researcher validated the presence of themes within the protocol and made note of other themes that may not have been captured during the previous read. The themes were assigned a unique color, and the researcher highlighted the transcript to facilitate ease of identification of the participant and the page and line number to allow the researcher to organize the data. At that point, the researcher noted patterns and relationships within the themes and subthemes that began to emerge. Being mindful of Colaizzi's recommendation, even the text that was not highlighted was reread to avoid ignoring themes that did not initially seem to fit with the others.

Integrating themes clusters into an exhaustive description. The researcher wrote the name that had been given to each theme on a card and placed them on the wall in the researcher's office. The cards were rearranged several times until they captured the overall essence of the nurses' experience as revealed from the participants' narratives about their experiences in a secure MTC. The essence was then entitled "Essence of a MTC-A Pathway to Professional Identity."

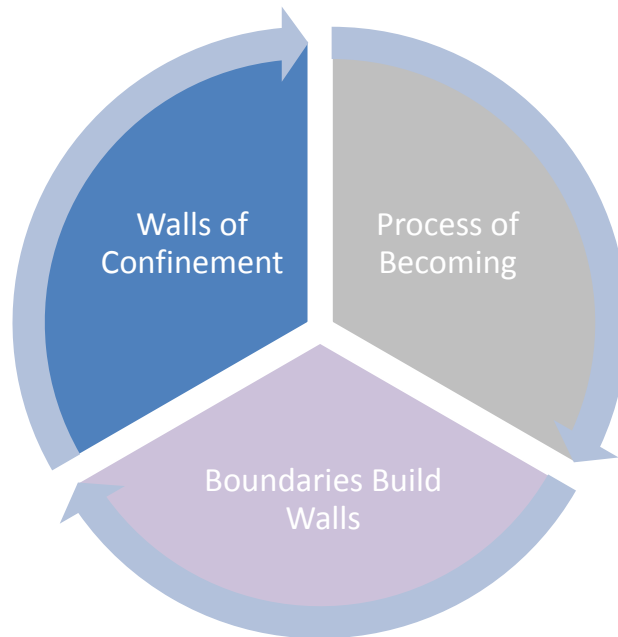
Identifying the fundamental structures of the phenomenon. The researcher noted that the final arrangement of the theme and subthemes cards elucidated the fundamental structure of the nurses' experiences. These three themes and twelve subthemes were arranged in a multidirectional diagrammatic representation of how the nurse participants experienced becoming a MTC nurse. (Figure 1) Of note, in order to

ensure the researcher's approach, the verbatim transcriptions were returned to each participant. Participants were asked to validate the researcher's interpretations of emerging themes as a form of member-checking (Lincoln & Guba, 1981). This validation from the participants helped to ensure that the researcher's interpretations represented their point of view even though the data had been analyzed through the interpretive lens of the researcher.

Overall Essence, Themes, and Subthemes

The researcher identified three main themes that reflected the nurses' experiences while working in a secure MTC. The themes include: (1) the process of becoming; (2) boundaries build walls; and (3) the walls of confinement. The three were delineated into subthemes, which contributed to the overall essence of a MTC— *A Pathway to Professional Identity*. The essence and themes are depicted in Figure 1. This model depicts movement as well as the connection that exists between the themes. Although occurring at various times throughout the MTC, each of the participants experienced these points along their professional pathway to reach identity.

Figure 1. Essence of a MTC—A *Pathway to Professional Identity*



Process of Becoming	Boundaries Build Walls	Walls of Confinement
<ul style="list-style-type: none"> • The community • Manipulation burns • Criminal thinking • Trust the system • Giving up the glory 	<ul style="list-style-type: none"> • Shutting down • Relationships break-up • Don't give an inch 	<ul style="list-style-type: none"> • Dissonance of care • Care in the system • Isolation • Rewarding

Theme: The Process of Becoming. This main theme arose from the researcher asking “Tell me what it means to be a nurse in a secure MTC?” Each participant shared his/her experiences behind what it is like to work in this unique profession of nursing. They all discussed having no experience or training that was helpful in this unique nursing profession. The participants talked about how they were not able to draw on their

past experiences to help them in the progression as well. Much of the process was learned from the staff, inmates, and trial and error. Part of the learning process is recognizing the manipulative ways of this patient population. Many of the participants note the greatest learning experience was the outcome of falling for manipulation and their repercussions that ensue. The nurses also felt like starting in this position ended their role as “center stage” of patient care. In time, the nurses stated giving up their role as a nurse was easier if they learned to trust the system of the MTC. Those reasons gave rise to five subthemes (1) the community; (2) manipulation burns; (3) criminal thinking; (4) trust the system; and (5) giving up the glory.

Subtheme: the community. This subtheme emerged as the ten participants discussed the meaning of their relationship with the family members, counselors, security, and administration at their respective MTC. Many of the nurses discussed a feeling of unease when dealing and caring for inmates, a very different patient population than their previous work history. Much of the intimidation is eased by knowing they have the support of security personnel. The communication between all members of this community seems to be a vital component to keep things running smoothly. Most of the nursing staff felt they had full support from the members of the community, but many state this relationship was not automatic. There seems to be a sense of unease when new members are brought into the community, and everyone is watched until trust is developed. Many of the participants stated it takes approximately one year before new staff are truly accepted into the MTC. The following excerpts are offered.

Kind of uneasy. You know you are really relying on your security and you don't know a lot about the people, what they have done. They are not murderers, but they are addicts and it's very uneasy to see them walking single file with security all around them and you only have a radio. It's uneasy too when they do come into

medical and when you are one on one sometimes by yourself. It is intimidating. You don't know why there are here and what they have done. Some of them have been drug addicts with violent behaviors, so I always took full advantage of security. As time went on you did get to know them, but I always called security to come down if I didn't know some person which I do quite often. (Mary)

Security protects their medical staff very much. They know that we are the women. They know we are the most vulnerable to these men who have not seen or touched a woman in years. They know that we have that soft compassionate side that they know they will eventually get out. We want to know more about them. How they got into the situation they got, what about their family. It's hard not to know that stuff. (Barb)

I feel like we have a really good working relationship with all of our staff. We all communicate a lot - communication to have that consistency for the family member. Every case is different, and you have to treat them all differently case by case. We have guys come in here that can't read and write so we have to do things differently for them. We work really close with all of the security, treatment, mental health. We are always talking.... We work really close with security. We are not allowed to do assessments on your own so you always have a 2nd staff member. That is a new rule that has taken effect in the last couple of years. If there are not two nurses in here we always have security come down and they are always really good when we call. They see far more than they want to see because sometimes we have to do assessments that they are not ready for. But I feel like we have a really good relationship with all staff. (Sarah)

The other departments joke with the guys. Spend a lot more time with the guys. I feel like the medical is watched more closely. I don't know if it is because we are all women and they have had bad history with the medical department. The other staff are watching. I feel like a guard is put up high in the beginning. (Molly)

What I was told coming in as the new girl, the people that I work with don't make me feel like they are watching me but they are. But just because I am the new female, I am sure that I am watched a lot. You know, making sure that I am not interacting more than I should be with the inmates.... For example, my first weekend on my own as a nurse I was in eating lunch, and I was really slow eating and two guys sat down at the table and instantly my adrenaline shot up and I just got up and left. I took my food back to medical and ate inside. I am like, 'oh my god I am so mean'. That is not it. It wasn't because I was afraid of what the guys would think. I was just afraid. I was afraid of the staff saying, 'hey your new nurse is having lunch with the guys.' (Molly)

... when I first came here, it's like a lot of these people have been working with these guys with behavioral problems for a long time, so they are possibly game players and seeking. So I think when a new staff comes in, they already have a raised eyebrow: "what is this person about?" Everyone that works here are so

used to working with inmates that they almost look at new staff that way until they get a real feel for who they are. It took about a year before I got on board with everyone and they were like o.k. he is here to stay and he is not a weirdo. (Tom)

On the staff side is what I didn't expect. I expected to be welcomed with open arms, and when I wasn't I was like this is insane..... It's the staff that waits for a while to see if the real person comes out; because you know you can only hide for so long before your true personality comes out so they are just waiting. They have been working with inmates and the DOC for so long and have been burned by them so many times that they even apply it to the new staff. I noticed that after the year mark hit that is when they seemed to accept me. I get tons of support then from the whole building, but that was not how it was when I started. (Tom)

Now, if the security was like 'hey Kris watch out for this,' I know that they would probably do that. But as far as the security goes, they have to have their reservations too until they get a feel for us just the same as the other guys because one single staff could bring a facility like this down. (Kris)

The thing is, you are analyzed for the first couple of months. But that is how we all are. That's how I am when new staff comes in. You do, you just become like that in this kind of facility. When you are working with criminals you try to read people, and you learn to read people before you let them in. You definitely have to prove yourself. But like in acute care as long as you are doing your nursing skills, and as long as you are doing your nursing job. Here, it's everything other than your nursing job that you get watched for. You get watched for if you do gravitate towards wanting to be around the guys; that is what they watch you for. That really and truly will make or break your job. It's funny that you can lose your job for being too social even if you do your nursing job. That is what is crazy about it. That is the thing. Not only are you watching everyone, but everyone is watching you. So, if you are having a bad day or something like that, it's very much everyone is watching everyone. Everyone is watching every single move. When you go to a hospital you can almost be invisible sometimes. A lot of times nurses are able to be invisible. Here, you are not invisible - especially a female staff in an all-male facility. You cannot be invisible. As much as you try, you can't be. (Kris)

Subtheme: manipulation burns. Developing relationships with staff is a way for the inmates to gain "something". The "something" could be extra time in their room, so they do not have to go to therapy otherwise known as a "lay-in". The "something" could be receiving medical assistance even when proper communication protocol was not

followed. Or, the “something” could be extra attention from a staff member. Nurses tend to give patients extra attention in most areas of nursing, but, in the MTC, extra attention can lead to staff splitting, manipulation, and “getting burned” due to the inmates’ criminal thinking behaviors. Five of the participants identified getting burned by the inmates was common but leads to learning the necessary skills of what it takes to last in this profession. They say this process is unfortunate but helps to pave the way to build attributes important for working with incarcerated individuals in treatment.

Because I got caught, everyone gets hooked. When I first started here, I had a guy come down and said ‘I can’t talk to you anymore,’ and that was the hook because I was like, ‘why, why can’t you talk to me anymore?’ And at the same time it was right when I started. I was butting heads with some treatment staff, trying to figure it out because I have never done this type of nursing before. So I asked him about it. Well, he was told by treatment to not even say anything, so he told me. I went and talked to someone else and got this whole ball rolling. Here, it ended up he was trying to hook me so he could get out of his write up and get on my good side. I have a good rapport with everyone. He got in trouble by treatment and was trying to split staff by coming to nursing, he was trying to hook me, and he did hook me. (Tom)

Well, the one time when I first started I had a guy that would come in at med pass, and he was having a hard time...come in crying, and I would ask if he wanted to talk about it, and he got in the habit of coming in here wanting to talk. Well, he wouldn’t talk to the other counselors, and then security saw this pattern. I didn’t really realize his pattern, and then I realized he was just trying to form a relationship. No lines were ever crossed, but I truly thought I was helping him out just cuz he really wanted to talk and he was only talking about what was going on with his dad, wife, and kids. To me it was all therapeutic, the treatment part, but umm...and then it was almost every single night. And then it was like...shoot now we are in trouble. I got talked to by corporate. It was tough because that was when the nurse from another facility just got in trouble for having relationships, and that is our corporate so they were dealing with that. Here I was a brand new young nurse, and I had to sit down with corporate, and they were digging down at my character and I was just sitting there with tears ready to just flow. They don’t even know me at all, but three years down the road I 100% understand where they were coming from. I do. (Kris)

The training really had nothing to do with all of the little details. The training was the med pass, the communications, the daily duties. Really, the daily duties can be done in an hour here. But that’s the thing. It is not until you are alone, that the

real things happen because the guys don't ask the questions that they are not supposed to ask, and they don't start saying 'well can I get a lay-in from you? Can I wear shower shoes? Can I get this from you?' They don't ask that until you are alone. So those are things you don't learn until you are alone. To begin with, I remember I gave a lay-in to a guy in the middle of the day because he said his back hurt. He was in here crying and everything like that, then staff called a couple hours later. Did you really put so-and-so on a lay-in? Yeah. He is in so much trouble right now. Yeah, he played you. So the nice thing is some of the staff here are really good at realizing that, and they allow you to make the mistake and they let you know. But some of them sit back and let you do the mistakes, and they just take notes. That is probably in any facility. (Kris)

Another nurse who came here, I know one reason she was burned out was because she was a very sweet, caring person. It was not anything against her character but the guys would flock to her. Like when I work on the weekends I only get a few communications. But when she would work, she would get loaded with communications because that is what they want the sweet, nice, caring nurse. And when they came in she would be nice to them. I am sure that probably burned her out along with staff starts to pull away from you. The staff would pull away from her because they felt like she was pulling the facility down because she is letting these guys manipulate her. If you don't get that coldness about you, and you are not ok with it, this would be a miserable job. It would be miserable. (Kris)

Sometimes the wool gets pulled over our eyes and then you think 'I should have listened to my gut'. But I trusted them that one time, and then the wool gets pulled. There are times - it doesn't happen too often because we are usually on the same page - that I trusted them and later have therapy come down laughing saying, 'Well he just pulled one over on you,' and it's like 'Dang it!' (Sarah)

I think I came to a breaking point with one gal. Every day I would get all of these communications when I would work, but the other nurses didn't. The inmates put them in for me because they knew I was the nice easy nurse. And finally I came to a spot where it was like NO I am not helping these people by giving them everything that they want all of the time. I didn't want to be known as the "easy and kind one". The nurse that they go to get something I didn't want to be that anymore. So with this one gal I was just all of the sudden I was like 'No I am not going to do it anymore!' Then it became easier and easier to do it. You know, when you learn to start saying no to people it does get easier after a while. (Jodi)

It's easy to listen to them and fall for their stories only to find out that what they tell you is not true. That was an eye opener in the first two weeks. I had a situation where one of the guys said his pregnant wife was killed in this car accident. He always seemed sad to me. I did. I fell for it. He would come in for a mental health day and you would try to console him and do the best that you can only to find out that he was an intoxicated driver, it was meth actually, and HE hit

a woman that was pregnant. There was no relation! It's easy to fall for their stories. I think the biggest problem was his guilt, but he twisted it so I would feel bad for him when ultimately it wasn't his story. They are master manipulators. (Mary)

Subtheme: criminal thinking. In this subtheme, seven of the nine nurses talked about learning the ways of thinking like a criminal. This did not apply to the crimes on the "street" but to the potential of crime and danger in a secure treatment facility. Several of the nurses said nursing school did not prepare them for this aspect, but they are learning from the inmates and staff at the facilities. The new knowledge causes nurses to even change their way of dress and demeanor as a means to be protected from the criminal mind. Nurses learn quickly to be wary of a compliment. Compliments are generally a form of manipulation in a MTC and a way for inmates to find an inside angle to get what they want.

None of my nursing education applied here. We did psych in nursing school, but this is not the same kind. It would be helpful to have had a class geared specifically toward this, even just criminal interviewing. You have to change the way you ask questions here. In typical nursing, they are open-ended, trying to get people to answer. Here, it's simple yes or no's because, if you give them a chance to talk, they will twist it in every way because they are experts in doing that. So, you have to change your whole thinking with them. A class geared towards that would be very helpful. (Mary)

Even you usually trust people to take their meds. But over time you get burned and do more mouth checks than when you started. They try to abuse anything. Even if they can't get a high from it they still try to pocket their pills or find some way just to get away with it. (Mary)

I learned very quickly to wear long sleeve shirts under my scrub top because they do eye you and make comments. So I tried to draw as little attention of myself as possible. It even got to the point that I wouldn't wear makeup when I was there. I wouldn't do my hair. It was intimidating, yes. Cuz a lot of those guys are big guys, and getting back to that a lot of them are violent offenders. It is intimidating. (Mary)

Treatment does a lot of training with the criminal thinking, and pretty much all that I learn is CEU's on the drugs. Honestly, coming in there I ask the family

members. They say a drug name, and I don't know what that is. I don't know how much is too much like they say 'an 8 ball.' I had to ask what that was because my drug lingo was nonexistent. But they have taught me, because they know it better than any of us. I have had guys tell me how they have snuck drugs into other facilities in the past so I take that info to security and say FYI. Like Ciboxalone they were sneaking it in by putting it behind envelope stamps. Their family members would send in these letters to the inmates. They had soaked them in this paper and then they would put it behind an envelope stamp. The inmates would peel off the stamp and they would put it on their tongue to get a high. So I took it to security and said, 'hey here is another way.' And when the new Nike shoes came out with the chip that you can take out - the Nike ID out- you can take that out and put Styrofoam over the top and put the sole back on it, and no one would even know what would be in it. So I took that to security. We learn a lot from the guys but they are telling us that. They will tell you in the past they have used it in coloring crayons. Mixed it with crayons, melted it down. Their kids would make them a picture, send it in, and they would get high from coloring crayons from their kids pictures. If some of these guys would apply what they know as a chemist, they would be very successful because some of their ideas. It is so sad that it is wasted. Some of them are so smart, and I tell them go out and do something. 'You guys are leaders here. Go out and do something. You can be a leader. It's not too late.' (Sarah)

I mean, I don't think you ever want a compliment, and you just feel uneasy about it. Like today, I had my Bobcat shirt, and one guy was like 'I really like your shirt,' and it was probably because it was a cat shirt. But these guys are looking for something. That is what we are told - not to give them a lot of information about you. Because if they are like 'I like the cats,' then every time they come in here they strike up a conversation about bobcats or something. They try to find the similarities, so they complement you and try to figure out your thing. Compliments, I don't like compliments. I don't like being complimented here in any way shape or form. It's just because you don't know the angle (Kris)

Well you give them meds, you watch them take it. But you are constantly thinking 'Are you going to throw these meds back up?' 'Do you have them in your cheek?' Cuz when they do, they have to hold their hand up; they have to have a clear glass. You feel like you are babying them the whole time. We have had guys here that the reason we had to go to clear glasses was because he was spitting meds back into the cup; and at that time we were not having them show us their cup, so we are just constantly trying to figure out all these things out. Just little things like that and when they have a smirk on their face and you are like Ok what is going on? (Kris)

I don't really interact with them too much because, with the element that we deal with, we get a lot of grooming behavior. They might come up to you and say that is a nice coat. The majority of them that is how they have been raised to get what they want. So they are grooming you to get on a 1:1 basis to make you feel good

about yourself, and then they start asking for more and more. So you have to really have really good boundaries. There is nothing wrong with joking around and taking some in return, but you have to know when to say 'hey, that is enough,' because you get it a lot. (Tom)

There are so many drugs that are being sold online now. These guys are doing that now. These guys are not stupid. If they put half the motivation into their life as they did seeking they would be so successful and millionaires. We had a wife bring in deodorant, and the security took it. Well then, later she brought in some sensodyne, and when it was taken apart there was a straw in it with a roll of dope. It goes far beyond just these guys when you have their family and kids supporting the behavior. In Colorado, they found a drone that had crashed that was loaded with cell phones and drugs that had crashed right outside of the prison. They are not stupid. (Tom)

Cuz even like a simple compliment, we are not supposed to let them go there with us or even acknowledge that stuff. But it is also a therapeutic community. That part is hard. (Molly)

Subtheme: trust the system. Part of becoming a nurse is to learn and trust the system it operates on. Much of the system of a MTC was foreign to nurses to begin with. When asked the question how they experienced the process of becoming a nurse in a MTC, many of the nurses discussed abandoning much of what shaped them in their training and previous employment. Accepting the role to maintain the inmates' physical health allows them to continue to work on the most important aspect of the inmates' stay, their mental health. The maintenance of health does not always allow for a nursing intervention, though. Learning to help the inmates work through uncomfortable times without medical treatment can be a challenge. The nurses talked about their feelings of having to adhere to rules which are incongruent, at times, with nursing practice for the good of the program.

...that was really hard for me when I started to not get caught up in that they are in pain, and we have to do something right away. It doesn't have to be instant gratification. That is what they have gotten all of their lives, and that is why they want to continue to get it here. Nothing is a real crisis usually. Once in a while

we have something that is bad but you can take the time to look, get their records, do some investigation, and talk to their previous provider, check with our doctor. Maybe all they need if they are having anxiety is to talk to their counselor rather than give them a bunch of meds. We are their first line because they sometimes think we are easy and will give them a pill to fix everything. We try to....it has taken me awhile to just put my foot down and say no we are going to try something else first, you don't need everything immediately, you don't need your meds increased right away. (Jodi)

You have to teach them how to take care of themselves and not just their drug and alcohol problem. And, when new inmates come in we say we are not here to take care of you, we are here to help you learn how to take care of yourself. I have to be this way for the good of the program. (Jodi)

I would get nervous and afraid that they would get upset, and now I just don't care if they get upset because a rule is a rule. I am really black and white when it comes to the rules here because I feel like the rules are the rules and you follow them. The guys will say to me, 'but it was just a small rule'. But it says it's a rule, and if you are willing to break the little rules here, the little rules turn into big rules, and that is how you end up in correctional. That is why when we have them, we enforce them, and we tell the guys that 'You are on these mental health meds for a reason if you are not willing to take them as directed here than you will not take them as directed when you leave.' And that is the whole point of it. We are not going to waste our time, your time, and money if you are not going to be compliant. (Sarah)

I guess making sure they are staying healthy? Cuz here I am pretty sure I think it says, 'Giving minimal medical care,' and it pretty much is making sure they are healthy throughout their treatment program because their main concern while they are here is to get through the treatment program in the healthiest means. So, but in the same sense, we can only offer minimal care. So if it comes to something that they need for long term treatment, we can't take care of them here: they have to go somewhere else. Because if it's medically something they need for long-term care they can't be here because they are pretty much filling up a bed. Their main priority is therapeutic, so you are basically trying to get them through the nine months, being healthy so they can go to therapy. (Kris)

Umm, the roles we have in medical - sometimes they seem so simple. To me, sometimes they seem so dumb sometimes, but to them they have to be like that. Just like yesterday, I had a guy get a bottle of Aleve. But right on their thing, they can't have it over 125 ct. His bottle was 130. So then you are coming into like, should you let it slide? But you have to follow the rules black and white. They ask if you can take some out so they can have it. But no, you have the paper, and you are the ones that tell your family what you can and can't have, and it's your responsibility. Sometimes little rules are frustrating. But that comes with the

accountability. You let that slide and all of the sudden you open a can of worms. It's nice because our rules are written down, there are expectations and guidelines but they are constantly trying to figure out a way to get around the rules.(Kris)

As far as my role in here, it is to hold them accountable on the daily things. Cuz if they know they can pull everything over in medical, then they are not getting their therapeutic part. So, as long as they are holding them accountable in the medical field with their meds, we are holding them accountable. We are not giving them a place to get all of their criminality out. (Kris)

It's just like here we have two med times that they know it is when they can get over-the-counters. I will have guys at noon coming down for Tylenol with a killer headache. And I say, 'no' and I feel bad, but I explain it to them, 'Hey if I do it for you, I have to do it for everyone,' and they understand and walk away.... You need to trust the process that the rules are here for a reason. At any other place we could give it to them. But these guys they have never had to follow the rules. So you have to trust the process and learn to not feel bad. My main focus is to work on their health and get their mind healthy to get them on the streets... lots of education. (Tom)

I did feel different because we are so accustomed to our care, and here you bring the therapist in because you are dealing with a different dynamic. You are dealing with people with psych issues and familial issues from childhood on, and I feel that there is sometimes a conflict with what we as nursing is looking at as compared to what we are being asked from the therapeutic aspect. Is it a manipulation or are they really ill? We all know what amphetamines can do physically and mentally to a person in the aftercare. So, are they picking and need to get up and move or is it manipulative? It is very difficult to ascertain because sometimes therapists get involved, but they present to you medically. It is difficult and a different environment. You are trying to ascertain what the therapist wants and be with that boundary, what administration wants, and what nursing should do with their scope of practice and what the patient really needs. You are trying to weed out because we are taught to see each patient as unique, treat each as unique, yet they are put together like herd health and everything is the same.(Shelly)

Subtheme: giving up the glory. Eight of the participants talked about the process of giving up many of the characteristics they identified with nursing. These nurses felt like “center show” in their previous areas of nursing. Most of the care was centered on them, many of the decisions were theirs, and they were performing advanced clinical skills. Here, they are adjusting to a whole new team and treatment plan which

puts therapy in the center. The skills are limited but assessments are valued and enhanced. They are the only ones present to answer medical questions as the physician is available via telephone. They see the inmates during medication pass but are not allowed to discuss any medical concerns with them unless a formal written communication request is submitted by the inmate.

I was used to working that the nurse was the one in charge and everything ran off of what the nurses did. Everything was centered around the nursing care and then you get here and it's the therapy. Well, wait a minute...this isn't about me? The training was focused on therapy. So we had to sit in on all of that. So it was just a different perspective coming in at a different angle. (Amy)

It was a lot different than what I was expecting. When I was hired, I was expecting more acute issues with the residents' treatments. My experience with being in a hospital setting was what I was expecting. When I got here it was nothing like that at all. It is more education to the residents or family members; we ended up calling them. It was teaching them to be their own advocate, to ask questions about their medical history, their prognosis that they were allowed to ask questions about the meds and side effects. I was more surprised that there was so much more of that than anything else, as far as the nursing aspect of it. (Amy)

... there is not a lot of nursing stuff. We don't do a lot of treatments; we just kind of do basic stuff. We don't get to see any guts and gore. You kind of have to give that part up. (Amy)

That is how my career has always been at the hospital and clinic. Those people sometimes just want to talk because they don't have the support. So they come in just for someone to talk to. Here the limited time with them is just with med pass. They are told not to ask questions unless, if a communication comes in, certainly it would be reassessed. It's different...it's hard. (Barb)

I don't feel like I am using my skills. I very much feel like I gave 100% of myself into their care, caring about them, trying to help them the best I could when they were not receptive of that. That is where my burnout is. There could be high burnout also because, comparing to my other experience in nursing, the self-management care is not there. Anybody else that you take care of wants to get better, they want to help themselves or they are in a situation beyond their control. These particular people have made choices in their lives and they play victim to that a lot. That is where the high burnout comes. Their goal in life is to manipulate a situation to better them. That is how they have gotten through life, and it is really hard to manage that. The other nurses that I work with... at our

table discussions, a lot of what I hear is that too. I don't understand why they don't want to help themselves. I feel like my efforts here are wasted. (Mary)

It is difficult to ascertain in nursing. We are taught to observe, report, and go from that point of view. Evaluate, but you're confined as a nurse here depending on what their therapist feels and if something else is going on. Is it truly a medical disorder? That becomes a fine line to walk because many of them do have disorders that need treatment. But you are confined to what you can do. (Shelly)

To me, well from a nursing perspective, since I came from the hospitals first... When I started here I came at a difficult time because, at the hospital setting, the nurses are in control of their patients and the flow of the work and are ultimately responsible. But unlike a therapeutic community, the nurse plays a big role, but they almost take a second seat to the therapy and treatment. So being a nurse in a MTC, you wear a bigger hat. You have to be a team player with not only the nursing staff but with the whole facility. (Tom)

There are a lot of different attitudes. It goes in ebbs and flows. Sometimes there are more chiefs than Indians, people butting heads. But, in the beginning, your skin is not as thick, you take things personally. But as you go on, you learn it is about them. It's not about us; it's about trying to get these guys off their feet to get off drugs and to give them the tools to do it. As soon as you figure that out and make that determination in your head, that it is not about me, that's when it seemed it changed for me. It wasn't about my nursing, what I knew or did, it's about how can I use it to help the team and help these guys. So that is when it really changed for me. I stopped caring so much about the bickering. I am here for one purpose - to help these guys. (Tom)

It was tough coming here. I was used to running my own show, and now it's the treatment, and it was a challenge. (Tom)

When they do say thank you, I do appreciate it. But I don't believe it sometimes. When you got thanked and appreciated at the hospital, you are like 'oh ok (smiling)' because they don't have to thank you there but when they do thank you; you are like 'oh well, thanks'. I mean everything you went to school to be a nurse for you have to let it go here. For one, you can't be nice to your patients; you can't believe them. And, I mean you are passing meds, and they have to open their mouth like a child. So, the hardest part is letting go of everything I wanted when I wanted to be a nurse like the ER, the OB, all of that. You gotta let it go if you are going to be here. One of the guys at graduation, he said 'thank you to everyone that told me what I needed to hear not what I wanted to hear.' And ever since he said that it was like, you can't tell 'em what they want to hear cuz that won't help them. You have to tell them what they need to hear and sometimes that's hard. Even in the hospital you take care of patients and you know you want to tell them what they need to hear, but you can't say that. You would be in so

much trouble if you told people in the hospital what they truly need to hear because you just don't do that. But here, that is what you do. That is where I guess loving the job has come from. You nurse through what they need to hear. (Kris)

The glory of nursing is you go into it because you care about them and comfort them when they need it but here you can't do that. The colder you are the better for you, and really and truly the better it is for them too. Because they have spent their whole life manipulating people to get what they want. There is a good percentage of time, more than not; they are manipulating you too to get what they want. So, if you don't let them manipulate you, you are truly helping them. But once you get there, it is hard to figure that out. In nursing you think that is not how to help someone. But here it really is. (Kris)

When I started, if the doctor would refer them to a specialist or order something, we have to get approval first. We have to get approval from DOC, of course, and you have to fill out all of these forms, email it to the state, and you have to wait because they are busy. So I guess in the beginning that was very frustrating because I was used to working with the doctors at the hospital, and you take an order and you absolutely, you do, you carry it out. So, for me to have to get all of these approvals and rely on that for me to do my job, it was frustrating, and our hands are tied to a certain extent. I can understand that too because there is not an endless pot of gold sitting there. The money is a big deal, and a lot of times these people come in and haven't taken care of themselves; they have never been to a dentist or eye doctor, or they broke their glasses and have never replaced them. Now, all of the sudden, they need glasses. So while, yes, you do understand that there are certain criteria, a certain way that we go about it. That was the most frustrating thing in the beginning. But I have grown a lot, and I understand that not everything is a crisis and needs to be taken right away or may not ever get fixed at all while they are here. (Jodi)

You feel like what you want to do, is not what you can do and that is the hardest part when I started. Not being able to give them what they want because they want it and that was how you were a good nurse in the past. You have to change your whole way of thinking. (Jodi)

Theme Summary. The first theme, “the process of becoming,” identifies the experiences and motivators that led each participant to explore the components of this unique area of nursing. These experiences were presented in the excerpts from each of the participants.

Theme: Boundaries Build Walls. This theme emerged as participants described how being a nurse in a MTC is different from other nursing experiences. All ten participants discussed how the interaction with the inmates is different than with other patients. Relationships are discouraged, and the common thread of coldness was described. The nurses admit this was challenging in the beginning. But as they have grown into the identity of a nurse in a MTC, boundaries are a security from the threats inside. These descriptions gave rise to the following subthemes: (1) shutting down, (2) relationships break-up, and (3) don't give an inch.

Subtheme: shutting down. Eight of the participants discussed the important step of shutting down as a means to build boundaries. This means they learned to stop any small talk, never to give out information about themselves, and not to become emotionally involved in the inmates lives or stories. For many, this is difficult and goes against the grain of how they were taught to have therapeutic relationships and communication with patients. For many it is easier when they shut down by limiting interactions with the inmates.

I had a guy a while back who was crying about his kids. We all have hearts and we feel bad for them, for these kids that they have, and they leave. One time I said to another nurse 'Gosh, it always breaks my heart when they start crying about their kids. It just makes me sad'. She said 'Well, does it make you sad that he broke his wife's jaw in six places?' Then you just get brought back down to reality. See, they are all criminals. That is why they are here. (Sarah)

It was kind of scary at first because you don't really know what to expect. They are felons, but a lot of them are just regular people that have made some bad mistakes. It was a little bit frightening and, as a rule, I am kind of an introvert. So for me to confront and say no to these people, it was really difficult. For the other nurse who is definitely an extrovert it was easy for her. It took me quite a while. It took me a good while, this job is not nearly as physically taxing as my other jobs - pushing med cart, surgery, being on your feet all day - so that is a plus. But it took me two and a half years before I was really able to assert myself with the people here and they know that. (Jodi)

You can laugh a little, but there isn't much joking. They can't talk in line. I get all the meds ready, and they all stand in the hall, and they come in one at a time, and they cannot talk in line and the guards are out there. The guys know they will get in trouble if they talk in line. Also, if they are joking with each other and I tell them it's time to stop they have to stop, or they have to write an apology letter. It is structured. I know that I am not my normal self when I work there because they are inmates. You don't tell them about your life, your last name. You don't tell them who you are. (Sue)

I guess it is different because I have been told not to give them any personal information. In a small hospital you talk about who you are, where you are from, and that kind of starts conversations. Here, I am so scared to even tell them my first name. They definitely try to be your friend and try to make conversation. (Molly)

I didn't expect it to be so hard to make boundaries; I know what my boundaries are. Obviously I am not here to find a man, but how to present myself in front of them. I don't want to appear mean, and I want them to not be scared of me, but to respect me. I feel like they respect me. It's been hard. My first weekend I did a write up for someone not following the rules, and I felt like, 'Good. Now they will know that I am serious.' But at the same time, I feel like, 'Gosh, I have to come in here and write people up and get them in trouble so they know that I won't be a push over?' They need to know that you mean business, and that is really challenging. (Molly)

I don't even talk to the guys about that, and the nice thing is they don't even ask anymore. They know it is just, I mean, your reputation here precedes you forever... So now your reputation, now I don't have to do anything. Now I can be nice every once in a while, and they don't think anything of it. But, for the most part for a long time, you just have to shut down until your reputation proceeds you and they can't get anything from you or receive special treatment because that is what they are looking for to receive special treatment. They are trying to see what they can get from this nurse that they can't get from another nurse. So, eventually they realize they can't get anything from them, and they stop asking. They really do. (Kris)

In the beginning? Oh my heart would start racing and it was like, 'Oh man, I don't want to hurt their feelings or make them mad by saying it.' And now, it's second nature to call them out. And I think, once it gets easy then they almost... I think they can tell if it makes you uncomfortable to call them out because then they start to push it a little more. Now they don't even push it because it must be

the way I say it. I feel comfortable in it so they just walk right away. They don't question it anymore at all. (Kris)

When I first took the job, I thought it was because I was taking a job for people that wanted to really change their lives and really needed my help. I saw it as a different aspect of nursing that many were not offered that opportunity, and that is why I took the job. Very quickly into that I realized you had to be very strong and not patient. If you are patient with them they almost take that...they are master manipulators. They take that and work with it. Everything I knew about myself with nursing, and how strong I was, and how knowledgeable I was kind of completely went out the door when I started working here. (Mary)

Strong willed, kind of almost, I hate to say this, but cold because you kind of have to be very shut down. A lot of them too, they try to dig into your life by asking you questions. So, to some without experience, you would tell them you are married with kids. But that is not the stuff you tell these people. You have to have a backbone. You have to be able to shut them down because; once they open that door and they establish that they know a little bit about you, they can use that against you. (Mary)

Subtheme: relationships break-up. Seven of the eight participants discussed the negative effects that relationships with inmates have on the entire community in a MTC. The system in the MTC is built upon staff trust and communication. The inmates are looking to develop a personal relationship with someone that may give them an "in" to the system. Most of the time relationships in a secure MTC are one-way. The inmates' intent is to develop a relationship in an attempt to penetrate and break up the system. This penetration happens easily when staff boundaries are down, when staff is not educated or aware of the criminal thinking behavior, and when the system of the MTC is not fully operating together. The following examples highlight the participants' views on the ill effects of relationships in the MTC.

I am ok with it because I am male. For females that is tough. You have human nature. Man wants a woman. So that is in corrections; and with these inmates there was not a lot of education before, so it goes back to primal attitudes...the respect thing. I see that a lot more with women here. If you have female staff they are just on you because, in their mind, they really think of how many women have actually been nice to them. A clean, educated woman and sometimes they

probably take it as, 'Wow this lady is being nice to me,' and they take it further than they should. A lot of the thoughts are the drug process; they have fried themselves. I have had guys try to groom me - nice clothes, nice shoes - and I will call them out right away. Why are you grooming me? You don't need to say it? You don't need to say it's a nice coat. You don't need to say it. Sorry. Then they get shot down right away. They know they can't do that. They can come talk to me, but not about me. I just put it under the radar and am like, 'you know I like you, but you don't need to know about my life'. I have straight up told these guys. Honesty is huge. That is the biggest thing that can help in these facilities is to just be honest with them. These guys have been lying their whole lives. They know when someone is lying, and if you give them an honest answer, whether they like it or not, they will respect you for it. A lot of staff becomes dishonest just to get away from them. No wonder why they get shitty attitudes about staff. I keep the boundaries. There is a poster they put around here: be buddies, be friendly, but don't be friends. (Tom)

My hardest thing is not to be their friend - to make that relationship like you would with patients in the hospital. (Molly)

I have to remind myself they are an inmate, they have broken laws to get here. It does feel like we treat them like children sometimes, and sometimes I feel so disrespectful sometimes to them because they are grown men. But there are things in them that show you why. I can see why there is burnout here because there is a constant effort with trying to do your job and keeping your boundary. It's not that I have ill intention here; it is simply being human and treating people nice and having conversations. It's just something that you have to get used to. (Molly)

Boundaries are your biggest thing, and I have gone through five nurses since I started three and a half years ago, and three out of five were boundary issues. Instead of looking at the family member as patients and keeping that boundary, they treated the guys like friends. And if you start divulging your personal life - like who does your hair, where you buy your shoes, where you go shopping - they start looking at you as a friend vs. as a nurse. And when those boundaries get crossed, there is no turning back. It's really hard too. It's easier to let your wall down than build it back up. That's why I don't even go there. And another thing with me personally, I choose not to know what their crime was to get them here and what they have done in the past. I just treat them all the same. And I feel like I do better that way because, if I know they have abused women or children or sexually assaulted, it's harder for me to not pass that judgement when they come in. I still treat them the same, but it is hard for me not to look at them in a different light. (Sarah)

With other nurses I have seen them have problems when relationships develop with the inmates and they start to have feelings for that person. And when that happens, you are in trouble because family members will push it. You do one

favor for them, and then it can spiral out of control. Then they want another, and another and about the time you stop, they say, ‘well you have done the last four why won’t you do this fifth favor?’ And then it comes back on you. So, I always tell the girls when they first start here if you are not willing to do this favor for 80 guys, and then don’t do it for one because it spreads like wildfire. (Sarah)

I had the boundaries there immediately. It helped knowing up front that you are dealing with manipulation. You are dealing with a population of men, so the reality is there had to be boundaries. I do think that it’s easy to have boundaries crossed. I know when I was looking in and doing reading on it I found that middle-aged women were the ones that typically boundaries were crossed when dealing with incarcerated males. I don’t know if that is because of abandonment issues or divorce, but one of the things that came up several times in the different sessions was that a women care giver was a high risk in male incarceration. I think the boundaries are established, but it is difficult because each therapist, even though they were supposed to have the same boundaries, but one-on-one they have different boundaries with the guys. If there is any turmoil of any kind it is difficult to establish boundaries of any kind. But I did not waiver. (Shelly)

Subtheme: don’t give an inch. The participants discussed what it is like trying to find a balance between providing nursing care while keeping strict boundaries. The answer is to not even give an inch. Consistency and clear-cut boundaries are the keys to avoid being manipulated by the inmates. Some nurses have difficulty with these boundaries but feel more at ease when putting this component in perspective with trusting the system. Unfortunately, some have expressed learning the hard way when manipulation burns.

Not saying you can’t be compassionate... but the second that you show them compassion, they take that and run with it and they kind of learned too. We had several nurses that came in and filled in from time to time, and they would take full advantage of them. I would come back and work after them, and it’s like all of these people had passes to miss group because they were not feeling well and most of them will not pass the program if they don’t do the groups. (Mary)

You have to be on your toes because manipulation is huge, and it’s not just coming from one family member; they could be working in tandem or there could be a group of them. They are trying to manipulate one or all of the departments. With being all male and all of the female staff, you definitely have to be able to stand up for yourself and not get too flustered over anything that they say. (Amy)

You have to have strong boundaries, consistency, and they notice. If they know they can get around it they will manipulate you very quickly. You have to be strong, and they will ring your bells. They try to find out what rattles you, and immediately for a new nurse going in there, if flattery doesn't work, then they are going to find out what rattles your bells. They are going to flatter you at first, and then they are going to ring your bells, and if you can withstand that you are o.k. But if you can't, once they have a weakness, they know it and it spreads. They are looking for someone that is going to give them empathy and then maybe an insight on something. It's that manipulation to see how far they can push the boundaries, and that is what got them to where they are. They are mostly sociopathic, and that is how they got where they are in life. It is not what the nurse is doing per se. It's this person's personality. (Shelly)

When I first started here it was really hard for me to say no, and you rarely say no in a hospital setting. You do what the patient wants. If they say their pain is a 9/10 you trust that it is a 9/10. So coming here you deal with so much manipulation that you have to figure out what is truth and what is not. So setting your boundaries... once the guys really figure out that your boundaries are set, they won't really push them. Once they figure out that you are not going to budge, they stop. Cuz if any of these guys... if you give an inch, they take a mile. I make my boundaries really clear. I don't talk about my personal life, my kids; they don't even know I am from Lewistown. I just feel that it is not any of their business. So a lot of them won't even ask how your weekend was. Because they know that I won't even divulge that information. (Sarah)

I usually say we don't talk about that here or I won't say anything. Sometimes I just look at them and they know. I just don't have guys even ask me anymore. The word trickles really fast on the units. When the guys first get here, they have already warned the family members who they can or can't get away with. (Sarah)

In nursing school you are not taught correctional nursing. You are taught psych and the different mental health disorders, but you are not taught how to deal with them. Coming in here I did not have a clue what I was doing at all. Much of what I learned has been from therapists and security on how to be consistent with the guys and how to set your boundary bar up high - cuz our admin was the first to say you set it up high and bring it down. You don't start low and try to build it up cuz the guys won't work with you. So school didn't really prepare me to come into a correctional facility AT ALL. A lot has been trial and error and feeding off of each other. There are things...the nice thing is that the other nurse and I both have different backgrounds and we both feed off each other. (Sarah)

Theme Summary. The second theme, "Boundaries Build Walls" identifies the process that nurses use to create boundaries and its importance in keeping the MTC intact. Participants were quick to state it is not an easy but necessary component.

Unfortunately, they have seen evidence of the effects of improper boundaries, so they are concerned about any infractions of the systems.

Theme: The Walls of Confinement. In this theme participants discuss what it is like to be a nurse in a secure MTC. In most cases the participants felt the care they provide is exactly opposite from how they were taught. Many of the participants said they went into nursing to be caring and compassionate, and those attributes are not expressed in the MTC. All of the nurses discuss having to learn the ways of correctional nursing. Not only do they take on the full scope of nursing responsibilities, but they now need to practice under the rules and regulations of the Department of Corrections. The participants discussed the learning curve and difficulties faced while understanding care in the system. Caring for this unique patient population created additional challenges for the nine female participants in the study working in an all-male facility. They talked about their feelings of vulnerability and unease and how these feelings caused many of them to isolate themselves to the medical department while limiting interactions with the inmates. Several of the nurses use this isolation technique as a coping mechanism to learn as little about the inmates as possible while some others isolate in order to not give the staff the impression that they want to form any kind of relationship with the inmates. Even though there are challenges to working in a secure MTC, nine out of ten participants do provide several examples of rewarding experiences. Those reasons gave rise to the following subthemes: (1) dissonance of care; (2) care in the system; (3) isolation; and (4) rewarding.

Subtheme: dissonance of care. In this theme the element of care becomes conceptualized in terms of the pressure of trying not to show human compassion to the

inmates. Several of the nurses provide examples of incongruences between facility expectations and how they were trained in nursing school.

Like with not trusting them. In acute care, if a patient says they have been up all night throwing up and diarrhea, you believe them. Here it is really hard because you are looking for all of those other assessments like how are they walking and getting feedback from others in the facility. The hardest part is really believing what they are saying. The other thing is being nice because, in the therapeutic community, I mean you gotta give them some respect to expect some respect back from them. But then you have to be able to draw the line. (Kris)

There are guys that come in that you can see swelling and pus oozing out, but we don't even have any pain meds here. We give them two Tylenol and three ibuprofen and ice. They know they can't have anything stronger. So I hope whoever is on the outside doesn't give them pain meds either. So here we try to help them through that without narcotics. I remember saying in acute care, 'you don't get a gold star for not taking pain meds.' I used to advocate the pain meds. But here, being an addict is different. (Kris)

My biggest struggle with working here is the relationship you have with your patients. It's really hard too after you are trained to be so caring and empathetic, and now it's learning their behaviors. That's just because they tell you something is wrong. We still treatment them like something is wrong and look into things, but it may not be why they are coming to you and saying what is wrong. It's hard to remember that they are a different population. And you think 'oh, they just don't feel good.' But really there is usually more to it. (Molly)

What I consider here to be a caring nurse is when they come down for an assessment and we try to help them – what is going on – and we help them with medications. It is all medical related. We more focus on their bodies. In the hospital you get to show more affection and empathy. If it is appropriate – like we had a guy with an appendectomy – then we were able to be more so. With the rest of them, unless you communicate, we are not going to say a word about it. In the hospital we always ask how they are feeling. Are you having any pain? Unless it is brought up from them, we don't bring anything up. In the hospital, we would be in trouble if we didn't ask. (Molly)

I enjoy the job, I enjoy the group of people that work here. And, as I said, my biggest challenge is knowing how I can act towards them without it being questionable or I am just not used to that. It's a therapeutic community. They are getting ready to go out in the real world. I think they should be able to say hi to us like they would to someone in the public. It's really hard to appear like I am not your friend. (Molly)

It was real difficult in the beginning for me not to touch people. I was used to touching people – touch their arm, hug – so a touch in nursing is a big part. So in the beginning I would touch their arm and say it's going to be ok. But now I don't, and that is just part of that growing experience not to do it because it is an entirely different group of people. It was hard in the beginning because that is what a nurse does. We touch people, we hug them, pat them on the back. (Jodi)

This type of nursing is so foreign. Everything that you have learned to do as a nurse, like ease their pain right away and touch, that you want to do as a nurse, the way you have done it in the past is a whole different ball game. It is under the umbrella of correctional nursing, but you throw that MTC in there and it changes everything. (Jodi)

In nursing school you are taught to be empathetic, caring, and warm. When you get to a facility like here, you have to make your boundaries so clear that that is not really allowed. We are not able to when they have lost someone on the outside or when they are sick; we are not able to rub their back or give them a hug when they are crying, and that is really hard for me because I am such an emotional person. So that makes it difficult. Also in nursing school, you are taught best practices as far as if a patient is on Depakote or lithium you expect them to be monitored for their levels. But in a correctional facility, they don't do those unless there is reason to think that we have to. So that is hard sometimes too because we know that they should be getting drawn regularly, and they are not. Just cost wise, we have so many guys on those kinds of meds. So it is super expensive. (Sarah)

You still have that compassion, but you definitely have to be guarded with it. There is no, 'I understand' or 'I am so sorry. What can I do to help you?' You really have to be careful how you address them when there are emotional issues coming up because it gives them an opening to get into inappropriate behavior. You have to be aware of boundaries and also aware of if this really something medically going on. (Amy)

During med pass and during the day you get the interaction with them that they have a headache. But they do that to get out of their groups and just stay in their beds rather than going through the processes that they have to get through. So it is a negative interaction, in my opinion, where you have to de-fuse those situations and kind of call them out. It is kind of opposite of what you learn in nursing school where you listen to your patient and you're sympathetic. You have to be very strict and very stern with those people because they take advantage of you. (Mary)

I wanted to help people, and I have always been mesmerized by medicine and I wanted to go that route. I have always been that caring, nurturing person. With most nursing, that is what it is; with this kind of nursing, it is complete opposite. (Mary)

Subtheme: care in the system. In this subtheme the participants talked about some of the differences of care between the secure MTC and that of the “outside.” Funding is limited, pain meds are limited, and the services are limited. The inmates tend to feel entitled to “outside” care, but are held to the confinements of the Department of Corrections. This creates a steep learning curve as well as additional challenges for the nurses. Another factor in this subtheme is being more aware of the care they are providing in the system. These are inmates; some of them are dangerous, so individual safety is of high importance.

When our guys get colds here, they don't know how to deal with day-to-day aches and pains when they come here without being on drugs. So it's really hard for me when they come down here and say they have a cold. They think they are dying, and there is not much we can do. They get a spider bite, and they think its cancer. They always go to the extreme; it's always the worst it can be. It gets frustrating for us because everything gets so catastrophized. So when they come down to us with a cold, when one person gets it, they all get it. I just had it this morning. 'I am stuffy.' 'Well, here is some decongestant.' They really want us to baby them, and we just don't. That gets really frustrating. We educate on proper hand hygiene, how to properly sneeze and blow your nose, and sometimes you have to bring it down to literally a kindergarten level. When you explain to them about oral hygiene it is foreign language to them. We have guys that have never seen a dentist. It gets frustrating to us because sometimes we feel like we are broken records and say the same thing over and over and over. And we tell the guys over and over there is nothing we can do when you have a cold. We just treat your symptoms. They want a magic pill that will take it away tomorrow, and they don't understand that is not how it works, and that becomes frustrating for us. The mental health becomes frustrating for us because they think that we are going to start them on Zoloft and by tomorrow they will feel like a new person. They come back to us in three days and say the Zoloft isn't working. You have to give it time, and we have to explain the whole process. It's frustrating because the guys on the units all feel like they are more knowledgeable about medical than we are. So they will all give each other medical advice and come down to us and say so-and-so says....and then we have to remind them that so-and-so is not medical. If you have questions you need to come to us. But to get them to believe us over another inmate is really hard because they really think that they know it all when it comes to medical or lawyers. (Amy)

I had a guy that cut through his AC artery, and I was walking down the hallway reading my communications, and another family came sprinting out of the unit yelling, 'We need you! We need you!' I run in there, and they point to the bathroom to what was going on. I ran in there, and blood was everywhere; it was pulsating on the ceiling. He broke the straight edge razor out of the plastic and cut right through it. Not intentionally trying to commit suicide. I think it was a cry for help and then cut too deep because he was the one that opened the door and asked for help. I ran in there, and my first thought was to stop the bleeding. So I yelled to the other family members to get me gloves, and they were Johnny on the spot and got me gloves, and I just clamped down on it. In the moment that was all I was thinking about. Looking back, the head of security came to me after and said 'did you make sure he did not have a weapon in his hands?' No, I didn't because my nursing mode kicked in versus my correctional nursing mode, and my thought was to stop the blood, and their thought was my safety. I get that now, but at the time... (Sarah)

But with the DOC and corporation there was really no other choice. It is frustrating. Sometimes with the medical stuff you do feel like you wish you could look into some things. But you can't because DOC can't pay for it because of funding, and this facility is minimal medical care. So once you go out of the range of minimal medical care, you just can't go past it or they can't be here. So that part is frustrating. (Kris)

They don't know where you live -- and I live out of town -- but I was doing dishes one time, and I saw one of the guys walking down the road. I could tell just by the way he walked, and I was like 'I know him,' and so I was peeking through the windows. Here it was one of the past family members who is a local guy. He was walking right by my house, and it make my guts kind of wrench. Turns out he lives a couple houses down from me now. Now *him* I wouldn't be worried about. But I don't know how they keep in contact with everyone else. And if he would visit with some of the other guys and say I live by Kris.... We don't wear name tags, so they only know our first name. But there are times when we have to sign paperwork -- like our DNA swabs that they see our names. Amy does not go by her married name -- they only know her by a different last name -- but they figure things out pretty quick, and staff slips sometimes. Amy has had a few family members that have requested her on Facebook, and she has blocked them, but I never had. We now pull in some guys with some serious mental health issues. We had one guy that admitted that he loved the taste of skin. He liked to cut pieces of skin out of his arm because he loved the texture and taste of it. He would look at people and imagine what they would taste like. And he had some terrible crimes and what he admitted to here. And those are the things you hear about... some of that stuff, it comes in here no matter what because of mental health referral, and they say we need to get them on some medication. These guys are expected to tell their deepest, darkest secrets because that is usually what is keeping them from staying sober because they don't want to live with these things. So when you get these guys that will open up about the past, you are like

‘man, if I were you, I would not say that.’ It is kind of scary knowing what you know is out there. There are guys that I know, if they showed up at my house, I would not hesitate to shoot them. There is a good handful, if they showed up on my property, I would not hesitate. That is because I know their secrets that they have let out of the bag here like that one guy who literally looked at people and imagined what they taste like. And he would cut his wife just to drink her blood. Like he loves blood and skin, so there is just a matter of time when he does something. Yeah, he is out on the streets right now. And we get sexual offenders in here too. Some of these things they have pled down. That’s the other thing I did not know nothing about – law or how any of that worked. I thought if you did anything wrong it would be on your record and it don’t go away. But there are some things that go away and some things you can plead down to. There are some things they have never gotten caught doing, but they will admit to it while they are here. That is the scary part you know. (Kris)

You are dealing with a broad spectrum of ideas and thoughts – a lot of abstract nursing versus concrete. Pill passing, the general duties that we may take for granted, but you are dealing with a lot of psycho-social, and you’re dealing with a broadband population. Even though it is men incarcerated, it originally started with a methamphetamine treatment program. But now there are extensive disorders and a lot of comorbidities because of addiction. I think it encompasses more abstract nursing, more independent thinking. Difficult to ascertain your client because of the situation you are in. With confinement, you are not open necessarily to have a relationship with them. By relationship I mean more on a social. But you are still looked at as a detainer of some sort. I am never treated disrespectful by the correction family members, inmates, but it’s still a clear cut boundary. There are certain limitations that you have to think about that may not pertain to your average clinical nursing. An example I can think about is your modification of dress, because truly these men have been incarcerated, and you have to socially think where their mentality is. Even though they may not be actually mentally seeing you in a sexual light, it can happen. Just the prompting of something that you are wearing. Its’ just a completely different mentality of nursing. (Shelly)

Subtheme: isolation. This subtheme discusses isolation in two ways. The first is in the physical sense; medical is an enclosed room where the nurses spend the majority of their time. There are few windows and little interaction outside of the department. Secondly, the nurses discussed the result of feeling isolated while working in a secure MTC. Most of them do not attend groups, do not go down to the units, and keep interactions to a minimum as a means of self-protection. Some of them feel that not

getting to know the inmates and not hearing their stories helps to keep the boundary and prevent human compassion. The other interesting component was some of the participants discussed feeling like their job “title” was also isolating. They felt like there is a stigma attached to working with incarcerated individuals in a therapeutic setting, and they are not able to discuss openly with the public any details of their profession.

I don't go on the units a whole lot. I really am not openly available to the inmates unless they come to medical. I wait until they go to breakfast before I go pick up communication because, when you do walk on the unit, they all stare, and it is uncomfortable. You do feel awkward sometimes, and they stop you fifty-five times when you are walking through, and they want to ask you a medical question and they are not supposed to do that. We remind them to put in a communication; we are not going to talk about it here. We don't go on the units unless we absolutely have to. We get our lunches before them. I go down to TC (therapeutic community) when I have to make an announcement. You just hate it. It is really uncomfortable because they are all looking at you. Even when we do the Med Ed, I like to do the Jeopardy because they are looking at the board and not us. (Sarah)

The only time I go is when if we have a nursing student that is not comfortable going to the groups themselves. Then I will go. Otherwise, I only go if they are talking medically in case someone has questions. Otherwise, I don't go because you hear everything of why they are here. Our new nurse is intrigued, and she wants to learn everything. She wants to learn about criminal thinking and the criminal mind. I do hear things because I go to staffing meetings. So, when they are talking about a family member, I hear about their past, and then I hear but I don't want to hear everything. Like we find out that they were sexually assaulted as a child, and you feel bad for them; and then you find out that they did it to someone else, and then you get mad. It's a vicious cycle. It makes you thankful for your upbringing. It makes you humble. (Sarah)

I think some of it, depending on facility, can be protocol, policy. Because I think, a lot of the times, there is a high staff turnover, so you can't reach a comfortable dynamic with the staff around you. In acute care you develop relationships and you feed off of each other; you develop a routine. I think [with] the turnover and the population there is always fear in the back of your head in this type of setting, and sometimes it's frustrating, and you see the person as human but you see them making the same mistakes and manipulation. It is really hard as a caregiver – almost like a codependency. You want to see them succeed, and it's really hard, and you burnout on seeing the constant downfall, downfall, downfall, the downfall...when are they going to get ahead. As caregivers, we want to motivate, and you are seeing them torn down, and you see them floundering. It's confined,

its dark, its dreary, it's not a bright setting and you can't have relationships. You try to envelop and bring them in, but there is a clear-cut boundary. If someone asks how my day is, how my husband is, you naturally want general conversation. But you avoid that here. You avoid anything personal, and so you never get beyond that level of sociability to make it personal. They want you to be family here... family members. They include you in many of the things, but then you have boundaries and that is where that conflict is. How close a boundary can you have if you give someone a hug when they need it? Is it inappropriate? And you are dealing with the situation that a hug to elderly women that has just been diagnosed with cancer is appropriate, but is it appropriate when a 29-year-old just lost his dad to addiction. And maybe it would be, but you are in a confined setting. You are a female touching a male patient, and how are they construing it coming from where they are coming from? So it is very difficult to get past the main level to see it in the humanistic side. I don't think you are allowed the humanistic side in this environment. The isolation, the darkness, the dreariness, the inability to have the relationship because of the manipulation and the safety factor... It is very difficult for some to work day in and day out if you are a caregiver. That is more on the codependent side. (Shelly)

When I came here I was expecting that I would be involved with the groups and all of that, but really you just aren't. You stay in your own medical. You can – and sometimes staff is like 'you should come down to group' – but it is just easier to not cross that line. I have gone to a couple groups like when we have had student nurses that did not want to go by themselves, so I sat with them. But then you hear about some of these guys' stories – what they have done – and maybe that's why, since it a treatment place, it's really hard to get past some of the things that they have done. I would rather just not hear about it because, when they come down to us asking for this, you are just like 'I know what you've done to your kids, wife, or mother.' So it's easier to just not cross that line. That was one thing I was expecting – to be part of the groups and all of that, which you still can – but I think as far as doing a better job as a nurse, it is easier not to know. (Kris)

Even yesterday, another nurse and I walked the track while they were doing the Rely for Life. No one came and approached us to walk or visit with us. They just don't because we are, I guess, the unapproachables. I don't think it's because they think we are mean; they just know we are not approachable. But if you start going down to the groups, like they will walk with treatment staff because treatment staff are involved in their lives. I don't know how that all works. I don't know how they keep their boundaries. I don't know all that. But you will see them walking around with the treatment staff. But we don't. They don't approach us, they approach everyone else. (Kris)

We nurses have an escape plan just in case. We get some guys....when I first started here it was no one that killed anyone. But now, as the years have gone by, we have quite a few guys that have killed someone. Like the one guy, he had mitigated homicide. He was high at the time, and he got off of it because he was

high and said he was stressed. But he stabbed a kid, eviscerated him. When I was doing his stuff and I looked on ConWeb and see deliberate homicide, all you have to do is google his name and you see all of the articles. Then we are putting him in the kitchen to work. So there was a time when I was like 'OK. We have someone who stabbed a kid, stood over him stabbing him saying "this is the day you are going to die," and we are going to put him in the kitchen with knives, and I am right across the hall. So there were months and months and months that I always had that door shut. (Kris)

Going down to the unit? I hate it. I hate it. It depends on the situation. If they are in a group down there, I am fine with it. But if they have free time and they are just roaming around down there, I feel really uncomfortable with it. I hate it. Like when I am walking out, and there is the reflection on the door and you can see all of the heads peeking around the corner as I am walking away. You know as a female staff in an all-male facility it is really hard. Security used to come down and say, 'so-and-so just got in trouble for saying this about you or for noticing they were watching you.' I got to 'just please don't tell me' because it would make me so uncomfortable. Because when I knew someone got in trouble for gawking at me, then for months I would almost feel like I was trying to avoid a situation when they are in the group. (Kris)

I only go to the units just to get communications. Even to this day, I don't do it unless I know. I try to do it when they are in TC. I go get the reorder slips when they are in TC because that is in the back of it. And the communications are by the door, and now they have morning group so only a few of them see you. I do arrange my day around that. I always wear scrubs. I used to wear jeans on Jean Friday but now I don't, because it's just not worth it. I hate going to the cafeteria when they are in the cafeteria. I just hate it. I only go in there when they are not in there. I only go when they are not there to get our food. Sometimes in the evenings, security will be like 'Want to go eat?' and I will still look at the clock, and security makes fun of me because, even in the three years that I have been here, I still look at the clock. And they are like, 'Stop it, Kris. We are with you.' And, if it looks like the guys will be in there, I will wait. I don't think that will ever go away. Ten years from now, I don't think that will ever go away. (Kris)

So I go down a few times – not to ever hang out. I was always there for a specific purpose. I go down a lot when they are at meals, when they are not down there to check their rooms and stuff. But when they were down there, I get a lot of stares. They are just looking at me. It feels very insecure, vulnerable, and just kind of borderline uncomfortable. I know they can't do anything because the guards are down there. But you still just get that look, and you are kind of giving me the creeps. So I just do what I need to do and get out. (Sue)

It's closed off to the community. So people don't really know much about it, and you can't really talk about any of it. (Sue)

No, they have to come to us for certain medications. In the community, we would visit with them and when they want to visit about something. We would be more involved out in the dining room and say 'hi.' That is just that. I don't know if I am not allowed to, but that is kind of the memo I have gotten. You just don't interact with them unless they do communications. I think it is very frustrating because that is not me. When I see them and they say hi to me, I say 'hi', nothing more. But it is like 'gosh, am I being watched because the other nurses don't interact?' But they have had more experience. (Molly)

I don't think you would have to worry about that. But it is like why is the medical department held to that standard when security can play games and recreate with them or the counselors visit with them one on one? I don't think that therapy has as much as a boundary. Just cuz I am so scared to feel that I don't have a boundary, then when I watch them, I am like why are they talking with the guys independently? (Molly)

The nurses usually eat in here. All other staff all eat in there, and sometimes we all sit together. I have seen where security is done eating and the guys will sit down at their table, and that does not seem to be an issue. For me, immediately, I was scared. I was like who is watching? I didn't want to get up and leave because I don't want to give that image either. They felt comfortable enough to sit down at my table. (Molly)

Subtheme: rewarding. For the participants, the experience of their nursing profession was filled with many challenges but also a new set of skills and rewards. Many claimed increasing their skills in assessment and educating. Even though they may not be able to outwardly show their compassion, many stated feeling emotional during the inmates' graduation ceremony or from receiving a follow-up phone call from one of them. Several of the participants provided examples of self-rewarding experiences like becoming more assertive and competent from working in the secure MTC.

Probably the more rewarding part happened outside of work when you see a former family member. This just happened a month ago. I saw a former family member that remembered me. He was one of the first groups of graduates, and he remembered who I was. I didn't recognize him, but he recognized me and he remembered my name and everything. And they come up to you and say thank you for what you did, thank you for listening to me that one time, and you don't even remember. (Amy)

It's been a really learning experience and a real growth experience for me, too, to really step out of the nurturing, caring, give me a hug that I was used to. (Jodi)

For us here, we can really sit back and kind of just concentrate on their physical well-being, and we do a lot of teaching. When you get out, this is what you should do: treat your blood pressure, stay on your meds, etc. We do a lot of encouraging. A lot of them try to lose weight while they are here because they have to go to gym for an hour every day. So they get here and decide that they should try to get healthy, tone up, lose weight. We encourage them to improve their overall well-being, not just their alcohol and drug problem. That is a big part of it too – to just get them healthy and teach them how to stay healthy. (Jodi)

Working here versus a prison is a lot different. We have the opportunity to make a big difference. I know that is supposed to be the goal in jails, in prisons too, but it doesn't usually work that way. But we have the opportunity to change lives and teach people how to have a better life and give them some hope. (Jodi)

I feel rewarded when I can tell that guy really felt good; we accomplished something while they were here. For example, I had a guy... I don't have as much experience, and maybe they have burned bridges with other nurses, but I feel like everyone has a clean slate when interacting with me. For example, this guy came down for a symptom, and it was related to a medication that he was taking, and there was something simple – to increase your water – and that will help a lot, and just talking with stuff like that. He was like 'thank you for looking into that, I didn't know that just increasing my water would help with that.' Anytime that, even just from a medical standpoint, if you can accomplish and help them get to what they want to do – even here when we are not supposed to be a super caring, empathetic nurse – just he knew that I cared to help him simply increase his fluids. Still when they say thank you, it makes me feel accomplished in my job. (Molly)

I think the meaningful thing is the guys coming back after they have been clean for a year or two, and they have been talking to the guys and tell us thank you. When you see them appreciative a couple years down the road, it is meaningful. At graduation it is meaningful. They always thank us, and they are always like 'thanks for everything you do,' but it's when they come back a few years later and they are still appreciative. (Kris)

The other thing is when we see them the day they get here. They are dirty. Not only their physical appearance, but you can see these are super broken men. And, all of the sudden, after five or six months, they come in here and they are smiling, and there is just a different way about them. And those are the things you are like, 'oh ok, this is good.' (Kris)

I actually like the growth of some of the people coming through there. All the time when you deal with addiction, there will be a recession [*sic*] rate. There is

always a recession rate. But it depends a lot on why they are there. Is [it] court ordered [or] are they there to truly help themselves? We know that even if they are there in earnest, they are going to fall and stumble. But what is truly rewarding is to watch someone that is 30 years old that sits down for Thanksgiving dinner and says, 'Wow, this is really cool because we always had a fight over who was going to smoke a bowl and drink a beer, and it turned physical when I was growing up.' So it is rewarding to have the senior family members bring newbies through and introduce to nursing. Primarily I didn't see that with therapy so much. But they would bring them to medical and say, 'These are our nurses. Be kind to them.' You know you are touching somewhere in an appropriate manner. (Shelly)

When I was younger I was not a saint, but I had people that loved me and supported me and only wanted the best for me. So I strongly feel that, without them, I could be in here. So I like working with the guys and have some understanding of what they are going through. Growing up, I didn't have the same crime but did have some of the behaviors. So, when I talk to these guys, it's not bullshit. I feel that working here, I can give back. This is a forgotten group of people. This is a part of society. I find it rewarding even if it doesn't change their life, even if it changes a day. Maybe they will say something to their kids or their wife that they never would have said if they are sober and clean and had good support and good people. Everyone that works here...their role is to put out the image that this is an example of a successful person. They are not perfect, but they are holding it together. This is what normal people do. (Tom)

This job has given me a backbone in my personal life as well. Before, I was like 'Yes, I will do it. Yes, I will do it,' and I have learned it's ok to say no. I have always been a people pleaser, and now I have changed a little bit. (Sarah)

The guys do know that we do care. And when they come in with a legit concern, even if something we can't fix it here, we give them info they take when they leave. We have guys call us and tell us thank you, and we get thanked at graduation. It's nice. A guy just graduated a few months ago, and when he first came, he and I went head to head on a daily basis. He would come in and ask for things that I already told him no, then to the other nurse. And I would find him and say, 'I already told you no.' We would call him out on it every single time. He challenged me for months...him and I. He would say he had migraines and need to go lie down, but no sign and symptoms of a migraine. He did not like me and made that very clear. When I would see him, he would "mean mug" me, and I brushed it off. But then, at graduation, he asked me to pass coin and I said to the other nurse, 'something is up. I feel like something is up. I don't know what it is.' At graduation they get a coin saying they have completed the program. And they pick one person to pass their coin, and I got picked for him. He was the first speaker. And before he even started his speech, he turned to me and said, 'I asked for you to do coins at my graduation because I feel like I really need to apologize. I was an ass to you when I first got here, and I challenged you, and you are here

for the right reasons. I want to thank you for it, and I hope that you accept my apology.’ He has called several times since he left, and he is doing great. It’s good to hear them come back when they know they were in the wrong. (Sarah)

When the guys graduate sometimes...I almost cry at every graduation, and you feel like it’s your kid graduating! You see them grow so much. And when the guys walk in here, the nurses and I will say, ‘They are going to make it or they are not going to make it’ after the first couple of hours after meeting them. And we love it when we are wrong and when we see them grow and graduate. It is so exciting to see, and you are so proud and even more proud when they call you back to say ‘I started a construction business.’ I had a guy call awhile back to say he had to do the Heimlich maneuver on his daughter, and I was the one that taught him CPR. And so, it’s like ‘Yeah!!’ Those little things...it brings you back. And that’s why I am here. And sometimes they are small differences, but it is still a difference. (Sarah)

Theme Summary. The third and final theme, “the walls of confinement” highlights how nurses feel about working behind the closed walls of a secure MTC. Some of the experiences are frustrating because the care provided is incongruent with their intuition and education. It can be isolating at times and difficult to navigate the system of the Department of Corrections. Yet, even with its challenges, the rewards are beneficial and can be two-way.

Chapter Summary

The lived experience of nurses working in a secure modified therapeutic environment was explained in three main themes and twelve subthemes from the interviews of the participants. These themes and subthemes contributed to the overall essence of a MTC, a pathway to professional identity.

Table 1.0 Cross-Case Analysis of Themes Across All Participants

Themes & Subthemes	Participants									
	Kris	Sarah	Molly	Tom	Barb	Amy	Sue	Mary	Shelly	Jodi
The Process of Becoming										
Manipulation Burns	X	X		X				X		X
The Community	X	X	X	X	X	X	X		X	X
Criminal Thinking	X	X	X	X			X	X	X	
Trust the System	X	X	X	X					X	X
Giving up the Glory	X	X		X	X	X		X	X	X
Boundaries Build Walls										
Shutting Down	X	X	X	X	X		X	X		X
Relationships Break-up	X	X	X	X	X				X	X
Don't Give an Inch		X	X	X	X	X	X		X	X
The Walls of Confinement										
Dissonance of Care	X	X	X		X	X	X	X		X
Isolation	X	X	X	X	X	X	X		X	X
Care in the System	X	X		X		X			X	X
Rewarding	X	X	X	X	X	X		X	X	X

CHAPTER VI

DISCUSSION AND INTERPRETATIONS

The purpose of this phenomenological inquiry was to describe, interpret, and gain a deeper understanding of the lived experience of nurses working in a secure Modified Therapeutic Community (MTC). In this research, three main themes and twelve subthemes revealed the meaning of these experiences as the essence of a MTC—A Pathway to Professional Identity.

Findings as They Relate to the Current Literature

An emerging trend in the treatment of substance abuse in incarcerated individuals is the Modified Therapeutic Community (MTC). A paucity of research exists on this type of treatment program. In addition, there is little research on the effect this program might have on the nurses working in them. As a forerunner in studying the lived experiences of nurses working in secure MTC, this phenomenologic inquiry aimed to describe, interpret, and gain an understanding of these lived experiences. While the findings of this qualitative, phenomenological study may expand and support the current literature, the nurses as participants in this inquiry are unique. The participant responses provide insight into their working conditions and provide meaning to their experiences.

Nursing Demographics

The participants in this study all are working as registered nurses in a secure substance abuse treatment facility that was designated as a MTC. All of the participants have experienced working in this environment and had experienced the process of adapting to the role as a nurse in a MTC. Although all of the participants had previous

nursing employment at various facilities, this inquiry was limited to their experiences of working in a MTC.

Theme: The Process of Becoming

Each of the participants described the experience of what it was like to become a nurse in a MTC. They emphasized the importance of all participants participating in the community as “being on the same page” and trusting the system. Several participants emphasized that even though care may not be demonstrated as they were trained, communication and consistency within the departments and inmates was critical. Many of the participants stated that this kind of relationship is optimal; however, these relationships did not always begin in this fashion. One of the participants stated it took one year before he felt like he had reached a trusting relationship with the staff members at the MTC. This finding is congruent with the current literature. VanderWaal, Taxman, and Gurka-Ndanyi (2008) state criminal justice personnel might view therapeutic approaches as enabling whereas medical and social services personnel generally view the approaches of criminal justice personnel as harsh. Vander Waal, Taxman, and Gurka-Ndanyi (2008) state these differences often lead to distrust, skepticism, and suspicion and can split staff.

The participants in this study discovered inmates’ manipulation and criminal thinking, an area new to them, as they experienced the process of becoming a nurse in the MTC. They all stated they had little preparation for this aspect of patient care. Much of what is critical in being a successful MTC nurse is being demonstrated by the security, treatment staff, and even by the inmates. Nurses have to learn to trust a system that is foreign to their educational nursing background and experience. This parallels the

literature as Miller & Miller (2010) state, “The modified therapeutic community differs from other treatment programs in that the primary therapist and teacher is the community itself.” (p.73). Most participants in this study provided examples of being “burned” by manipulation, the effect of being underprepared for this patient population. Study participants stated there is little skill involved in this position and felt most of the emphasis was on the treatment (counseling) staff. This, coupled with the other subthemes, could provide reason as to why administrators report hiring nurses to fill vacant positions more difficult and time consuming than hiring counselors in secure MTC’s (Knudsen, et. al, 2011).

Theme: Boundaries Build Walls

Several study participants initially questioned their decision to work in a MTC and gradually came to understand the relationship they once had with patients’ needs to be different in this setting. Shutting down and getting a backbone were two common characteristics participants felt were important to create the boundaries needed to work in the MTC. The participants noted that consistency, and not “giving an inch” was a critical focus when working with incarcerated individuals. Semple, Zians, Strathdee, and Patterson (2008) state felons are found to differ in terms of social stigma and impulsivity. It is important for nurses to maintain consistency as impulsivity and impairment in learning and attention have shown to be affected with methamphetamine and other substance-use disorders (Semple, et. al, 2008). Previous explorations focused on the nature of emotional labor in prison nurses and highlighted the effects relationships can have on the profession (Nolan & Walsh, 2012). Emotional labor is defined as having these components: “the faking of emotion that is not felt and/or hiding of emotion that is

felt” (Nolan & Walsh, 2012, p. 165). Nolan and Walsh (2012) support the participants’ statements that emotional labor can be a source of stress and high burnout. Most of the study participants understand the importance of adhering to strict boundaries but provide several examples of the effects when boundaries are crossed. Interactions with inmates are kept to a minimum to decrease emotional labor; participants classify this behavior as “shutting down”. Monks, Topping, and Newell (2012) support this behavior in a qualitative study examining nurses’ attitudes towards known substance abusers in the hospital setting. The findings of Monks, et. al (2012) report nurses limiting their time and interactions with patients who abuse illicit drugs because of mistrust. In the present study nurses describe building a wall that is high so as to gain respect by the MTC community. Respondents in this study also state that process of building a wall to assist in maintaining boundaries is usually recommended by the other staff or from hearing about the effects of improper boundaries between the inmates and other nursing staff in the past. These behaviors which are used to maintain boundaries are similar to behaviors used in Monks, Topping, and Newell’s (2012) study. They found that detachment was chosen by nurses to assist them in limiting any engagement in emotional work with users of illicit drugs. Festinger’s (1957) theory of cognitive dissonance suggests that when beliefs are at odds with behaviors, individuals adopt several cognitive behavioral tactics, like shutting down and avoidance, to reduce the emotional stress. All of these tactics were used by the participants in this study.

Theme: The Walls of Confinement

Several of the study participants noted that learning how to provide care under the confinements of the prison system was difficult and, at times, frustrating. This is

consistent with Mosher and Phillips' (2006) report that defines external accountability in the system as a constraint to care. These researchers discuss one of the most interesting findings in their study. It was the extent to which secure MTCs have to answer to and accommodate the many competing levels of oversight. Each staff member must not only be accountable to the facility administration but they are also governed by the policy and procedure with the contracted Department of Corrections. Mosher and Phillips' (2006) findings highlight how misunderstandings can be manifested through the many layers of oversight and can affect the day-to-day operations of the MTC.

Most of the participants in this study discussed the many ways care in the MTC was different from the educational and theoretical underpinnings from which they were taught. The nurses in this study mimic the results from Monks, Topping, & Newell's (2012), findings when they state that none of them received any formal training in their nursing education to prepare them to care for patients using illicit drugs. Like the findings of Monk, Topping, & Newell (2012) the participants in this study spoke of feeling mentally challenged by this patient population and used isolation and avoidance to limit or buffer these feelings. This is also consistent with Nolan & Walsh (2012) findings that when nurses care for challenging prisoners, they may find it difficult to provide care at all. This behavior is in conflict with the intrapersonal relationships that nurses have with their professional selves, leading to high levels of emotional labor, stress, burnout, and subsequently impacts her mental well-being.

An important component of the MTC framework is that nurses should be a vital component in the therapy of the inmate (Perfas, 2012). Unfortunately, the majority of the nurses in this study stated they are choosing not to become involved in the therapy. The

reason is that many of the study participants perceive their role in the MTC as limited to dispensing medication and educating inmates on healthy living. Many of these nurses chose to isolate themselves in the medical unit and limit interactions to only when it is required. This is exactly opposite of the goal of the MTC approach which is to remove the semblance of the prison experience and set a standard of behavior that is family-oriented.

Because there is a high correlation of substance use disorder and co-occurring mental illness, the majority of the inmates are taking mood-stabilizing medications. The anatomical brain-related changes of long-term use of methamphetamines and other substances leads to the increase in mental health issues as well as behavioral changes that can be difficult to manage. The use of medication requires monitoring and assessment by skilled registered nurses. The nurses in this study are fulfilling this role well, however are limited in the development of therapeutic relationships with inmates at the facilities. This self-preserving behavior could avoid situations that may be misinterpreted by the inmates and staff or could be due to lack of education on how to develop therapeutic relationships with incarcerated individuals.

Implications for Nursing

The findings of this phenomenological study offer various implications for the profession of nursing. First, the qualitative research contributes to the science of nursing by offering nurses, nursing researchers, and students a better understanding of the meaning and lived experience of nurses working in a MTC. These programs are currently growing in the United States to address the overcrowding of prisons nationwide. The stories of the study participants inform current nurses and nursing

administration, who are involved in MTCs, what they may expect and validates that they are not alone in their experience. For those considering entering into a nurse profession in a secure MTC may be able to better prepare and anticipate what they may experience.

While the nurses are fully operating under the Nurse Practice Act of their state, at its current level the nature of practice does not allow for much professional growth to maximize practice. Historically, nurses have been viewed as caregivers in both the sense of emotional contribution and clinical expertise (Benner, 1984). During the recent nursing shortage and with anticipated changes in national health care, professional nursing has become involved in developing a theory of caring that can be practical in client interactions and teachable in schools of nursing. Caring, in its broadest sense, has become the watchword in nursing practice. The use of the word “caring” in a professional sense, can be related to “three categories: attention to or concern for the patient; responsibility for or providing for the patient; and regard, fondness, or attachment to the patient” (Chipman, 1991 p. 171). Caring is “the willingness to provide support for others in times of need” (Chipman, 1991, p.171).

Caring theory is difficult to delineate concretely. The concept is illusive and seems to defy objective investigation, though nursing researchers are continually pursuing new strategies to generate data which will demonstrate the value of caring. Caring, as it relates to nursing, is predominantly a humanistic philosophy. This philosophy has enriched the profession, and, yet, so many times, we see the negative effects of lack of caring.

The practice of nursing is based on a variety of nursing theories. Though some experts argue that nursing, as a social science and caring profession, should not be

restricted by a particular paradigm (Robinson, 1992), present conceptual models are seemingly best understood in the context of a fundamental nursing paradigm. These models address the interrelationships among the descriptive categories of nursing, person, health, and environment (Fitzpatrick & Whall, 1989)

Patricia Benner developed models of caring which are currently foremost in describing the essence of professional caring. Benner's model places caring as a necessary component in her theory of skill acquisition "from novice to expert" (Benner, 1984). She describes nursing as an "enabling condition of connection and concern" (Benner, 1984, p. 192) which implies a high level of emotional involvement in the nurse-patient relationship.

Patricia Benner speaks of the "power" of caring. Her description of the caring role involves the concepts of transformative power, integrative caring, advocacy, healing power, participative/affirmative power, and problem solving (Benner, 1984). She emphasizes that nursing care is more than the application of mere skill; it is relational and involves the nurse's response as a human being, first and then secondarily, in the nursing role. The nurses in this setting describe the inability to demonstrate a caring environment which can contribute to the dissonance of care leading to burnout. However, maybe it is time for researchers to further define the many aspects of caring and explore if caring would present itself differently in this setting.

The participants describe personal accountability, peers, and administration as essential components of their support system. Understanding manipulation, boundaries, and criminal thinking patterns were characteristics of successful nurses most noted by the participants in the MTC. Since these are not addressed in typical nursing education

programs, the study participants stated there is greater dependence on the community of the MTC to teach them how to incorporate the realities of manipulation, boundaries, and criminal thinking patterns into a therapeutic environment. Thus, it is important for administrators to understand the behaviors modeled by the staff provide the nurse with direction on what behaviors are acceptable on the unit thus dictating a number of standards on how a correctional nurse might deliver care.

A somewhat unexpected finding was that several study participants felt that they had to prove themselves to the staff before a professional relationship developed. This was isolating and highlights the need for additional support when new nurses are hired and a strong mentoring program should be implemented to integrate nurses into the community.

Finally, this research provided a unique look at the experiences of nurses who are currently working in a secure MTC. Preconceived notions, life experiences, other varying factors and inexperience working with inmates affect the care the nurses provide in these facilities. These factors often leave the nurse feeling isolated and dissonant. It will be through the continued collection of evidence and implementation of a mentorship program that this isolation can be overcome.

Limitations

Findings from this study is limited to one geographical area of the United States and the study participants' experiences in three secure MTC's. In addition, while diversity was sought, the sample reflects predominately Caucasian, female participants.

Recommendations for Further Research

van Manen (1990) states phenomenological inquiry is an individual interpretation of the human experience with potentially richer description. It is hoped that the findings from this study will spark dialogue among nurses, nurse directors, nurse educators, and administrators to discuss the unique problems nurses have in integrating and participating as equal community members in the MTC. This study also needs to be replicated to validate the themes and subthemes. The themes could be tested on other subject groups or similar types of programs for comparison and validation.

The participants' stories raise some important questions about the preparation of the nurses as they enter into this unique specialty of nursing. A great amount of variability surfaced in the participants' perceptions of the importance of their physical presence in the MTC in terms of how much they should interact with the inmates. These findings suggest a need for more education and/or mentoring programs to aid nurses in the process of professional identity in the MTC.

Chapter Summary

This chapter presented interpretation and discussion of the study's phenomenological inquiry. While many of the study's findings support those of the reviewed literature in many ways, this research provides new information regarding nurses' experiences in a secure Modified Therapeutic Community. Included are implications for nursing and recommendations for further research.

Conclusion

Ten participants volunteered to participate in this study of the meaning of the lived experience of nurses working in a secure Modified Therapeutic Community. The findings resulted in three themes with a total of twelve subthemes that provide an exhaustive description and interpretation of the essence of the phenomenon. The findings and the model of the fundamental structure of the overall essence of a MTC—A Pathway to Professional Identity were validated through member checking with participants. Gaining insight into the meaning of the experiences of nurses working in a secure MTC has several implications for the science of nursing. Participants found the “process of becoming’ as challenging, and it was a new learning experience for them. Boundaries proved to be a noteworthy factor in the participants’ experiences. Due to the nature of the environment and patient population, nurses often became disengaged and isolated from relationships. Building a strong support system with the staff contributes to the overall success of the program.

APPENDIX A

Recruitment Flyer

NURSES WANTED FOR RESEARCH STUDY

The Lived Experience of Nurses Working in a Secure Modified Therapeutic Community

My name is Victoria Plagenz, and I am currently a student in the PhD Nursing program at the University of Nevada, Las Vegas (UNLV) School of Nursing. I am also a nursing professor for the Montana State University-Northern.

For my doctoral research, I am exploring the meanings of the lived experience of registered nurses working in a secure modified therapeutic community (MTC). I will be conducting audio-taped, semi-structured interviews with interested nurses who work in facilities with established MTCs. You are invited to participate in the study if you:

- Have held a full or part-time position in a MTC
- You are a licensed registered nurse

It is estimated that the initial private interview will be approximately one hour in duration. The interview will take place at a location that is convenient for you. A few weeks later, you will be contacted via telephone for a follow-up conversation that may last about 30 minutes in order to confirm the transcription accuracy, descriptions, and interpretations. At that time, you can add or delete information if you so choose. It is hoped that the themes that emerge from the study may lead to a greater understanding of the meaning of being a registered nurse in a MTC. Your participation is strictly voluntary, and you can decide to withdraw from the study at any time. You can refuse to answer any question and complete confidentiality will be maintained during and after the study. Your name or other personal identifiers will not be used in reported study findings.

If you are interested in contributing to the growing body of knowledge about MTCs, please feel free to contact me for additional information. I will be happy to answer any questions. Contact information is provided below:

Victoria Plagenz: vplagenz@outlook.com or plagenzv@unlv.nevada.edu

Phone: (406) 366-2507

Or

Dr. Michele Clark, Faculty Chair: michele.clark@unlv.edu or (702) 895-5978

APPENDIX B
INFORMED CONSENT



INFORMED CONSENT

Department of Nursing

TITLE OF STUDY: The lived experience of nurses working in a secure modified therapeutic community

INVESTIGATOR(S): Dr. Michele Clark, PhD, RN and Victoria Plagenz, MSN, RN

For questions or concerns about the study, you may contact Dr. Clark: (702) 895-4807, Mrs. Plagenz: (406) 538-3334

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

Purpose of the Study

You are invited to participate in a research study. The purpose of this study is describe, interpret, and offer insight into the meaning of the lived experiences of nurses who work in a secure modified therapeutic community (MTC).

Participants

You are being asked to participate in the study because you fit these criteria: (1) you are a licensed registered nurse; (2) you are currently working full- or part-time in a secure modified therapeutic community.

Procedures

If you volunteer to participate in this study, you will be asked to do the following: Participants will agree to complete a short questionnaire and agree to a private face-to-face audiotaped interview. The recordings will be transcribed by the researcher and sent to you via your preferred method of correspondence. In addition, participants will agree to a follow-up telephone interview that will be used to clarify any errors in the verbatim transcription and misinterpretations of the researchers regarding themes that will allow participants the opportunity to add any additional thoughts about their lived experiences as a registered nurse in a MTC. Participation is completely voluntary and confidential. Each interview will last approximately one hour and will be held at a private location that is convenient for you.

Benefits of Participation

There may be no direct benefits to you as a participant in this study. Participants will have the opportunity to reflect upon the meanings of their experiences as registered nurse in a MTC. The data collected will contribute to the body of knowledge of nursing practice and education and will enhance understanding of how nurses experience their role for all MTC stakeholders, future MTC nurses, and the administrators who support them.

Risks of Participation

There are risks involved in all research studies. This study may include only minimal risks. There may be some discomfort discussing your experiences as a registered nurse on a MTC and the feelings associated with those experiences. You will be assured that you can withdraw from the study at any time. There are no risks if you decline participation in the study.

Cost Compensation

There will be no financial cost to you to participate in this study. The study will take approximately two hours of your time.

Confidentiality

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

Voluntary Participation

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

Participant Consent:

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

Signature of Participant

Date

Participant Name (Please Print)

If your study includes the use of audio/video taping, you must include a separate signature line for the consent to audio or video tape. Otherwise, delete this section.

Audio/Video Taping:

Use language similar to:

I agree to be audio or video taped for the purpose of this research study.

Signature of Participant

Date

Participant Name (Please Print)

APPENDIX C

Demographic Questionnaire

Please answer the following questions. You are free to omit the answer to any questions that you choose not to answer.

1. What is your age?

20 to 29

30 to 39

40 to 49

50 to 59

60 to 69

More than 69

2. What is your gender? female male

3. What is your ethnic background? _____

4. What is your highest degree BSN MSN PhD EdD DNP
 Other (Please Specify)

5. How many years have you been a nurse? _____

6. How many years have you been at your current facility? _____

7. Have you had any previous nursing employment elsewhere? yes no
Explain _____

APPENDIX D

Initial Hermeneutic Interview Question:

What does it mean to be a nurse working in a Modified Therapeutic Community?

Probes to further the dialogue (if needed)

1. Can you tell me a story that will help me understand what that means?
2. Can you elaborate more on that?
3. Can you share an example of that?
4. Do you recall how you felt that time?
5. What did that mean to you?
6. Will you share what you are thinking now?

Probes to elicit additional information (if needed)

1. How is being a nurse in a modified therapeutic community different from other nursing experiences?
2. What is the meaning of your relationship with the family members, counselors, security etc in the therapeutic community?
3. How did you experience the process of becoming a nurse working in this environment?
4. Can you share a story as a nurse working in the modified therapeutic community that you find personally meaningful?
5. Can you recall any situation as a nurse in the MTC that you felt you were especially (enlightened, frustrated, disappointed, rewarded, and unexpected)?

APPENDIX E

Participant Profiles

Participant Pseudonym	Age Category	Gender	Ethnicity	Highest Earned Degree	Years in Nursing	Years at MTC	Previous Nursing Experience
Jodi	50-59	F	White	ASN	29	6	Surgery, nursing home, home health, hospice
Shelly	40-49	F	White	BSN	5	1	Labor and deliver, case management, clinics, pediatrics
Mary	30-39	F	White	ASN	8	1.5	Clinics, acute care
Sue	30-39	F	White	BSN	8	1	Mental health, clinic
Amy	40-49	F	White	BSN	9	4	Float nurse
Barb	20-29	F	White	BSN	4	.9	Acute care, clinic
Tom	30-39	M	White	BSN	7	2	Acute care, ER, clinic
Sarah	30-39	F	White	ASN	5	3.5	ICU/PCU
Kris	20-29	F	White	ASN	5	3	Acute care
Molly	20-29	F	White	ASN	1	.9	Acute care

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