

**THE EXPERIENCES OF SUBSTANCE USE NURSES
PARTICIPATING IN THE HEALTH PRACTITIONERS'
MONITORING PROGRAM IN VIRGINIA**

Patricia Ann Owens

Dissertation submitted to the faculty of the Virginia Polytechnic Institute
and State University in partial fulfillment of the requirements for the degree
of

Doctor of Philosophy
In
Counselor Education

Nancy Bodenhorn, Co-Chair
Penny Burge, Co-Chair
Lisa L. Onega
Hildy G. Getz

March 20, 2018
Blacksburg, Virginia

Keywords: monitoring program, substance use, nurses, overwhelming,
internal and external coping skills, accountability

THE EXPERIENCES OF SUBSTANCE USE NURSES PARTICIPATING IN THE HEALTH PRACTITIONERS' MONITORING PROGRAM IN VIRGINIA

ABSTRACT

The purpose of this phenomenological study is to describe participants' experiences in a monitoring program for impaired nurses in Virginia, determine what beliefs and attitudes underscore the participants' abilities to cope with the program, and uncover what meaning is made of the experiences. In Virginia, health care providers are supported through the Virginia Health Practitioners' Monitoring Program (HPMP).

Limited research exists concerning the lived experiences of substance use nurses who are participating in a state monitoring agency. Research focuses on how a nurse copes with personal and job-related stress and the use of peer support as an important aspect of recovery. This study helps to uncover what policies are effective and ineffective and serves as valuable feedback to ensure the success of monitoring programs, the recovery of substance use nurses, and the safety of the public.

In this phenomenological study, five participants were solicited, four females and one male. Three out of the five participants were near completion of the HPMP experience. Two participants were relatively new (over one year) to HPMP. The study focused on three primary research questions: (1) What has been the lived experience of the participant in HPMP?; (2) What beliefs/attitudes are used by the participants to cope with the monitoring experience?; (3) What meaning do the participants give to their experiences in the HPMP?

Initially, a pre-interview was held on the phone. Then, two interviews were conducted in the participants' hometowns spaced one week to ten days apart. The first

interview centered around gathering a focused life history and on the details of the experience. The second interview afforded the opportunity for reflection on the meaning of the experience in HPMP.

Data analysis began with an immersion into the descriptive words of the lived experience of each participant. Through the compilation of textural and structural descriptions, three themes emerged from the rich data. The findings indicated that the participants felt overwhelmed with the program's requirements. Participants found the use of coping skills helped them work through the overwhelming rules and regulations. Finally, participants discovered that with acceptance of the program came accountability.

GENERAL AUDIENCE ABSTRACT

A message on a t-shirt read, "I'm a nurse...what's *your* superpower? Our society admires and respects the nursing profession. Nurses provide a service that is vital to patient comfort and recovery. Because of this responsibility, nurses are often under a tremendous amount of pressure. For relief, some nurses may turn to substance abuse. The discovery that a nurse has a substance abuse problem may lead to a sense of shame and dishonor and negatively impact the nurse's career. This study focused on the experiences of nurses who were seeking treatment for substance abuse through the Virginia Health Practitioner's Monitoring Program.

The purpose of this study was to describe the experiences of impaired nurses who had been part of the Virginia Health Practitioner's Monitoring Program and to find which policies were successful and which were not. Five participants were selected for this study. Two participants were new to the program and three had almost completed it. Three primary research questions were used in the study that focused on what participants had experienced in the program, their attitudes toward the program, and what meaning they gave their experiences. A phone interview was followed by two face-to-face interviews in which participants answered the research questions.

The researcher analyzed the data by becoming immersed in the interview transcripts while looking for commonalities. The researcher discovered three themes that emerged. First, participants felt overwhelmed by the program's requirements. Secondly, they all used coping skills to help them work through the rules and regulations of the program. Finally, they learned accountability and acceptance.

DEDICATION

Nurses have a unique relationship with their patients, often seeing them in times of vulnerability and crisis. Furthermore, nurses seek to help relieve suffering and foster health. This dissertation is dedicated to nurses who are in recovery from substance use. A nurse in recovery brings wisdom, awareness, and compassion to others with substance use issues. These nurses are a vital part of the community and healthcare system. To be in recovery requires intense personal commitment, constant awareness of relapse warning signs, and the implementation of appropriate coping skills. It can be hard work, yet the payoffs to recovery are invaluable.

This dissertation is also dedicated to the substance use recovery professionals who offer treatment and support to the nurses in recovery. These professionals range from the counselors, support group members, addictionologists, work-place supervisors, medical professionals, and monitoring professionals who are committed to guiding those in need of recovery. The work can be arduous, joyful, heartbreaking, and challenging.

ACKNOWLEDGEMENTS

I would like to thank my co-chairs, Nancy Bodenhorn and Penny Burge for their feedback, guidance, and support. Their devotion to my research encouraged me to keep working. Thank you for giving me the opportunity to complete my terminal degree and for your dedication to seeing this dream to completion. Many thanks to my committee members, Hildy Getz and Lisa Onega for your time and thoughtful consideration. A special thanks to Kathy Tickle for her expertise and assistance.

I wish to express my heartfelt gratitude to the participants of this study, Julia, Harriet, Clark, Rebecca, and Melissa. Without their honesty, this study would not have occurred. The courage and openness they gave in the interviews was an inspiration. I would also like to give my appreciation to my work colleagues, Lynda, Susan, and Diane to my mentor, Anne, and to my friends, Jill and Vickie, for supporting me throughout this adventure.

Thanks goes to my sister, Jeanie, for her editing skills. I could not have completed this dissertation without her tireless effort, love, and support. Also, I wish to express gratitude to my Mother, Angie, my siblings: Linda, Jimmie, Sandy, and their spouses Larry, Angie and Larry. Thank you also to my nieces and their spouses: Heather and Lamar, Emily and Christopher, Carrie and Andrew, Annelise, and Courtney; and to my nephews and their spouses: Landon and Becca, Jed and Kourtney, Lukas and Janelle, Caleb, and Eli; and to my very special great niece and nephews: Mallorie, Bryant, Carter, Jarrett, and Walker. Your love enabled me to continue and persevere. Also, I would like to give appreciation to my extended family who supported me in this endeavor. A special thank you to Zumba class, Margie and the magnificent seven.

TABLE OF CONTENTS

Abstract	i
Dedication	v
Acknowledgements	vi
Chapter 1 Introduction	1
Background of the Problem.....	2
Health Practitioners’ Monitoring Program	4
Statement of the Problem	8
Purpose of the Study.....	8
Significance of Study.....	9
Primary Research Questions.....	9
Theoretical Framework.....	9
Definition of Terms	10
Summary	11
Chapter 2 Review of the Literature	12
History of Substance Use	12
History of Impaired Nurses	19
DSM-5 Criteria for Substance Use Diagnosis	20
Biological Process of Addiction	22
Relevant Studies.....	23
Stress Factors and Nurses... ..	27
Substance Use Nurses’ Relationship with Peers	29
Summary.....	32
Chapter 3 Methodology	34
Purpose Statement.....	34
Rationale for Methodological Framework.....	34
Quality and Rigor of Research Methods.....	36
Member Checking	38
Participant Selection and Sampling Size	38
Participants	39
Data Collection	41
Data Analysis	43
Reflexivity Statement.....	45
Summary	47
Chapter 4 Results	49
Julia.....	49
Textural Description for Julia.....	50
Structural Description for Julia.....	51
Harriet.....	52
Textural Description for Harriet.....	53
Structural Description for Harriet.....	55
Clark	55
Textural Description for Clark.....	56

Structural Description for Clark.....	59
Rebecca.	60
Textural Description for Rebecca.....	61
Structural Description for Rebecca	63
Melissa	64
Textural Description for Melissa	65
Structural Description for Melissa	67
Summary of Textural Descriptions	67
Summary of Structural Descriptions.....	68
Themes	68
Theme One: The Lived Experience of HPMP is Overwhelming.....	69
Theme Two: Acceptance is the Answer.....	73
Theme Three: Accountability.....	76
Summary	80
Chapter 5 Discussion and Conclusions	81
Summary of the Results.....	81
Discussion of the Findings.....	82
What Has Been the Lived Experience of the Participants in HPMP?.....	83
What Beliefs/Attitudes Are Used by Participants to Cope with the Monitoring Program?	84
What Meaning Do the Participants Give Their Experience in HPMP?...	86
Connection to Literature.....	87
Limitations	91
Implications.....	94
Future Studies	95
Summary	98
References	100
Appendices	111
Appendix A: Virginia Tech IRB Approval	111
Appendix B: Participant Flyer.....	113
Appendix C: NIDA Confidentiality Certificate.....	115
Appendix D: Participant Data Form.....	119
Appendix E: Virginia Tech Consent Form.....	121
Appendix F: Interview Guides.....	125

CHAPTER 1 Introduction

A message on a t-shirt reads, “I’m a nurse...what’s *your* superpower?” Our society has a high regard for nurses and their abilities. Nurses provide primary care and support to patients and are often the most integral aspect of their recovery. Because of this, society holds nurses to a high standard of behavior and nurses often put a tremendous amount of pressure on themselves. In a study of nurses’ personalities utilizing the Myers-Briggs Type Indicator, Jain and Lall (1996) found half of the study participants received the personality type *Sensing, Feeling, and Judging*. They state, “(Nurses) are described as practical, realistic, conservative, effective problem-solvers, trustworthy, caretakers, respective of rules and hierarchy, like to serve others, and seem resistant to change” (p. 938). Many nurses demand perfection from themselves and other nurses, and can be described as possessing a Type A personality.

The common traits of a Type A personality (perfectionistic, over-achiever, multitasking, sense of time urgency) may promote chemical dependency in nurses, as the natural stress of the job is so intense and demanding. In Bissell and Jones’ (1981) study of the alcoholic nurse, many of the participants graduated in the top percentile of their classes and continued to further their formal training. When personal high expectations of behaviors are not met, low self-esteem and stress may prevail. In his research study, Burns (1991) found that low self-esteem and stress placed nurses at risk for increased substance use. The intensity of the nursing profession and the tendency to see nurses as super-human may create an internal environment in which nurses are unable to deal with the stresses of their occupations and their personal lives.

The medical culture revolves around using medications to treat a myriad of issues. Nurses themselves work in a culture where “drugs are tools of the trade” (Abbott, 1987, p. 871). Epstein, Burns, and Conlon (2010) state, “Because nurses perceive themselves as invincible and work in an environment with access to drugs, nurses are at an increased risk for drug use” (p. 516). Using drugs as an escape from the stress of everyday life, nurses may begin the cycle of drug use that progresses to an addiction soon noted by co-workers and supervisors. A study by Lillibridge, Cox, and Cross (2002) found some nurses misused substances in order to feel more positive about themselves and to handle the daily expectations set for them by the nursing profession.

The discovery that a nurse has a substance abuse problem may lead to a sense of disbelief and dishonor, which could negatively impact her career in the health care industry. Furthermore, a nurse’s reentry into the nursing profession may be hampered by the social stereotypes associated with this disorder (Shaffer, 1988). This study will be focused on the lived experience of substance use nurses in Virginia and their participation in the Virginia Health Practitioners’ Monitoring Program (HPMP). A rich description of the phenomenon will provide further information to enhance monitoring programs and improve psychotherapists’ awareness of counseling issues in this special population.

Background of the Problem

The American Nurses Association (ANA) designates impairment as follows:

Nursing practice is impaired when the individual is unable to meet the requirements of the professional code of ethics and standards of practice because cognitive, interpersonal, or psychomotor skills are affected by conditions of the individual in interaction with the environment. These factors may include psychological dysfunction or excessive use of alcohol and drugs (American Nurses Association, 1984, pp.2-3).

Impairment can be from psychiatric, substance abuse, or physical disability. For the purpose of this study, *impairment* will be used to refer to substance use.

Approximately 3% to 6% of nurses practice impaired due to chemical dependency (Trossman, 2003, p.27). Monroe, Kenaga, Dietrich, Carter, and Cowan (2013) concur that an estimated 6% of nurses are impaired; however, they suggest it is difficult to ascertain the exact number. Their study does indicate a possible increase of 14% to 20% of RN's being substance use impaired in the United States (Monroe et al., 2013). A study by Trinkoff and Storr (1998) found that 2% of nurses indicated a drinking problem and 8% had abused drugs.

As nurses are the front-line of patient care, guidelines for an impaired nurse's recovery in a monitoring agency must be fully outlined. The ANA Code for Nurses (1985) in part demands the nurse should maintain the integrity of nursing. Incompetent care due to a substance use disorder, does violate this code. Carpenter (1994) indicates that the issues surrounding an impaired nurse are both legal and ethical in nature stating, "For nurses, such punishments may include revocation or suspension of the professional license, participation in recovery programs, and possibly imprisonment. However, ethical concerns are less explicit and without defined punishments" (p. 139).

Ethical dilemmas abound for the employer, co-workers, and nursing supervisor of the impaired nurse. Much of the literature surrounding impaired nurses concerns how colleagues respond or do not respond to the impaired nurse. Bugle, Jackson, Kornegay, and Rivers (2003) found nursing faculty were uncertain as to their ability to identify impaired nursing students. In addition, Beckstead (2002) surveyed nurses' attitudes toward impaired nurses and found that an isolated relationship between "moralistic and

punitive attitudes” created a very judgmental environment that was counterproductive in aiding the afflicted nurse (p. 548).

Many researchers in the past indicate a discrepancy between enabling behavior from coworkers and a lack of compassion when the addicted nurse is discovered by administration (Barr & Lerner, 1984; Bissell & Jones, 1981). A need exists to educate nurses and health care professionals on substance use. Brennan (1991) believes that nurses fail to realize their own humanity while, paradoxically, offering compassion and care to their patients. Nurses tend to ignore the fact that they are under the same stressors and health concerns as everyone else in society. Moreover, coworkers fail to recognize that the opportunity for substance use is prevalent within the nursing profession due to everyday stressors and access to medication (Brennan, 1991). Thus, an incongruity exists within the nursing profession regarding compassion for a patient with a substance use issue and a lack of understanding for a colleague who abuses substances. Getting help for the impaired nurse is crucial. Any individual or institution who reports an impaired professional, in good faith, is exempt from civil liability (Ziegler, 2015). In Virginia, an impaired nurse seeking recovery must submit to the Virginia Health Practitioners’ Monitoring Program.

Health Practitioners’ Monitoring Program

Each state has established its own way of monitoring and treating substance use nurses. The Virginia General Assembly established the Virginia Health Practitioners’ Intervention Program (HPIP) in 1997. In 2009, the name was legally changed to the Health Practitioners’ Monitoring Program (HPMP) to indicate a more concrete representation of the function of the program. Also, the Department of Health

Professions (DHP) became the executive agency and contracted services with Virginia Commonwealth University's Department of Psychiatry, who continues as the operating agency. DHP offers management and support to fourteen health regulatory boards that license health care practitioners in the Commonwealth of Virginia (Ziegler, 2015).

HPMP is funded through professional licensure fees; however, the portion of funding is determined by DHP. In addition, DHP has established a Monitoring Program Committee (MPC) to oversee and coordinate program policies, operations, and any specific cases that need attention. The director of DHP appoints seven members and meetings occur six times per year (Ziegler, 2015).

According to the 2013 report on program performance, the HPMP's primary mission is to "help ensure the safety of the citizens of the Commonwealth by providing monitoring services to impaired healthcare practitioners and to assist practitioners in the recovery process" (Health Practitioners' Monitoring Program, 2013). The HPMP program goals are (1) to raise public awareness regarding the recognition of impaired practitioners and available services; (2) to increase identification of impairment and encourage treatment and recovery; (3) to assist participants with obtaining comprehensive assessment; (4) to develop recovery monitoring contracts that address the medical, psychiatric, and substance abuse treatment needs of the participants; and (5) to provide comprehensive, timely and effective monitoring services to participants (Health Practitioners' Monitoring Program, 2013).

In a statistical report, the Monitoring Program Committee details that on December 31, 2013 there were 359 nurses participating in HPMP with 91% participating due to a substance use disorder (Health Practitioners' Monitoring Program, 2013). Of the

total amount of nurses participating, about 66% were RNs (Registered Nurses), and less than 25% were LPNs (Licensed Practical Nurses). The remaining percentage consisted of CNAs (Certified Nurses Assistants), CRNAs (Certified Registered Nurses Anesthetist), and NPs (Nurse Practitioner).

As of December 2014, there were 351 nurses participating in HPMP in Virginia. While 26 nurses were participating due to psychiatric and/or physical issues, 325 nurses were enrolled in HPMP for substance use issues (Health Practitioners' Monitoring Program, 2014). The authors of the 2014 HPMP Performance Report indicate a 38% completion rate and a 42% dismissal rate for nurses (Health Practitioners' Monitoring Program, 2014). Dismissal is indicated as discharge due to noncompliance, urgently dismissed for noncompliance, or noncompliance at time of resignation. Approximately 7% of the nurses participating in the 2014 report resigned from the program (Health Practitioners' Monitoring Program, 2014). As of December 2015, there were 305 open cases of nurses in the monitoring program (Health Practitioners' Monitoring Program, 2015). Limited research exists that explores the lived experience of substance use nurses as they participate in a state-monitoring program.

A nurse may enter HPMP prior to a Board of Nursing (BON) hearing and/or completion of a BON investigation. Often BON investigations can take six months or longer. The nurse signs a 5-year contract with HPMP which indicates her intent to adhere to all treatment recommendations. Upon entering HPMP a nurse must complete a comprehensive assessment by a mental health professional who is also certified or licensed as a substance use professional. Recommendations for treatment are given to the intake coordinator of HPMP. These recommendations can include inpatient

hospitalization, participation in an Intensive Outpatient Program (IOP), outpatient individual counseling, and/or outpatient group counseling.

The nurse is assigned a case manager and must complete an orientation to HPMP which is conducted in Richmond, Virginia. Of course, if inpatient care is needed immediately, the orientation will take place upon completion of hospitalization. Participants are oriented to the program and are given a handbook providing the regulations needed for program participation. Attendance to Alcoholics Anonymous/Narcotics Anonymous three times per week, and Caduceus meetings twice per month (a support group for only healthcare professionals) is expected and monitored.

The healthcare professional is not allowed to work until given approval by the HPMP caseworker and treatment team. Furthermore, when the nurse is allowed to return to work, a worksite monitoring program is developed. The HPMP participant must inform their case worker promptly as to any vacations or changes in work scheduling, treatment plans, medication, or when switching primary care physicians or other treatment professionals. All changes must be approved by the participant's HPMP caseworker and treatment team. In addition, the nurse must call in monthly to her assigned caseworker and remit all required forms by the beginning of each month. Nurses returning to work are not allowed to administer narcotics for ninety days.

Each weekday the nurse must call the drug screen phone number in order to determine if she has been selected for a random drug test. If selected, the nurse must obtain the screen by the end of the work day. The drug screen company, Affinity, provides forms and requires the participant to place monetary funds into the participant's

account which are deducted when a screen is given. The HPMP requires dedication to maintaining recovery (Ziegler, 2015). Understanding the experience of these nurses is the basis for this study.

Statement of the Problem

The problem for this study involves the limited research and understanding concerning the voices of impaired nurses who participate in a state monitoring program. Without this understanding co-workers, hospital administration, nursing supervisors, and counselors will lack the skills to interact in a knowledgeable and insightful manner. This research will be focused on nurses who participate in the Virginia Health Practitioners' Monitoring Program.

Purpose of the Study

The purpose of this phenomenological study is to describe participants' experiences in a monitoring program for impaired nurses in Virginia, determine what beliefs and attitudes underscore the participants' abilities to cope with the program, and uncover what meaning is made of the experiences. At this stage in the research, experience is generally defined as the process of personally engaging in the HPMP through personal observations, participants' perceptions, the implementation of coping skill strategies, and the practical wisdom acquired over time. Stress is defined as any problematic emotional experience that results in biochemical, physiological, and changes in behavior (Baum, 1990). The monitoring program is defined as an agency that is organized to protect the public from nurses who are substance users (impaired) and that monitors the nurse upon reentry into the workforce. In Virginia, the agency is the Health Practitioners' Monitoring Program (HPMP).

Significance of the Study

Understanding the meaning given to the experiences of impaired nurses as they participate in a monitoring program will begin to uncover a clearer perception of the phenomenon. Learning from the participants what policies are effective and ineffective and what coping strategies are useful, will be valuable feedback to ensure the success of monitoring programs, the recovery of substance use nurses, and the safety of the public. Also, implications for counseling this special population and strategies for stress management may unfold in the meanings provided by the participants.

This study will be limited to selected substance use nurses in Virginia; however, what will unfold from the experiences of the participants will likely be transferable in understanding the scope and breadth of the issues of being a substance use nurse in a monitoring agency throughout Virginia and in other states. Also, understanding the experience of this special population will provide an understanding and awareness for counselors. Hearing the experiences of substance use nurses will strengthen and advance comprehension of how to care for these important caregivers.

Primary Research Questions

1. What has been the lived experience of the participant in HPMP?
2. What beliefs/attitudes are used by the participants to cope with the monitoring experience?
3. What meaning do the participants give to their experiences in the HPMP?

Theoretical Framework

There are several theoretical models concerning substance use; however, I have chosen to focus on the stress-reduction theory. I acknowledge the validity of neurobiological process, reward theories, and the role of genetics in substance use.

According to Anton (2010), “The stress-reduction theory posits that the normal stress of everyday life (job, marriage, money) as well as abnormal stress of severe events (rape, assault, war, accidents) can be relieved by the use of a substance, and that this relief in and of itself is rewarding, causing the individual to seek out the substance again and again to provide relief of the stress” (p.738).

As observed through the researcher’s professional counseling experience, the job stresses for a nurse can be profound life and death issues, family conflicts stemming from shift work and/or holiday work, personal illness related to chronic pain concerns, maintaining charting and computer accuracy, patient workload, conflicts with coworkers or supervisors, and the length of the shift. In the Lillibridge, Cox, and Cross (2002) study, the nurse participants believed the substance use was due to work stress. Furthermore, some nurses believed that because of the length of their shift work, they had less energy to cope with every day stress and fell into substance use as a way to manage on a daily basis (Lillibridge, Cox, & Cross, 2002).

Definition of Terms

- Health Practitioners’ Monitoring Program is an agency organized to monitor health professionals in the state of Virginia (Orientation Handbook, HPMP, 2015).
- Substance use is a “cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance related problems” (Diagnostic and Statistical Manual of Mental Health Disorders, 2013, p. 483).

- Impairment is “the inability to perform one’s professional duties and responsibilities due to cognitive, emotional, or psychomotor dysfunction... can result from substance abuse, mental illness, or both” (Beckstead, 2002, p.538).
- Caduceus is “a peer-based support group for medical professionals who suffer from substance abuse issues” (Wile & Jenkins, 2013 p.481).

Summary

Multiple issues are present for the substance use nurse such as shame, perfectionism, recovery from addiction, dealing with co-workers and supervisors, unemployment/employment, safety of the patients, personal issues, and the requirements of participation in HPMP. Only a few researchers have explored the experience of the substance use nurses and their participation in a monitoring program. Ethical issues related to treating, supervising, monitoring, and caring for substance use nurses will be important factors as the job of nursing is demanding and stress producing. The purpose of this phenomenological study is to describe participants’ experiences in a monitoring program for impaired nurses in Virginia, determine what beliefs and attitudes underscore the participants’ abilities to cope with the program, and uncover what meaning is made of the experiences. Hearing the voices of substance use nurses will provide information that may enhance counseling and monitoring programs.

Chapter 2 Review of the Literature

The purpose of this chapter is to review relevant literature pertaining to substance use nurses. A history of substance use literature is provided, along with a review of the literature relating to impaired nurses, criteria for diagnosis, biological processes of addiction, stress factors for nurses, and substance use nurses' relationships with peers.

History of Substance Use

It has been speculated that human society began around the consumption of alcohol. Archeologists and anthropologists have found Stone Age beer containers dating back to 8,000 BCE (Hanson, 2015). According to Henninger and Sung (2014), records from 5,000 BCE indicate Egyptians with alcohol issues received nurturing and assistance in private-treatment homes. Rituals and beliefs developed around alcohol and mind-altering substances as people developed substance use issues.

Every culture has its own history of how the substance use individual has been treated. According to White (2014), substance use treatment in North America began in 1750 with sobriety circles created by Native American tribes. Later, the temperance movement became an extensive social platform and opened several sober houses for men (Stolberg, 2006). Henninger and Sung (2014) state, "The temperance movement played a pivotal role in the evolution of substance abuse treatment by sparking a new way of viewing addiction and recovery" (p.2259). Not long after, Dr. Magnus Huss introduced the disease concept and the term alcoholism. In 1864, New York State opened the first Inebriate Asylum and others followed. In 1867 the first institution for treating women opened in Chicago. Throughout the late 1800s, facilities for the homeless began services for substance use and private for-profit facilities emerged (White, 2014).

White (2014) explains that habit-forming behaviors were unknowingly encouraged through the use of various addictive drugs. During the Civil War, for example, opiates were used and sent home with the soldiers upon discharge. Furthermore, cannabis, morphine, and cocaine were widely utilized to treat an assortment of “female problems,” and as a result women addicts outnumbered men three-to-one (Heise, 2003). Specific advertisements were focused on women, making them the dominate population of opiate consumers (Casey, 1978). Also, Sigmund Freud suggested cocaine could be used to treat alcohol and morphine addiction, which gave rise to home cures and concoctions sold by traveling vendors that contained addictive substances (White, 2014).

One such concoction was Coca Cola. With the discovery of coca leaves in South American in the early 1800s and the leaves’ subsequent production by the late 1850s, many upper-class individuals found the act of chewing coca leaves disgusting (Markel, 2011). This led a French chemist, Angelo Mariani, to produce the coca in a liquid elixir that became the forerunner of Coca Cola (Markel, 2011). Coca Cola was advertised to be a healthy drink and claimed to be the “cure for neurasthenia, impotence, headaches, and morphine addiction” (Markel, 2011, p. 59). For a time, the consumption of Coca Cola was widely used by the American people and it was not until 1929 that cocaine was removed as an ingredient.

Between 1910 and 1925 a shift regarding treatment for substance users emerged as most asylums and facilities were closed, leaving only the wealthy able to obtain treatment. In 1914 the Harrison Tax Act placed opiates and cocaine under the control of physicians. The passages of the act did contribute to a decline in opiate and cocaine use

(Durrant & Thakker, 2003). Around 1935 the federal government became involved with research and treatment of addiction. Around the same time, Alcoholics Anonymous was organized by Bill Wilson and Dr. Bob Smith.

According to Durrant and Thakker (2003), Alcoholics Anonymous is based on the idea that alcoholism is a disease where an individual loses control of drinking and abstinence is the only solution. Alcoholics Anonymous is one of the most successful support groups not only in America but worldwide (Hanson, 2015). Research on addiction was encouraged with the first journal, *Quarterly Journal of Studies on Alcohol*, published in 1940 (White, 2014). Throughout the 1940s, research, organization of committees/commissions, and Alcoholics Anonymous gained momentum. By 1950 Disulfiram (Antabuse) was introduced as an additional treatment for alcoholism, Al-Anon for families of substance users began, and the halfway house movement started later in the decade. In the mid to late 1950s, the American Society of Addiction Medicine was established as well as programs within the Veterans' Administration. Also at that time, the first college class in alcoholism was offered at Fordham University (White, 2014).

The 1960s began with an important publication by E. M. Jellinek called *The Disease Concept of Alcoholism* (White, 2014). The American Bar Association and American Medical Association's joint report stated the need for community based treatment programs. In 1963, federal funding was designated for community mental health centers, anti-poverty programs, and criminal justice diversion programs. Additionally, in the 1960s, methadone was introduced for narcotic addiction, insurance companies began reimbursement for substance use treatment, and the Narcotics Addict

Rehabilitation Act passed to support treatment (White, 2014). Moreover, the American Medical Association encouraged members of the health professions to take seriously the complexity of the disease of alcoholism and encouraged treating alcoholic and drug use patients in community clinics (Henninger & Sung, 2014). Toward the end of the decade, counseling services were established within the Armed Forces. Furthermore, the Federal Advisory Committee on Traffic Safety reported on the role alcohol played in car crashes and developed new laws and referral/treatment for those arrested for driving under the influence of alcohol (White, 2014).

In 1970 Congress passed the Comprehensive Alcohol Abuse and Alcoholism Prevention Treatment and Rehabilitation Act which led to the establishment of detoxification centers across America (White, 2014). This contributed to a rise in not only detox centers, but also treatment programs and the development of different treatment approaches (Durrant & Thakker, 2003). That same year, the Joint Commission on Accreditation of Hospitals standardized treatment programs. The National Association of Alcoholism Counselors and Trainers was founded in 1972 and eventually became the National Association of Alcoholism and Drug Abuse Counselors (NAADAC). By 1974 a process for credentialing addiction counselors was in place (White, 2014). A sociologist and recovering alcoholic, Dr. Jean Kirkpatrick, founded Women for Sobriety in the mid 1970's. Women for Sobriety is dedicated to the support and recovery of female substance users (Fenner, 2012). In 1978, First Lady Betty Ford spoke to the public about entering treatment for her own addiction, prompting her to open the Betty Ford Center in 1982 (White, 2014).

The early 1980s introduced America to Mothers against Drunk Driving and Nancy Reagan's *Just Say No* campaign. The latter brought about an unfortunate lack of tolerance for addiction, thereby reducing the federal government's support for treatment and significantly increasing the number of incarcerated drug users (Schoenfield, 2012). The federal government also transferred responsibility of treatment and prevention to the state government level (White, 2014). President Reagan announced a war on drugs, establishing a drug-free workplace. Additionally, federal dollars were taken away from the treatment of substance abuse and given primarily to law enforcement. The war on drugs has proved to be a cultural and gender debacle as incarceration for African Americans, males and females, has elevated since its implementation (Lynch 2012). Pregnant women and mothers have faced additional difficulties seeking treatment since the war on drugs began (Lynch, 2012).

Ironically, the American Medical Association (AMA) believes that all drug dependency should be viewed as legitimate issues for doctors to treat. Furthermore, AMA established a membership for the American Society of Addiction Medicine into their House of Delegates, the policy-making body of the American Medical Association. Yet, the U. S. Supreme Court declined to overturn a Veteran's Administration (VA) regulation allowing the VA to continue to classify alcoholism as willful misconduct. This regulation was later changed by an Act of Congress (White, 2014).

In the late 1980s and early 1990s, insurance companies reduced payments and allowable charges, eliminating payments for hospital detox and many treatment facilities. Johnson and Roman (2002) state, "Like health maintenance organizations (HMOs), preferred provider organizations (PPOs), and other private insurance companies, public

insurance in the form of Medicare and Medicaid also reimburse centers at a pre-established rate well below the centers' typical charges. Such low reimbursement rates could prove detrimental to center survival" (p. 116). Also, Mark, Levit, Vandivort-Warren, Buck, and Coffee (2011) found that during the period of 1986 to 2005 funding for mental health and substance abuse treatment was substantially less than other health related issues. The standard 28-day treatment stay was eliminated. The focus became detoxing at home and the use of intensive outpatient groups. The emergence of the internet added a means for the recovering addict to receive support through the many online groups. Also in the 1990s, a resurgence of drug use by adolescents sparked a renewed interest in treating this population differently since adult substance abuse treatment was proving ineffective for the adolescent population (Zavala, French, Henderson, Alberga, Rowe, & Liddle, 2005). Many programs were developed to treat teens over the next few decades (Zavala et al., 2005). In 1994, the Federal Drug Administration (FDA), approved naltrexone to treat alcoholism although the drugs implementation has been slow to gain support due to the past emphasis on abstinence and the social treatment model (Abraham, Rieckman, McNulty, Kovas, & Roman 2011).

In 2000 the *Journal of the American Medical Association* indicated that addiction needed to be treated as a chronic medical issue. Today, outpatient treatment remains the standard of care for addiction. Inpatient care is very expensive, utilized primarily by wealthier individuals. The 2010 Affordable Care Act (ACA) includes treatment for substance use disorders and health care plans sold under the health insurance exchange must provide these services. According to Buck (2011) the ACA will change the field of substance use treatment and "the degree of this change maybe as great as, or greater than,

that for any other area of health care” (p. 1404). This may help make inpatient hospitalization affordable for those who need this level of care.

Alcohol is not the only substance addiction of concern. Cannabis became lawful in Colorado in 2014, in Alaska, District of Columbia, and Oregon in 2015, and in California, Massachusetts, and Nevada in 2016. Furthermore, at least twenty states allowed the use of Cannabis for medical purposes. Hall (2016) reiterates that the effect of legalization of Cannabis may be uncertain for a “decade” (p.1770) and recommends further research. Methadone and Suboxone clinics have emerged as options for treating opiate addicts. While Methadone has been used since the 1960s, Suboxone was FDA approved in 2002 and physicians were limited to distributing it to 30 to 100 patients (Turner, Kruszewski, & Alexander, 2015). The 2016 passage of the Comprehensive Addiction and Recovery Act (CARA) has included Nurse Practitioners and Physicians Assistants in an effort to stem the rise of heroin addiction.

Many areas of the country have halfway houses to aid the recovering person in developing life skills to live a sober life. Alcoholics Anonymous and its affiliates continue to offer support groups. The advantage of living in a densely populated area is that it can offer more variety of AA groups than in rural America. However, the advent of the internet has made the recovery world smaller and more accessible to all. A slow-growing movement to decriminalize non-violent drug crimes has also surfaced. The New Jersey Senate passed a law that requires non-violent drug offenders to undergo treatment rather than serving time in jail (White, 2014). Treatment and recovery of a specific group of substance users, such as nurses, has its own defined history.

History of Impaired Nurses

Beginning with Florence Nightingale, assistance with recovery has not been the priority when dealing with substance use nurses. Florence Nightingale was dedicated to nursing, inspiring many; however, her lived experience did occur during the Victorian Era. Because of her focus on the moral behavior of nurses, she is said to have dismissed substance impaired nurses from their duties during the Crimean War (Church, 1985). The Florence Nightingale model of nursing was adopted into the United States' initial education system for nurses around 1873. With it came the philosophy that if a nurse abused substances, she would be viewed as a person who had no sense of control or moral fortitude (Heise, 2003). One of the five qualities for a nurse in the 1890s was sobriety (Heise, 2003).

In America, nursing became a career path for women in the Civil War era. Society saw addiction as a moral affliction and as sinful. Nevertheless, according to Heise (2003), early writings from 1908, 1911, and 1915 indicate that nurses had easy access to substances and used them to help manage the stress of the job. Little treatment was offered to nurses and many had to detox on their own.

In the mid-1960s a national study was undertaken by Dr. Solomon Garb of Cornell University which indicated a severe under-reporting of addictions in nurses and physicians (Heise, 2003). In the 1970s attempts were made to treat the impaired nurse, but were short-lived. Research and treatment for the impairment of nurses began in the 1980s, as the American Nurses Association worked with the National Council on Addiction on the development of peer-assistance programs and monitoring programs,

such as the HPMP (Heise, 2003). While nurses encompass a distinctive group, they experience the same characteristics as any other user.

DSM-5 Criteria for Substance Use Diagnosis

Many terms are used in the addiction field, including substance abuse, substance use, chemical dependency, and addiction. These terms are often used interchangeably. Recently, the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) reviewed the use of the words *abuse* and *dependency* and concluded the term for diagnosis is “substance use disorders,” which are categorized in levels indicative of mild, moderate, or severe impairments (Diagnostic and Statistical Manual of Mental Health Disorders, 2013, pp. 484-485). Impairments affect daily life and produce distress. Examples include health problems and the inability to meet responsibilities at work, home, or school. According to the DSM-5 (2013), a person must have at least two of the following over a 12-month period to be given a substance use diagnosis (2-3 indicates mild use, 4-5 moderate, and 6 or more for severe):

- Drinking or using a drug in an amount that is greater than the person originally sets out to consume (or using over a longer period of time on a given occasion).
- Worrying about cutting down or stopping, or unsuccessful efforts to control use.
- Spending a large amount of time using a substance, recovering from it, or doing whatever is needed to obtain it.

- Common use of a substance resulting in (1) failure to take care of things at home, work, school (or to fulfill other obligations); and/or (2) giving up once-enjoyed recreational activities and hobbies.
- Craving, a strong desire to use alcohol or another substance.
- Continuing the use of a substance despite problems caused or worsened by it in areas of mental (e.g., blackouts, anxiety) or physical health, or in relationships (e.g., using a substance despite people’s objections or it causing fights or arguments).
- Recurrent alcohol/substance use in dangerous situations (such as driving or operating machinery).
- Building up “tolerance” as defined by either needing to use noticeably larger amounts over time to get the desired effect or noticing less of an effect over time after repeated use of the same amount.
- Experiencing withdrawal symptoms (e.g., anxiety, irritability, fatigue, nausea/vomiting, hand tremor or seizure in the case of alcohol) after stopping use (Diagnostic and Statistical Manual of Mental Health Disorders, 2013, pp. 483-493).

Specifiers can be used to accompany a substance use diagnosis and include: in early remission, in sustained remission, on maintenance therapy, or in a controlled environment. Substance use diagnosis covers the use of (a) alcohol; (b) cannabis; (c) phencyclidine; (d) other hallucinogens; (e) opioid; (f) sedative, hypnotic, or anxiolytic; (g) inhalants; (h) stimulants (specify amphetamine or cocaine); (i) tobacco; (j) other (Diagnostic and Statistical Manual of Mental Health Disorders, 2013, pp. 490-589).

Biological Process of Addiction

Nurses experience addiction the same as other individuals. The American Society of Addiction Medicine (ASAM) states:

Addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social, and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors (American Society of Addiction Medicine, 2011).

Substance use changes the way the brain functions as substances increase a neurotransmitter called dopamine in the nucleus accumbens, which is the pleasure center of the brain. In MRI studies by Kalivas and Volkow (2005) and Myrick, Anton, Li, Henderson, Drobos, Voronin, and George (2003), brain scans of substance users show a stronger response to images of alcohol than social drinkers. This indicates an alteration in brain chemistry in dopamine mobilization. The presence of cues (environmental, sensory, etc.) stimulate dopamine into the nucleus accumbens (Anton, 2010).

In the brain, the neocortex and the limbic system are known as the reward pathway. The neocortex helps distinguish between what is reality and fantasy in how a person understands, has rational thoughts, and experiences. In a substance abuser's brain, this becomes distorted and an inability to distinguish risk-taking experiences is present (Genung, 2012). This is evident by nurses who use denial and rationalizations as well as whose addictions progress to diversion and/or using on the job. Pakdaman, Wilcox and Miller (2014) state, "Persistence of cravings implies and neurobiological research has confirmed that chemical dependence changes brain chemistry in those regions of the brain that are associated with emotion, motivation and decision-making (the limbic

system)” (p.52). Poor decision making caused by substance abuse can be life-threatening not only to the nurse who uses, but to patients in her care.

Pakdaman, et al. (2015) developed an Integrated Like-Want-Need theory (ILWN) of substance use. Like indicates feelings of pleasure and high with a substance, and use is positively reinforced with continued use. Want indicates craving for the substance. Thus, the brain has learned the positive consequences of use. Need is present when the brain has acclimated to the substance, and, therefore, the brain cannot function normally. At this stage, the substance may provide little enjoyment or high. The use becomes a rationalization of a need to function on a daily basis, or just to make it through the day. With abuse the experience has consequences (hangovers, tardiness to work, conflicts with others due to use). With dependency the individual uses just to feel normal.

Relevant Studies

In 1984, the American Nurses Association developed policy on the issue of nurses’ substance use. From 1984 into the 1990s research on substance use flourished; however, since that time attention and focus on this important topic has waned. Few studies have concentrated on the perspective and lived experience of the substance impaired nurse. Lillibridge et al. (2002) state, “The nurses in this study, said that in participating in these interviews was the first chance they had had to voice their story and they felt it was therapeutic. They wanted to help other nurse to avoid the same pitfalls” (p.227). Being heard is of vital importance to the human spirit, and the voices of the experiences of impaired nurses is a missing piece that needs to be incorporated into society.

A phenomenological study from Australia uncovered five themes related to the experiences of impaired nurses as (1) the nurses' justification for using substances; (2) the fear surrounding being 'discovered'; (3) the meaning of substance misuse for these nurses; (4) the professional impact of substance misuse on individual nurses; and (5) the turning point in their road to recovery (Lillibridge et al., 2002, pp.222-223).

All substance users justify the use of substances. This rationalization is needed to make the use acceptable and to make sense out of the use. Lillibridge et al. (2002) state, "Nurses needed substances to feel good about themselves and to deal with the high expectations they perceived that society and the nursing profession had of them as nurses" (p.224). Nurses have high expectation for their own behavior, which can lead to feelings of guilt and shame. Both are important issues of exploration for recovery.

Other significant findings indicate the trauma (stress) inherent in the workplace leads to substance use, such as the fear of job loss/licensure, the loss of integrity/confidentiality with co-workers, and the lack of care/concern from co-workers (Lillibridge et al., 2002). This study indicates that nurses fear the loss of employment and licensure. Furthermore, nurses feel concerned about the absence of confidentiality while seeking treatment due to the fear of being "...stigmatized because they are viewed as weak and undisciplined and are associated with the undesirable characteristics of addicts" (p. 227).

The Lillibridge et al. (2002) study provides an authentic representation of substance use nurses' experiences. The sample size for this phenomenological study was twelve which is adequate according to Creswell (2013). One weakness acknowledged by the researchers is the inclusion of nurses who recently had been in withdrawal. It

appeared these nurses could offer less reflective information. The researchers also made a decision to not offer member checking stating:

For nurses with a substance misuse problem, withdrawal and reflection might lead to significant changes in their lives and revisiting the previous experience through a written transcript may be both distressing and unwanted. For this reason it was not considered appropriate to contact nurses for verification of transcripts (Lillibridge et al., 2002, p.222).

While the safety and welfare of the participants is of utmost concern, valuable feedback and descriptions may have added to the rigor of the study. One participant did ask for member checking and was included. The researchers engaged in one interview per participant. While one interview is acceptable, engaging in multiple interviews would have provided more information rich description of the phenomenon and enhanced credibility for the study (Morrow, 2005). Offering the participants who were new to recovery an opportunity to be more reflective, may have provided a wealth of information into the phenomenon. Another lived experience study indicates similar results.

A phenomenological study conducted by Burton (2014) interviewed fourteen recovering substance use nurses from the state of Utah. Participants were recruited from the Utah state monitoring agency. The purpose of this study was to explore the lived experience of nurses with substance use issues. Burton (2014) noted five themes of impaired nurses: (1) fear; (2) shame and guilt; (3) poor coping skills; (4) increased need to control their environment; (5) a belief that addiction would never be an issue for them (p. 154). Nurses primarily feel fearful about being caught, the loss of their job/license, rejection from others, and fear of relapse. Moreover, guilt and shame are consistent themes in addiction. Participants of this study felt ashamed of not controlling the use (or stopping the use) of the substance. They also felt shameful for interacting with those who

knew of the addiction and ashamed of any diversion of medications. The participants engaged in “self-condemnation” and “... realized they compromised their professional role, and that they often have compromised relationships of trust – both with employers and sometimes patients, as well as dealing with their families and legal entities” (p.156).

In addition, all participants indicated they did not know how to cope with the stressful situations in life. Healthy coping skills may have offered an alternative to using a substance. Theme four of the study refers to denial which Burton indicates “was strong” for the participants and lead to a “false sense of control” (p.157). In the beginning, all participants believed they could control their use, which progressed and led to a shift into denial. Typical for all substance users, denial concerns the psychological issue of pretending that things in life are not the way they really are, and that their addiction is actually helpful. Denial encompasses feelings of grandiosity which was indicative when “... false sense of control came because of their education and training as nurses – they felt they were immune to addiction since they knew everything about the medications they were using...” (Burton, 2014, p.158). Theme five reveals a majority of the participants were shocked that they became addicted and had held beliefs that addiction would never happen to them (Burton, 2014). This is a universal theme for substance users who are surprised when they discover the extent to which their addiction has unfolded.

The Burton (2014) study sample size was adequate for a phenomenological study and sampling was purposive (Creswell, 2013). The researcher refers to using observation and note writing during the interview process. It is unclear what was being observed and it seems distracting to write observation notes during an interview. Each participant was

interviewed once (for 30 to 60 minutes). While one interview is acceptable for a phenomenological study, adding additional interviews would have added to the context of the participant's narrative and lived experience (Seidman, 2013). It does not appear that member checking was used which would have increased the credibility of the study (Morrow, 2005).

The study conducted by Bissell & Jones (1981) used research assistance to interview 100 nurses and 97 physicians over a five year period. The nurses in this study were all Caucasian women and the physicians were all male. The interviews appeared to use a questionnaire detailing specific areas of the lives of the impaired nurse. The findings indicated that 66.7 percent of impaired nurses graduated in the upper third of their class; however, 31% indicated making an "overt" suicide attempt (Bissell & Jones, 1981, p.98). Additionally, 53% of nurses sought help from a psychiatrist, 34% from clergy and 58% from non-psychiatric physicians. There was no indication given of participants receiving counseling from a counselor or social worker (Bissell & Jones, 1981). Based upon the findings indicated in the previous studies, a belief in unrealistic expectations for performance and behavior may compel some nurses in this category to develop substance use issues.

Stress Factors and Nurses

Research continues to support the biological theories of addiction. In addition, another model is the stress reduction theory (Koob & Kreek, 2007). Anton (2010) summarizes the stress reduction theory as follows:

...the normal stress of everyday life (job, marriage, money) as well as abnormal stress of severe events (rape, assault, war, accidents) can be relieved by the use of a substance, and that this relief in and of itself is rewarding, causing the individual

to seek out the substance again and again to provide relief from the stress” (p.738).

Stress is inherent in the work of a nurse. Life and death decisions are a constant, as well as the intense regulations of the job (charting, patient care, HIPPA monitoring, etc.). In addition, nurses experience personal issues. Epstein et al. (2010) states, “Nurses often cite ‘stress’ as a major factor in choosing to abuse drugs. Stress in the workplace is often caused by excessive workload, rotating shifts, overtime, and floating to multiple units” (p. 414). Goffnett (1985) views substance use in nurses as an “occupational hazard” (p.37). This is due in part to a nurse’s inability to have effective coping skills to manage stress. In relating his own use of substances as a nurse, Hastings states:

Drugs numbed my mind and body and made it possible to ignore the stressors around me that I didn’t want to face: my own mother’s failing health, the demands of caring for my mother-in law, poor communication in my marriage. The more drugs I took, the more I wanted” (Hastings & Burn, 2007, p. 76).

Stress can be overwhelming and coping skills may be deficient due to family-of-origin issues. Childhood trauma may play a part in ineffective coping strategies for nurses, although more research needs to be conducted in this area. The grounded theory study by Farley and Hendrix (1993) used interviews from seven participants to obtain data on three groups of nurses: previously impaired, non-impaired, and previously impaired pilot study. After preliminary data was analyzed the researcher randomly chose one participant per group for a member checking interview adding to the credibility of the study. Results indicate a higher rate of parent-to-parent conflict and parent-to-child conflict reported in the previously impaired participant group versus the non-impaired nurses group. Farley and Hendrix (1993) encourage a mindfulness in the family-of-

origin issues in nurses, as dysfunction can lead to feelings of abandonment, guilt, and shame. If left untreated, substance use may develop as a coping mechanism. In a study of early risk indicators of substance use in nurses, West (2002) explains, “Although substance-impaired nurses may share common characteristics, they vary in development, progression, and severity. These diverse patterns of substance use and abuse help to explain a person’s unique pattern manifestations” (p. 192).

Moreover, personal life stress can add a dimension that, in addition to work, can be overwhelming. An article by Priest (1986) describes a nurse named Katherine whose personal and work responsibilities became overwhelming. In addition to her duties as a charge nurse, Katherine took care of her sick mother. Katherine felt that her supervisor was not listening to her concerns over maintaining her excessive workload. Feeling considerable stress at both home and at work led to a drug addiction. Katherine is just one example of how the expectation of being a super-human nurse, who is supposed to be able to handle all responsibilities with ease, is supported by the culture of the nursing profession. Thus, life stressors for a nurse may be exacerbated by the importance of the profession, the cultural belief in high ethical work behavior, and the accessibility to drugs, leading to a drug addiction.

Substance Use Nurse’s Relationship with Peers

The substance user’s relationship with peers has been noted to be a major issue. O’Connor and Robinson (1985) indicate, “Staff often excuse the impaired nurse from full responsibility simply by failing to deal with inappropriate behavior, and thereby sanctioning it. The impaired nurse is exempt from constructive criticism; gossip, grumbling, and criticism are instead passed on to others” (p.2). This behavior enables the

addicted nurse to continue on in denial by not allowing the addicted nurse to be fully responsible for her behavior. In the study conducted by Lillibridge et al. (2002), the participants felt “let down” (p. 224) by their colleagues who did not confront them about their obvious substance use and behavior. The participants felt uncared for and, upon being exposed for their substance abuse, felt colleagues no longer trusted them and felt punished for being truthful. This is a difficult paradox for the substance use nurse.

In a survey concerning nurse’s experiences with substance using peers, Damrosch and Scholler-Jaquish (1993) found one report indicated, “When there was only hearsay information, the respondents overwhelmingly (90%) reported taking no action. On the other hand, of those with some direct evidence, most (60%) took one or more actions” (p.159). The concern of the impaired nurse in the workplace is two-fold: the compassion for the impaired nurse, and concern for the patient’s wellbeing. “For a nurse to do nothing about a suspected chemically impaired colleague is, in effect, negligent. Ignoring such evidence would put the client, the facility, the staff, and the impaired nurse at risk for injury and liability” (Brennan, 1991, p.15). The importance of colleagues intervening with the impaired nurse cannot be understated. It is harmful to avoid addressing the issue and doing so perpetuates denial (Patrick, 1984). Ethical concerns for substance abusing nurses abound and nurse managers play a vital role in addressing these issues:

It is especially important managers recognize that discipline is not an effective strategy in mitigating substance-related risks. There is an urgent need to implement more effective policies for reducing substance-related risks to patient safety and nurse health amongst the nursing workforce; other strategies can be much more helpful and lead ultimately, to better management effectiveness, staff well-being and patient safety (Kunyk, 2013, p.62-63).

These alternatives include peer assistance, substance use treatment, coordination of care with the human resources department, and nurse involvement with a monitoring agency.

Most studies indicate a need for educating members of the health profession to the issues of substance use. Beckstead (2002) found that “positive attitude toward substance abuse treatment was significantly related to perceived impairment and to intention to report impaired colleagues to supervisors” (p. 548). Beckstead’s findings show that impaired nurses will respond more positively and with more motivation when educated about treatment options, rather than being told that their substance use is a moral or ethical issue. For that reason, it is vital that administration, management, and staff support policies that advocate for the impaired nurse (Barr & Lerner, 1984). Tanga (2011) states, “... nursing leaders and executives have an ethical, legal, and moral obligation to preserve patient safety while maintaining the integrity of the profession to assist nursing colleagues to seek treatment for this affliction. Nursing leaders must promote a non-punitive environment that encourages participation in a rehabilitation program for chemical dependency” (p. 15).

Peer support has been invaluable to the impaired nurse, whether through a nurse support group, Caduceus (peer support group for medical professionals), or 12-step based group such as Alcoholics Anonymous/Narcotics Anonymous. In exploring the value of attending Caduceus groups, Wile and Jenkins (2013) discovered, “The therapeutic aspects of the group were valued in that it facilitated further self-understanding and provided opportunities to explore ways of dealing with stress other than resorting to substance use” (p. 484). Furthermore, in a review of Michigan’s nurses peer assistance programs, Fletcher (2004) found, “The strength of peer assistance was that recovering

nurses were able to reach out to, identify with, and practice tough love with their impaired peers” (p.92). In a study conducted by Burton (2014), recovering nurses believed their experiences would prove beneficial to nursing students who are on the cusp of their nursing career. Thus, peer support was vital to the recovery of these addicted nurses as it led to better recognition and support.

In a 1998 study, Trinkoff and Storr explored substance use among nursing specialties. Overall findings suggest, “Critical care nurses are likely to use cannabis or cocaine; oncology nurses are prone to increased binge drinking; psychiatry has an increased rate of substance use and nicotine was most likely used by “psychiatric, gerontology, and emergency room nurses” (p. 584). Nurses who were employed in pediatrics and women’s health held the lowest incidences for substance use. This study also suggests a correlation between physician and nurse specialties with substance use. There is an increased risk of substance abuse among nurse anesthetists (Wright, McGuinness, Moneyham, Schumacher, Zwerling, & Stullenbarger, 2012).

The purpose of this phenomenological study is to describe participants’ experiences in a monitoring program for impaired nurses in Virginia, determine what beliefs and attitudes underscore the participants’ abilities to cope with the program, and uncover what meaning is made of the experiences.

Summary

Substance use has existed throughout history. Treatment for substance use in America has been complex, often intertwined with current events and the political climate of the times. Impaired nurses are a unique subgroup in the population and little treatment has been offered to them. Currently, each state offers nurses a monitoring

program to address substance use and a method to stay sober, compliant, and return to work.

There are only a few studies that have offered nurses who experience substance use an avenue for her voice to be heard, among them are the Lillibridge et al., 2002, and Burton, 2014, studies. These studies both indicate that nurses desire to fulfill the high expectations of job and life demands; however, the stress of the workplace influences substance use, creating feelings of guilt and shame over the use and the inability to control the use. Furthermore, the substance using nurse's relationship with her coworker is complex, as the coworker can be torn between compassion for the impaired nurse and concern over patient safety. Stress has also been a consistent theme in many studies which indicate the inherent difficult demands of the nursing profession which can lead to the use of substances.

Chapter 3 Methodology

In this chapter the researcher describes the qualitative research methods used in this study, the rationale for methodological framework for the interviews, the criteria used for selecting participants, and a description of the data analysis used in this study.

Purpose Statement

The purpose of this phenomenological study is to describe participants' experiences in a monitoring program for impaired nurses in Virginia, determine what beliefs and attitudes underscore the participants' abilities to cope with the program, and uncover what meaning is made of the experiences. The following questions are the focus of the research:

1. What has been the lived experience of the participant in HPMP?
2. What beliefs/attitudes are used by the participants to cope with the monitoring experience?
3. What meaning do the participants give to their experiences in the HPMP?

Rationale for Methodological Framework

According to Creswell (2013) there are five approaches to qualitative research: narrative research, phenomenology, grounded theory, ethnography, and case studies. For this study, phenomenology was used. Based on German philosopher Husserl, finding the essence of experience is at the heart of phenomenology. Phenomenological studies are rooted in understanding and describing the lived experience of others. Phenomenological researchers focus on gathering thick-rich descriptions of how participants experience the world. The intent of phenomenology is to delve "back to the things themselves" (Husserl, 1970, p. 252). Thus, phenomenological researchers explore the meaning that a

person gives to an experienced phenomena. Rossman and Rallis (2017) state, “Those engaged in phenomenological research focus in depth on the meaning of a particular aspect of experience, assuming that through dialogue and reflection, the quintessential meaning of the experience will be revealed” (pp. 85-86).

Background, frame of reference, and vocabulary in the exploration of finding meaning are necessities in the determination of how the phenomenon is lived by the participant. By exploring multiple perspectives, a researcher can begin to shed light on experiences and make some generalizations concerning the experience of the phenomena (Van Manen, 1990). In addition, the researcher describes what participants have similarly experienced as a result of the shared phenomena (Creswell, 2013). As stated by Moustakas (1994), “The empirical phenomenological approach involves a return to experience in order to obtain comprehensive descriptions that provide the basis for a reflective structural analysis that portrays the essences of the experience” (p.13).

With past experiences in mind, the researcher in this phenomenological study focused on how a substance use nurse made sense of the experience of participating in a state monitoring program and what beliefs and attitudes were used by the nurse during this experience. With only a few studies on the lived experience of substance use nurses, these descriptions added to the understanding of the experience of participation in a state monitoring agency. Gathering the themes of the lived experience, while setting aside preconceived ideas and utilizing reflexivity, was the hallmark of this phenomenological study. Adding the voices of nurses to the literature can offer rich information to help guide policy development for monitoring agencies and treatment providers.

Data was collected by modifying the three in-depth interviews method introduced by Seidman (2013) into two interviews. Each participant was interviewed for 90-minutes per interview, with the second interview occurring one week to ten days after the first. This allowed for the participant to reflect on the experience and kept the phenomena in the forefront of thought. By maintaining this in-depth interview structure, the validity and trustworthiness of the study was enhanced. The first interview centered around gathering a focused life history and on the details of the experience. The second interview afforded the opportunity for reflection on the meaning of the experience in HPMP (Seidman, 2013).

Quality and Rigor of Research Methods

Morrow, Castaneda-Sound, and Abrams (2012) list four factors that influence trustworthiness in qualitative research: social validity, reflexivity/subjectivity, adequacy of data, and adequacy of interpretation. First, social validity means having research that is committed to social justice. As there are few researchers who have examined the lived experience of substance use nurses in a monitoring program, this study was designed to hold social validity by adding to the overall knowledge and implementation of monitoring programs. Secondly, researcher reflexivity and memoing was utilized throughout the research process to increase subjectivity. Also, the researcher was the data gathering instrument and reflexivity acknowledges the researcher's biases and experiences. Third, the use of Seidman's interview process and the sample size aided in saturation of data by providing thick-rich descriptions of the participants' context and meaning of reflection of the phenomenon. Two important factors for saturation included sample size and heterogeneity of the participants. As data was gathered from a specific

group of nurses who experienced substance use, had been in the Virginia monitoring program, and volunteered for this study; heterogeneity was based on these factors. Finally, phenomenology addresses the meaning making of the participant and meaning making is an ever-evolving process. A participant may give a response and, upon reflection over time, may realize a different meaning. Thus, immersion into the transcribed interviews by this researcher brought an understanding of the themes as they evolved and provided a basis of interpretation.

Quality and rigor address issues of validity and reliability of the research design. In qualitative research, validity encompasses the trustworthiness and credibility of the study. Reliability refers to the rigor in which the researcher reviews that the design of the study is stable (Creswell, 2014). Ways to increase trustworthiness in this study included (1) the use of member checking, or participant validation, through participants' review of transcripts and the interviewer's review of emerging themes; (2) the use of thick, rich descriptive words by participants; (3) the inclusion of researcher reflexivity throughout the study to clarify biases; and (4) the presentation of the negative case or discrepant information as it emerges in data analysis (Creswell, 2014; Rossman and Rallis, 2017). To support rigor, the researcher was mindful of the concepts put forth by Rossman and Rallis (2017) throughout the study. They suggest making certain that (1) the methodological decisions were grounded in a conceptual framework; (2) the methodological design reasoning were transparent; and (3) the researcher documents and revealed her decision-making process (p.54).

Member Checking

Member checking was completed to ensure the credibility and rigor of the study. Two participants reviewed Chapter 4. One participant, Melissa, provided a written response. When asked if she felt the themes made sense, Melissa responded, “Absolutely! Each participant expressed feeling of anxiety, disrespect, frustration, and feelings of being out of control.” Melissa believed that the themes had been fully developed as she wrote:

Each participant expressed their point of view in great detail. This is accurate information coming from real people who struggle with life as an addict. All of which are in recovery and looking for support and guidance to keep them clean and sober. Each participant talked about the requirements or contracts they were required to abide by or be threatened of being in noncompliance with HPMP and dismissed from the program. Hence, if you’re not in the program you can’t return to work, if you can’t return to work, how are you supposed to pay in the program? HPMP says the program is free, but each participant pays out an average of \$300.00/month to stay in compliance. This is a stressor that could potentially cause relapse.

As to whether the overall account was realistic and accurate, Melissa indicated:

Yes, the content shared in the interview is outstanding. My hope would be for good change to come out of it. I agree with each interviewee, their comments are real. The emotions that I felt while reading this documentation is overwhelming. HPMP needs to be more supportive in assisting each client to recover with as less stress as possible. Mutual respect must be present with all parties involved.

Melissa’s observations confirm the credibility of the results and adds integrity to the study by affirming the research’s analysis.

Participant Selection and Sampling Size

Creswell (2013) recommends a sampling size of 3 to 15 participants for a phenomenological study. Seidman (2013) is reluctant to give a specific number and asserts that saturation of information is important. He indicates gathering more

information is better than less. He also believes time constraints and financial issues need to be factored into the number obtained for a study. Typically, phenomenological studies use a smaller sampling size and seek out rich descriptions from individuals who share experience with a phenomena. For these reasons, after gaining IRB approval (Appendix A), five participants were selected for this study.

Participants were substance use nurses who participated in the Virginia Health Practitioners' Monitoring Program (HPMP). For this phenomenological study, specific selection criteria included:

- The participants must have participated for at least one year in HPMP.
- The participants must not have used substances since entering HPMP.
- Each participant must be a licensed nurse.
- Each participant must be eligible to return to work.
- Participants must be residents of Virginia.

Saturation is a concept related to sampling size that was followed throughout the process of this study. "The point is to gather enough information to fully develop (or saturate) the model," (Creswell, 2013, p. 89). The essence of meaning unfolded during the data analysis process. The goal was to gather enough information from the five participants where no new themes emerge.

Participants

The researcher used three ways to recruit participants. First, the participants were recruited from the allnurses.com website that offers a specific stream for Virginia nurses. This website provides information to nurses and nursing students concerning job opportunities, schools and programs, and blogs to discuss both personal and professional

nursing issues. Contact was made with allnurses.com in order to obtain permission to post a flyer on the website (Appendix B). Secondly, the same flyer was distributed to Virginia hospitals in order to solicit Virginia nurses. The flyer was mailed and/or emailed to nursing supervisors in Virginia hospitals. Supervisors were asked to place the flyer on an employee bulletin board. Third, the flyer was handed out at Caduceus meetings throughout the state of Virginia. A Caduceus group contact list was obtained. A letter and flyer were mailed or e-mailed to each of the contacts.

Finding suitable participants became difficult, and this surprised the researcher. At first, some who replied did not fit the study parameters. Of the potential participants, many had concerns over confidentiality, even with the added security of the National Institute of Drug Abuse (NIDA) Certificate of Confidentiality (CoC) (Appendix C). The Virginia Tech IRB staff believed it would be important to obtain the CoC due to the sensitivity of the subject matter, and the researcher agreed.

The second recruitment challenge arose when the on-line service of allnurses.com would not allow a flyer placed on the website. The third obstacle emerged when hospitals refused to display the flyer. Hospitals require outside researchers to apply to their internal IRB process and this was too time consuming to be a viable resource. Finally, Caduceus meetings produced several participants and word-of-mouth/referrals (snowball sampling) produced the remaining participants. Qualitative research is based on purposeful sampling, which means that the participants were selected based upon the purpose of the study (Rossman & Rallis, 2017). Snowball sampling is a type of purposeful sampling that “identifies cases of interest from people who know people-who know what cases are information rich” (Marshall & Rossman, 2011, p.111).

Since the sample came from the state of Virginia, all interviews were conducted in person near the participants' home communities. It was important for the researcher to meet the participants in a neutral, yet safe, place. For that reason, private study rooms in local libraries were utilized. One participant elected to meet in her church. It was clear that the participants wanted to be heard concerning their participation in HPMP.

Three out of the five participants were near completion of the HPMP experience. Two participants were relatively new (over one year) to HPMP. This researcher did not want these two participants to be distinguishable in any manner. Restricting the identifiable markers did not have an effect on the data/meaning units for this study. Participants ranged in age from 29 to 49 with one male and four females. Four were Caucasian and one African American. All participants held a license as a registered nurse (RN). While two participants had legal charges prior to their work in the nursing profession, no participant had been charged as a result of substance use while employed as a nurse. For this research, the participants are referred to as Julia, Harriet, Clark, Rebecca, and Melissa.

Data Collection

Confidentiality in data collection is of utmost importance and helped build trustworthiness between the researcher and the participant. Pseudonyms were used and every effort was made to mask participant information. At no time did the researcher release identifiable results of the study without the participants' written consent. Once a participant had been selected for the study, and agreed via email or telephone to participate, a pre-interview meeting was arranged where procedures and consent forms were thoroughly explained. The pre-interview meeting was conducted via a phone call

and lasted 15 to 30 minutes. Appendix D shows the data form that was used by the researcher during the phone interviews. Participation in this study was voluntary and participants could dismiss themselves at any time in the process. No compensation was given for participation in this study as outlined by The Informed Consent for Participants found in Appendix E.

After the initial pre-interview, the two face-to-face interviews were held, at 90-minutes each. During the first interview, the participants were asked to communicate their substance use stories and the details of their HPMP experiences. After a short break, the second part of the first interview focused on what coping skills nurses found effective or ineffective. Questions during the first interview centered on the first and second primary research questions involving the participants' lived experiences with HPMP and their coping strategies as shown in Appendix F.

The second interview focused on the participant's reflection of meaning of the phenomena. As suggested by Seidman (2013), the second interview took place within a week of the first and focused on reflection of meaning. Questions during this interview centered on the third primary research question involving the meaning the participants give their HPMP experiences as seen in Appendix D. For this research, the interviews were designed to reflect on past, present, and future.

Brinkmann and Kvale (2015) acknowledge the interview research as “an interpersonal situation, a conversation between two partners about a theme of mutual interest. In the interview, knowledge is created ‘inter’ the points of view of the interviewer and the interviewee” (p.149). For this researcher, awareness of contacting the participant with mutuality was of utmost importance. Listening to the words and

description of meaning given by the participant was the central focus of this research. At the beginning of the interview, this researcher described the purpose of the interview and answered any questions the participant may have had concerning the interview process. At the end of the interview, a period of debriefing offered the participant and this researcher a moment to reflect on the interview and give the participant an opportunity to add any details that they wanted (Brinkmann & Kvale, 2015). The format for the second interview included a moment at the beginning for a reflection on the comments made during the initial interview. The second interview ended with a reflection of the interview and any additional comments from the participant.

Each participant appeared open and forthcoming as they discussed their drug use, family issues, and history of co-occurring disorders. On several occasions, this researcher had to be cognizant of not falling into the counselor role. Also, participants wanted to share deeply, which made it difficult at times to redirect the interview. As confidentiality was of utmost concern, the researcher chose not to use specific identifiable markers in order to enhance participants' confidentiality. By the end of the first three interviews, the researcher obtained verbiage indicating saturation with recurring ideas.

Data Analysis

As described by Moustakas (1994), "The empirical phenomenological approach involves a return to experience in order to obtain comprehensive descriptions that provide the basis for a reflective structural analysis that portrays the essence of experience" (p. 13). Phenomenological research is an inductive process involving thematic analysis that will describe the essence of experience with the phenomena. Using phenomenology,

researchers do not look for patterns of behavior nor the development of a theory related to the phenomenon. Rather, phenomenological researchers allow themes to emerge from the meanings participants describe based upon their experience of the phenomenon.

Themes are phrases and sentences used by the participant to describe how the participant makes meaning of the phenomena.

The researcher implemented the steps of data analysis used by Creswell (2013) who based his steps upon the work of Moustakas (1994). Interviews were transcribed by Landmark Associates, Inc., whose services met the Health Insurance Portability and Accountability Act (HIPAA) and the National Institute of Health (NIH) confidentiality requirements. Once transcriptions were completed for the content of each interview, an initial line-by-line reading was thoroughly performed. This process was repeated several times. Transcriptions were stored on a password protected flash drive at the researcher's home office. A broad set of manual coding was undertaken, and slowly a set of common meaning units/codes emerged from the rich and descriptive data. Horizontalization was observed as each meaning unit was given equal value. Meaning units were then studied to discern if common themes emerged as a combined unit. Selecting an overall word or wording for these common meaning units was addressed. This required contemplation, as there were initially some overlaps. After many reviews, the themes emerged into a cohesive essence of experiences.

The process of phenomenological data analysis for the researcher was to engage with data reflectively, to become immersed in the data by reading through the transcripts marking points of interest, to list statements of meanings, group them into meaning-units, and to produce a textural description of how and what happened to the participant which

is the essence of their experience (Creswell, 2013). A synthesis of the meanings and verbatim statements used by the participants added to the authentic voice of the experience. A written textural and structural description was compiled. A written description of what each participant experienced, including specific examples, gave the authentic voices of the participants. This is called the *textural description* (Creswell, 2013, p.193). The *structural description* is a written description of how the experience occurred (Creswell, 2013, p.194). The final step in data analysis, concerned a written reflection that combined both of the descriptions. “This passage is the ‘essence’ of the experience and represents the culminating aspect of the phenomenological study” (Creswell, 2013, p. 194). Describing the essence of the experienced phenomenon is the fundamental principal of phenomenology.

Reflexivity Statement

Reflexivity is of utmost importance in qualitative research as the researcher is the mechanism by which information is gathered and analyzed (Luttrell, 2010). Reflexivity involves the acknowledgement by the researcher of biases, self-reflection, and the theories that underlie the researcher’s beliefs (Luttrell, 2010). The researcher’s background, experiences, and beliefs will “advance the meaning they ascribe to the data” (Creswell, 2014, p. 186). Reflexivity is a process of self-reflection and awareness throughout the research process and is shared here as well as other points throughout the study.

The researcher began her counseling career at a state managed inpatient substance use detox center for indigent clients. For the next five years, she learned a vast amount of knowledge and skills concerning the substance use population. While still employed

with the state of Virginia, her job focus changed from inpatient to outpatient counseling. In 1996 the researcher joined a private practice group to work with clients experiencing mental health issues. She has learned much of herself, both personally and professionally, throughout her substance use training. Part of her private practice work consists of working with healthcare workers who are participating in the Virginia HPMP. She offers individual and group counseling for these clients. The researcher's interest in the meaning making of clients who participate in HPMP has been the driving curiosity toward choosing this as her dissertation topic. No current or past client will participate in this research, nor will she counsel anyone she meets in this study in the future.

During the researcher's five year work at the detox center, she began to explore aspects of herself that could influence her counseling by entering into individual counseling. She wanted to work on insights in order to gain more awareness of herself and the use of self in counseling. She engaged with a therapist who provided a sense of safety, genuineness, and a place to be heard. As a result of experiencing her own therapy, awareness through reflection has become a part of her daily life. The effort required for reflection has helped in the researcher's therapeutic contacts, personal experiences, and worldview. As a phenomenological researcher, she is devoted to hearing the voices of the participants and accurately portraying their lived experiences. After all, a study is influenced by the worldview of the researcher (Kincheloe & McLaren, 2008).

The researcher considers herself a Gestalt therapist and has studied Gestalt extensively through the Cleveland Institute, the Gestalt Institute of the Pacific, and as a co-creator of the Appalachian Gestalt Therapy Institute in Asheville, North Carolina. In her opinion, the counseling experience is sacred and provides a place of safety for clients

to explore all aspects of the self. “One of the implicit values in the Gestalt approach is the belief that the persons who come to us for help have intrinsic value simply because they are persons. Therefore, they must never be thought of or treated in ways which reduce them to the value of either objects of thought or useful instruments” (Crocker, 1999, p.271). She views the participants of this study as persons deserving of respect and dignity and will aim to provide the same environment of safety through the use of self.

One primary philosophical tenant of Gestalt therapy is the incorporation of a phenomenological stance. Attending to how a client makes sense out of her life is what the researcher does daily, albeit with the ears of a therapist. Listening as a therapist, however, differs from listening as a researcher. During this study, the researcher applied a different way of processing what she heard. Being aware that her role is as a researcher rather than a therapist, bracketing was used to reflect upon her own beliefs related to past work experiences (Moustakas, 1994). For this reason, she used a reflective journal throughout this research process, completed a member check, and utilized dialogue with her dissertation co-chairs as needed. This helped to examine how she was engaging during the interview process and with all the dimensions of this study.

Summary

Phenomenology is the study of how we make meaning out of our experiences and provides the guiding methodological principles for this study. By using a phenomenological approach, a better understanding emerged concerning the lived experiences of impaired nurses in the HPMP. Utilizing purposive sampling, five participants were solicited and two interviews per participant were conducted. Each participant engaged in a pre-interview, via telephone, where IRB issues were addressed,

including confidentiality and consent. Two interviews focused on the three primary questions using interview guides. Obtaining personal descriptions of the lived experience provides the essence of the phenomenon. Using reflexivity, the researcher was aware of the biases, and personal philosophy that may have influenced the research. Thematic results were represented through the synthesis of meaning units and verbatim words. The phenomenological approach provided an organized method for data gathering and analysis that allowed the meaning of the phenomenon to emerge and unfold from the essence of the face-to-face interviews.

Chapter 4 Results

The purpose of this phenomenological study is to describe participants' experiences in a monitoring program for impaired nurses in Virginia, determine what beliefs and attitudes underscore the participants' abilities to cope with the program, and uncover what meaning is made of the experiences. This chapter includes profiles of the participants, a written description of participants' experiences related to the phenomenon (textural description), a written description of how the experiences occurred (structural description), the development of participant themes, and a description of the essence of the experience. Each participant profile provided background information for context and a clearer understanding of factors that influenced how each participant experienced the phenomena. The participant descriptions of how the phenomenon was experienced uses the rich expressive words that provide the data and will result in the essence of the phenomena experienced.

Julia

Julia was from a semi-rural area situated near a larger city. She was raised in a conservative home where substance use was frowned upon. She had an uncle who would isolate himself to consume alcohol. Julia developed a mental health diagnosis prior to her substance use disorder and has had chronic medical issues. Due to her chronic medical issues, she was prescribed narcotics. However, her drug of choice was in the sedative classification (administered IV). Julia reported that she never diverted medication from a patient who was prescribed the sedative. Instead, she diverted the sedative from the Pyxis MedStation by ordering it for patients, and then cancelling it out so the patient would not be charged. She believed the sedative helped to mitigate her

chronic pain, increased her ability to deal with stress, and allowed her to function on the job and in her personal life. Her nursing license was not revoked as long as she participated in the HPMP. She worked as a nurse at the time of the interview, and participated in counseling and support groups. Also, when looking back at her mental health issues, she did not believe she was adequately treated, which led to a deterioration of life and subsequent substance use disorder. Julia recalled:

But I've had a lot of realizations in my recovery. I had trauma that I never addressed. It happened when I was 17 and then I had issues at home. They probably weren't bad compared to other people, but I try to learn not to compare. They were my issues that I never addressed and I'm addressing now. They're my issues that caused me pain.

Textural Description for Julia

Upon meeting Julia, the researcher observed Julia's anxiety concerning her chronic medical condition, and the possibility of it becoming disruptive to the interview process. Despite this, she was eager for her HPMP experiences to be heard. Julia described what brought her into the HPMP program:

I really had no business being in the med room at all. But I went in there to get the sedative and one of my co-workers saw me coming out before I was leaving to go home. After I left, she called the pharmacy and it got the ball rolling.

Julia's boss confronted her about the missing sedatives and initially Julia lied. Julia recalled, "At that point I was so ashamed of myself. I couldn't look at myself in the mirror and admit it to myself. Much less could I admit it to her." At this time, she entered HPMP and was required to immediately stop working and began inpatient treatment. Julia reflected, "When I went to get treatment, I went through the whole guilt of how much my parents have to pay for the treatment center." After completing thirty days of inpatient treatment, Julia was required to attend an intensive outpatient program

(IOP) for three to four months. Her treatment consisted of both group and individual counseling once per week.

In describing her initial experience with HPMP, Julia experienced confusion, anxiety, and frustration over being excluded from treatment decisions. Upon an initial monthly check-in, Julia's HPMP caseworker informed her that she had to receive inpatient care:

He said, 'We've met about your case and we decided. We think it would be best for you to go to inpatient treatment.' Nothing at this point had been said about this, absolutely nothing, and I was of course dumb-founded about it. But, I said, 'Okay,' because, at this point, I've learned it's pointless to say anything other than that to any of them.

Her subsequent experiences with HPMP continued to be filled with anxiety and frustration over the cost of treatment and drug testing, time required, paperwork, contact with case manager, and feeling unsupported, disrespected and excluded from treatment decisions. Julia believed the program was "very, very expensive and you have to pay out-of-pocket. I just got a job and I'm told that for the first six months my drug testing will increase! I'm already being tested once per week." Furthermore, Julia noted that attaining and returning the contract needed by HPMP to return to work was arduous:

It's not just the contract either, you have to get it back to them ... all the signatures of all your counselors, work site monitor, and your boss. It's frustrating and stressful...I've done my part in getting it faxed right back to them, but it's been a good two and a half weeks since I got the okay (to work).

In addition, the time required to participate in weekly counseling, attend three AA/NA meetings a week, and two Caduceus meetings per month was overwhelming.

Structural Description for Julia

The underlying beliefs concerning Julia's lived experience of HPMP encompassed feelings of frustration, shame, and guilt. The latter she experienced when

she took the sedatives from work, and in her acceptance of financial contributions from her parents. She felt shame primarily from what she viewed as the shame-based treatment of her case manager. She experienced frustration when she had to deal with the disorganization of the HPMP. Even though the HPMP treatment demands were stressful, Julia gained insight into her addiction and self. She was able to explore her feelings of guilt and shame, as well as her frustration with the HPMP program. Her belief about the program evolved, “I don’t think they need to make the program quite so hard. But at the same time, I guess, they do it for a reason...it keeps a lot of people accountable and it keeps them from relapsing.” Though her HPMP experience, Julia recognized how feelings of worthlessness intermingled with her addiction and self-worth. This is another significant issue that she courageously explored. In addition, she gained knowledge and awareness of her addiction. Julia reflected, “Prior to HPMP, I did not have the terms that I have now. I just didn’t realize it. And now I have gained the tools to live one day at a time, one minute at a time.” While Julia would have wanted the program to be more individualized, she accepted her powerlessness to change the program and focused instead on her need to fulfill the requirements.

Harriet

Harriet was from an urban area. Growing up was traumatic for her as she experienced significant childhood abuse. Her family believed alcohol was acceptable to use, but drugs were not. She began drinking at age ten, using cannabis by her mid-teens, and abusing amphetamines in her later teens. She used cannabis and amphetamines (both smoked) on a regular basis until her late twenties when she entered a rehabilitation facility. After one relapse, she was able to remain clean for nine years. Unfortunately,

she relapsed on amphetamines, her drug of choice. This relapse occurred when she was trying to save her husband from his addiction, but ultimately began using again.

It was a lesson and the reason why I say that is because for years I had been given signs that this was not the way to go. He was not the man for me. I would override those signs and I just kept doing what I was doing. I joke about it now but it was like the bush was burning and I saw the flames and I felt the heat, but I went over there anyway... I mean it just took this-not the monitoring program-but it took me relapsing and it took me getting a charge. It took all of that to get me away from him and to totally leave him alone.

Harriet is a survivor of childhood abuse and of emotional abuse by her ex-husband. Her addiction led her into a cycle of poor choices and an unhealthy lifestyle. Harriet chose to have her children raised by family members, in order to reduce the impact of her addiction on their lives. Harriet was arrested, charged, and placed on legal probation. She wanted to change her life, so she obtained a nursing degree. Due to her past legal issues, Harriet was required to be in HPMP to obtain employment. She is currently working as a nurse and participating in counseling, and support groups.

Textural Description for Harriet

Harriet's willingness to participate in this study was surprising because of her distrust of others. It was impactful to hear of the childhood abuse and of the dysfunction that had been a constant in her life. Harriet began drinking alcohol at ten and smoking marijuana at 15, which progressed rapidly into the use of crack cocaine. Upon reuniting with her husband, she was charged with possession and placed on a year of probation. Her relationship with her husband had always been destructive. Furthermore, she allowed her children to be raised by a family member as she believed they were better off not being with her. In spite of this, she made it through nursing school. When registering

for her nursing license, she was flagged for her past probation. Harriet last used drugs approximately ten years ago.

Harriet's initial experience with HPMP and her case manager were scary and anxiety ridden. The case manager was very cold and uncaring. Harriet recalled, "It was like she thought I was still in active addiction. She just wanted short-pat answers...it was degrading." Since the initial meeting, Harriet's relationship with her case manager was challenging:

I think so much with her is just how she comes across, like I'm scum of the Earth. First of all, I've never taken the drugs from my patient. I was not a nurse who diverted narcotics. My damage, I did to myself and I did it prior to coming into the program. I hurt myself, my family and she wants to (judge) and put me in a box. She talks very condescending and sarcastic all the time.

The financial requirements were difficult, since she was not employed as a nurse, yet she had to pay for counseling. Harriet lamented, "It's financially stressful and causes a lot of pain-financially. Just a whole lot of stress... like having to check-in. That parts has gotten- I mean it is what it is."

Unlike the other four participants, Harriet's experience with counseling was negative. Her counselor, Harriet believed, had not invested the effort to get to know her. Harriet's counselor attended the same Caduceus group, which may have been an ethical boundary issue. About her counseling sessions, Harriet recalled, "I just go and I bullshit for thirty minute. I get annoyed. I mean I tell her what's going on, but I don't want to parrot (what's said in support group). I want to be able to work through some stuff."

Finding employment was a source of frustration for Harriet after HPMP. She estimated that she had applied for 100 jobs. This was due in part to HPMP's regulation of not being able to administer narcotics for at least the first three months of employment.

Harriet remembered, “As soon as I told them (potential employers) I was in the monitoring program, the whole tone of the interview changed.” Harriet acknowledged the employers could also see that she had a past felony charge. With the amount of time it took for Harriet to find employment, HPMP waived the requirement and allowed her to administer narcotics. Ultimately, Harriet reported that she used perseverance and determination to navigate the HPMP process.

Structural Description for Harriet

Perseverance and resiliency were at the core of Harriet. These were the underlying beliefs that described her experience with the phenomenon of participation in HPMP. “I’ve been encouraging one of the girls in the program. I would encourage her to stay in it...it’s worth it in the end...you worked too hard for your license.” Through this process, Harriet learned to stand up for herself: “Me today, I don’t tolerate people mistreating me,” Harriet stated. She stated that her past sense of shame and worthlessness was replaced with dignity and self-care. She discovered that if she stayed present-centered and organized, she was capable of managing stress (from work and the monitoring program). One area of the HPMP requirements that helped Harriet were the support group meetings. Taking personal accountability for her addiction was the backbone of her experience.

Clark

Clark lived in a town setting. His parents were open concerning their family history of substance use. The majority of his siblings were alcoholics. He began consuming alcohol in his mid-teens and felt an instant sense of relief. He affirmed that

his role in the family was that of the family hero and the family's focus was maintaining a positive family pretense of perfection:

So that definitely came at a price, especially in my later years in high school, emotional instability, anger. And, my interpersonal skills, from an extroverted (view) were, as many would say, stable but internally I even had thoughts of suicide my junior and senior year.

His drinking increased in college, as did his use of cannabis. Clark used drinking as a form of self-medication that he felt helped him manage his codependent behaviors and thoughts. Later, he was diagnosed with a mental health disorder that went untreated for a number of years, leaving him feeling irritable and emotionally unstable at times. Clark indicated that his mental instability was more detrimental to his work as a nurse than his drinking. His substance use and mental health issues led him to a rehabilitation facility. After which, he entered into HPMP. At the time of the interview, Clark was working as a nurse and attended support groups. He appeared bonded to his therapist and this trusting relationship appeared to have helped him gain awareness of his issues.

Textural Description for Clark

The researcher met Clark at a beautiful old library. The room was large, but a small corner desk was used that felt comfortable. Later in the interview there was a terrific and terrifying thunderstorm. This added some amusing skittish reactions from the interviewer and the interviewee. Clark was an engaging person, full of enthusiasm and ready to discuss his HPMP experiences. Clark's family had deep roots in his hometown. It became clear that keeping up appearances was an important family legacy. "I never felt good enough for my family and once I got drunk (age 14), I remember specifically feeling connected and on the same level with my family members." He believed he would overcompensate his behavior by taking on the "good kid" role, and did not drink

again until he was 18- years old. He did engage in familial codependent behavior. He was trying to prove “that I’m worth something in the family.” Clark stated:

I grew up in a very loving family and alcohol and substances weren’t part of the family as a whole-except my sisters. But I was always reminded when you left the house, remember you’re a member of this family. People are watching. So it was always what you are putting forth externally.

This type of pressure was stressful and he found relief in alcohol and marijuana. Clark remembered, “That definitely came at a price especially in my later years, in high school, with emotional instability, anger, and poor interpersonal skills.” He was involved in many activities in college where drinking was part of the social environment. After college, he experienced bouts of emotional instability. This led to hospitalization for a suicide attempt. Sometime after this attempt, Clark experienced an epiphany as he recognized that his alcohol consumption differed in quantity and method from his peers. He noted that his thoughts and emotions were heading into a dark state and that he needed help. He spoke with his therapist who recommended an inpatient facility. Within a week of discharge from inpatient care, he entered HPMP. The initial meeting with HPMP was intimidating and informational. Clark was able to continue counseling on a weekly outpatient basis as well as the normal HPMP requirements of three AA/NA meetings per week, two Caduceus meetings per month, and drug testing. Clark recalled:

HPMP was intimidating because, I think realizing the restrictions that it placed on me. I couldn’t look for a job. I couldn’t start a job. I couldn’t select my schedule or anything without the monitoring program’s approval. The fact that I couldn’t set foot in my hospital or any health care facility (until they said it was ok)...I was lumped in with- I was viewed the same way as someone who had diverted and passed out with a needle in their arm... I went back to where I viewed myself as a moral failing. I got that (from HPMP) and still feel that with the monitoring program.

This was a familiar feeling from his childhood. HPMP had the external appearance of helping professionals, but internally, according to Clark, “It’s ‘You’re guilty until proven innocent’...this isn’t what you mean. It’s you (HPMP) covering your butt, and it’s just more efficient to assume the worse about me and everyone in the monitoring program.”

Clark had a different case manager than the other four participants. Initially, he found his case manager to be helpful and easily accessible. As time passed, the accessibility waned. “I’d say maybe I heard from my case manager once every two months,” Clark indicated. Still Clark described his relationship with his case manager as positive. Clark did not lose his employment; however, he experienced issues with the length of time it took to get his contract for work approved:

They were going to staff it, and it was actually another three weeks to a month before I actually got my contract. Then it was another week or two before they said you’re good to work. That was frustrating because since I had maintained my employment, I had a manager asking ‘when are you coming back?’ I had to tell them, over and over, ‘maybe in two or three months. I don’t know. I wish I had a better answer.’ I think it’s difficult on the employers that HPMP doesn’t communicate with them. That it’s led me as the participant to tell my employer, I don’t know when I’m coming back. I don’t know what my restrictions will be...from an employer standpoint, I can’t imagine how difficult and frustrating that is as they have positions to fill and shifts to schedule.

An HPMP requirement that Clark had to adjust to was working day shift. He had worked night shift for many years, but HPMP initially only allowed day shift work. He recognized that day shift work helped him attend meetings and counseling and he soon realized that day shift was healthier for him. A frustration he experienced with HPMP was their disorganization, primarily losing reports, which he also heard from others in his group therapy. Clark noted, “That’s frustrating especially because some of the consequences of not having those reports can very much impact my professional practice.” Clark was frustrated at the length of time it took for an HPMP staff member to

contact him, “I would say the unknown of not being able to contact someone or hear back in a timely fashion, the lost reports, and the financial strain (were all stressors).” Clark indicated that working relieved the financial burden of paying for the screenings. His experience was that HPMP ultimately held him accountable.

I think it’s (HPMP) even more effective and accountable than just people coming out of rehab and going to meetings. I think it’s more effective and accountable than just people holding me accountable because I can fall back into ‘well I relapsed’ and now they’re guilting me-which means ‘I’m not worth it,’ and that’s something I’m really good at but it’s not helpful. The monitoring program is very objective. If you had a drug test and failed the drug test, well that’s just how it is.

Structural Description for Clark

Clark’s underlying beliefs in experiencing the HPMP phenomenon included taking personal responsibility of his behavior. His mental health issues underscored his substance use issues. Counseling helped Clark learn coping skills to manage his mental health issues as well as develop coping skills for his substance use. His colleagues noticed his emotions were not so sporadic. “If I was irritable, I was renowned for being sassy over the radio...but people started saying that they noticed I was more stable.” Counseling and his therapy group were a vital component to his recovery and experience in HPMP. Clark experienced initial issues of worthlessness and shame stemming from family of origin issues. He was able to learn the coping skills vital to dealing with these deep seeded issues. “I believe being able to advocate for yourself is not only good for recovery, but also self-esteem.” He came to an acceptance of surrender in the HPMP program, “I accept what I can’t change.” This shift in acceptance helped him cope with the demands of the monitoring program; however, he advocated for a more individualized approach to HPMP:

To take more of an individualized approach to what works and doesn't work for someone's recovery... I think the monitoring program, for simplicity sake, does have very broad-generalized guidelines for time management. I don't think they have the staffing to really individualize the program. I do feel the more individual approach would be helpful because there are others that don't find twelve step meetings as helpful as their therapist and their group therapy.

He indicated that personal growth and self-awareness were vital in the learning process:

I would say accepting the things I cannot change and being appreciative and having gratitude for what the program does for me as opposed to dwelling on the negative. I think that's a useful skill, not just in the monitoring program, but in daily life.

Rebecca

Rebecca was from a rural area. She had a family history of substance use.

Rebecca experienced childhood verbal abuse from her alcoholic mother. A maternal aunt died from complications of alcoholism. Rebecca began using narcotics (orally) to ease her depression about a year after she became a nurse, attaining them through an acquaintance. She soon diverted narcotics from her job. She would assess the patient and ask if they required a narcotic. If the patient did not need the medication, she took it herself, rather than disposing of it. Concerning her drug use, Rebecca explained:

I guess I felt like it was-it was just how I coped with things. I guess it was just how I was so used to coping with my feelings. I just didn't know another way to cope. I didn't know another way to go about things.

Rebecca was not charged for diversion, but supported by her nurse manager and employer to enter HPMP and rehabilitation. After inpatient care, she began a local Intensive Outpatient Program (IOP). She returned to work as a nurse. Rebecca embraced a sober lifestyle and her husband and children participated in her recovery program, including counseling.

Textural Description of Rebecca

Rebecca presented herself as a bright, caring, and mindful person. We met at the fellowship hall of her church, which was quiet and peaceful. Rebecca appeared to be open and honest when reflecting on her experiences regarding substance use and HPMP.

Initial issues of depression, due to relationship issues, caused Rebecca to use narcotics. She began using with a friend and within six months her addiction affected her work. She checked to see if a patient wanted their narcotic medication. If they did not, she would take it. It was difficult for Rebecca to make sense of her behavior.

I was just wanting to feel better myself. There's really no making sense out of it. Now that I look back, I'm like, gosh, I'm so stupid. But at the same time I wish I could understand why my mind worked that way at that point in my life. And why I chose to go that route. I also knew that financially I couldn't keep buying it off the street. I also couldn't seem to face what I was dealing with, with a sober mind, so I didn't know which way to go. It just comes to the point that if someone's hurting, you hurt other people in the process of it all. That's what I did.

After an intervention by her supervisor, Rebecca entered an inpatient facility. When she returned home, she immediately contacted HPMP; however, the initial process of entering HPMP took three months. Rebecca relapsed by using her father's medication.

He knew it was me. He got to the point that he locked it up. So, there was absolutely no way I could get to it. Talk about a low point. You know what I mean? Like everything had blown up and I feel like I don't have any other route...I just don't know how to live without medicating myself...I'm never going to be a nurse again, so I was worried about that. Worried about what I was going to do financially because my dad was, literally, supporting me. He made sure that car payments were paid. I didn't have anything. I mean at that point, I felt pretty worthless.

She felt anger toward HPMP for the delay and believed obtaining counseling right after her inpatient stay would have benefitted her. During this time, the love and support of her parents helped her to survive. Rebecca was trying to cope with feelings of sadness, worthlessness, shame, and guilt. Her lack of finances caused Rebecca to reside with her

parents while her two children lived with their father. This was upsetting for her.

Rebecca stated, “I knew I could focus on myself at this point, and my parents knew that’s what I needed.” The support of her family made a positive difference in her life as a recovering addict.

When Rebecca attended the orientation for HPMP, she felt overwhelmed with the regulations. Yet, she experienced a sense of accountability right away. Her experience centered on frustration with the financial cost and her relationship with her case manager. As for the financial impact of the program Rebecca stated, “I can’t wait to be done with the program for the fact of cost. That’s the only reason. Everything else, they can continue to do everything in this program, if they didn’t charge me an arm and a leg for everything.”

Furthermore, Rebecca’s experience with her case manager was difficult. She commented:

I don’t have a lot of positive things to say about her, just for the simple fact of how she’s approached me. My question is does she approach everyday people in her life like that or is it just me? Or is it just the people that are in the program? Because we already feel-now granted, I don’t feel bad about myself at all now. I feel like I’ve come leaps and bounds of where I was. To feel that way (badly) just in that moment is hard. It’s hard because- it doesn’t bring me back to where I was, but it brings me back, and reminds me, you’re still on a chain. And, she still controls everything. There’s one person that can make you have a bad day, and she’s it. I cope with her by making minimal contact. I know that sounds so bad, but I do. I do what’s required of me when it comes to her. I don’t do anything extra...I’m not asking her to be lax with me. I’m just asking that when she addresses me, she address me with just as much respect as I address her with and doesn’t make me feel inferior to her. Even though she is my superior in this program and she is the one I answer to, I feel like if she would just look at it as more like-look at me as a person rather than just a number in her file. That’s how I feel she looks at me.

Rebecca believed she did not receive support from her HPMP case manager. However, she experienced positive feelings from her Celebrate Recovery group, her church family,

counseling, and the support of her family. Rebecca valued her relationship with her counselor as she stated, “I have gained (an) awesome relationship with my counselor, I love her. She’s wonderful...I can go in there and just let off any steam that I have, just okay this is what’s bothering me today.”

Concerning HPMP, Rebecca had issues with the length of time it took for her case manager to revise a contract and return her calls. She experienced stress from the program and utilized her support groups to help cope. Rebecca benefited from the support of her nursing supervisor and administration. She experienced minimal work related issues due to program participation.

Structural Description for Rebecca

The underlying beliefs that Rebecca described concerning her experiences with the HPMP program were shame, guilt, lack of support from case manager, structure, and accountability. The beginning of the program was difficult due to the delayed start time and the lack of counseling. She felt unsupported by her case manager throughout her participation in HPMP. With that said, she persevered in the program and believed it offered her structure and accountability. Rebecca indicated:

Accountability is wonderful. I love having accountability. It’s good for those that need the structure. The program holds me accountable and has given me time to learn how to cope with things better and learn how to live life sober. I mean, if I look at it that way, then it’s easier for me to cope with them.

Dealing with shame was difficult for her:

Because I was so used to putting on a front of having it all together, even though I didn’t that I wanted to still put on that front that I had it all together, even though I felt so shameful. It took me a while to break down that wall and that barrier and really just open up and talk about how that made me feel, because as a nurse it’s almost like you are put into this position where at times you’re not allowed to have certain feelings, like a feeling of shame or a feeling of guilt. Partly this is due to what she believed were other people’s expectations of her. People that have

no idea what you're going through. On the work front I had it all together, but one co-worker knew I didn't have it all together. She knew if I needed a break. I would cry and I would go outside and she'd follow me and we'd cry together. My counselor and my family knew, so I was able to vent those things I needed to. I think that's extremely vital and important in recovery because if you don't, if you're not able to express yourself, you bottle it up, and then it's just going to happen all over again.

She came to understand the stress of being a nurse and being in a vulnerable occupation where emotions are up and down. Rebecca stated, "I think there needs to be a coping skills class for nurses, to really teach them how to cope with things." Rebecca grew in the HPMP program. "Back then all I thought about was myself. I guess the older you get, the wiser you get, with years, and with counseling, and groups and stuff. I've learned that you think the only person that you're affecting is yourself, but in reality you're not."

Through counseling, her spirituality, and her personal growth she became a more empathetic person and nurse.

Melissa

Melissa was from a small town, situated near a larger city. Alcohol use was acceptable for her parents on the weekends, as Melissa described them using socially. However, as a child, Melissa's mother would take her along to bars and use her as an excuse to leave early. Melissa's maternal uncle died from alcoholism and her brother was incarcerated on drug charges. Her father had been incarcerated in the past for drug charges.

Melissa, who experienced childhood abuse by a family member, began consuming alcohol at fourteen, primarily on the weekends. When she was sixteen, Melissa married an abusive man and divorced him at nineteen. The pattern of weekend drinking continued until her early thirties when her father died. Shortly after his death,

Melissa had a life-threatening experience with the abusive family member, and, in addition, was in a car accident where she was subsequently prescribed a narcotic. Also, at this time, she tried to speak with her mother concerning the childhood abuse; however, her mother did not believe her. These experiences were traumatic.

She used narcotics sporadically until a co-worker offered her an opioid for a headache. This instantly re-ignited the good feeling she received from the use of opioids. Melissa continued to consume alcohol in addition to narcotics (orally). The drugs helped her cope with her grief and the stress in her life. She stated when she used, “All my troubles went away.” She did not divert narcotics from patients, but obtained them from other outside sources. Her drug of choice was opiates (oral consumption). She participated in an inpatient program and entered HPMP. She remarried and has one child.

Textural Description for Melissa

Upon meeting Melissa, her enthusiasm to be heard was apparent concerning her HPMP experiences. She explored her past childhood issues of abuse, her abusive first marriage, and the addiction issues that brought her into the HPMP program in a very open and honest way. Melissa entered HPMP due to a positive drug screen at work. She was accused of diverting medication, but has never done so. The medication came from friends, family, and the streets. Looking at past use of narcotics and working as a nurse, Melissa was appalled at her choice to work while under the influence.

Well today, clean and sober that wasn't a good choice. My mind at that time could not have been where it needed to be. I was more focused on where I'm going to get my next drugs, and trying to get the minimum done at work, just to get my paycheck. I was thinking of myself. It's sad but true. I wouldn't harm my patients intentionally for anything. I want to help them. It hurts today to think-it does. It hurts me about a lot of things but especially that. They trusted me and I

was living a lie. It just wasn't me. That was a completely different person. My entire personality changed. I said and did things I would never do today...I just didn't care.

Upon beginning HPMP, she entered a ninety day inpatient treatment facility.

For the first few years of HPMP, Melissa did not work as a nurse. She found employment with a local company. She worked in order to pay her personal bills and to afford being in the HPMP program. As mandated by HPMP regulations, Melissa was still required to attend three AA/NA meetings per week, Caduceus twice per month, drug screens, and counseling in order to maintain her restricted license. In her third year of HPMP, she found work as a nurse, but initially she could only work day shift, since HPMP policy stipulates that nurses returning to the workforce can only do so during the day where supervision is more prevalent. Frustration with her case manager and HPMP regulations hindered Melissa from seeking employment as a nurse.

I went for my interview, and the hospital made me an offer. I had to fax the job description to my case manager for staffing. You're asking an employer, a potential employer, to wait four to six weeks before you can say, 'I can take the job.' They're needing someone now. That process is too lengthy. That was what hindered me from getting a job. My case manager told me I could look for a job, and I said, 'Well how long will I have to wait to tell them it will be before I can give narcotics?' Her answer was, 'A while.' I said, 'I need a timeframe.' I need to be able to tell these people right now I can't give narcotics, but at this time I will be able to. They're going to want to know what kind of time frame they're dealing with. Is it three months? Is it six months? Is it a year? She said, 'Just tell them- a while.' That was the smart-aleck answer I got...There's no point in me looking for a job, when I can't tell someone a time frame.

She described the HPMP experience as "very stressful. I've just had to suck it up, and explain, and get what I needed done, and go on with my life."

Frustration with the program's cost, being excluded from treatment decisions, and feeling shamed by her HPMP case manager were significant experiences with the program. Concerning her case manager, Melissa indicated:

I feel like I was talked down to. If anything it was more of a stress for me to deal with them. The screens were a breeze-except for the financial part (that's hard to do). They don't care. They have the attitude of, 'It's not my problem, it's yours.' I was going to have to submit to doing what she was asking me to do in order for me to get back to my life... There are certain requests, demands that (are in) your contract, like respect. It clearly says it's mutual. It goes both ways, but that's not the way I see it at all.

The HPMP experience for Melissa was frustrating, shaming, demanding and overwhelming.

Structural Description for Melissa

Melissa's underlying belief in her participation in HPMP evolved from her initial sense of shame into a positive sense of self. Her resilience through childhood abuse and marriage was remarkable. She used the same coping skills from childhood/young adulthood to muster up perseverance toward her participation in HPMP. This internal resilience kept her grounded and allowed her to gain awareness of issues.

I pray a lot. I pray a lot. I look at the positive things in my life, and the good things that are going to come. Because I'm not going to let anyone defeat me... When I get called out on something I've done in the past, then I say, 'Yes, I own it.' Because I'm not going to be put down or made to feel ashamed of myself. I know what I've done... Taking responsibility-taking it and owning it has been huge for me.

Counseling and attendance to group meetings allowed Melissa to explore her personal responsibility and mind set. This aided her in accepting issues that were beyond her control with HPMP.

Summary of Textural descriptions

All participants experienced exasperation with the rules and regulations of the HPMP program. The feelings of being overwhelmed were initially strong, yet became habitual. The cost of the program was of concern, as was the length of decision making by the HPMP. Being treated with respect by their assigned case worker was an issue for

four of the participants. Finding employment for three participants was difficult. All participants experienced shame and guilt with their initial experience in HPMP. Four of the participants experienced shame and guilt in their family of origin.

Summary of Structural Descriptions

Participation in counseling for four participants was described as a valuable experience. Attaining coping skills was vital in personal growth and development. For Harriet, counseling was not helpful, yet she gained insight through attending support groups. All participants believed the monitoring program helped by holding them accountable. Learning that the rules cannot be changed helped each participant toward acceptance. Shame and guilt appeared to be relieved by acceptance. Paradoxically, the four participants with the same case worker seemed to have gained self-esteem through the case worker's negative disposition. They appeared to use her negativity to help them persevere in the program. All participants wanted the program to improve through individualized treatment options.

Themes

From the data analysis, three themes emerged to explicate the meaning of the lived experience of substance use nurses participating in the HPMP program of Virginia. First, the participants interviewed indicated that the lived experience of HPMP was overwhelming. Secondly, they all acknowledged the importance of acceptance. Third, each participant focused on personal accountability. These themes, and their subthemes, emerged from the primary research questions in this study: (1) What has been the lived experience of the participant in HPMP?; (2) What beliefs/attitudes are used by the

participants to cope with the monitoring experience?; (3) What meaning do the participants give to their experiences in the HPMP?

Theme One: The Lived Experience of HPMP is Overwhelming

Each participant indicated that the initial orientation at HPMP headquarters left them feeling anxious and overwhelmed. Attendance to meetings including counseling or treatment, urine screenings and cost, inability to regain employment, work site regulations, and contact with case manager were deemed as stressors. Harriet described her initial HPMP contact with one word, *anxiety*. She stated that HPMP's response to her was cold and impersonal. Julia's reaction to her initial HPMP contact was traumatic:

I remember when I walked out of there thinking to myself, 'Had I not gone to treatment and gotten tools in my tool belt, I think I would just walk out of here and want to kill myself.' What wasn't overwhelming? Everything is overwhelming.

Julia indicated that the 5-year HPMP program was daunting. She mentioned that having to check in five days per week, within a twelve-hour time frame, created stress. In addition, Julia stated that participants had to check in with case managers once a month and complete monthly paperwork. Additionally, attendance to three Narcotics Anonymous per week was mandatory, as were two Caduceus meetings per month.

Melissa, too, expressed the overwhelming nature of the requirements:

I really believe the intent behind it is to rehabilitate healthcare professionals. I believe that. However...they put so many requirements in the program. You know, how are you gonna have time to do anything else? Three to four meetings a week, forty hours a week of work, and drug screening(s).

Rebecca's experience was straight forward, stating that the program was overwhelming because it had "zero tolerance."

Clark also found the initial contact overwhelming. “It was intimidating,” he stated, “just because I hadn’t realized... (there were so many) restrictions...I think the hardest thing for me also was not knowing when I was going back to work.” Clark mentioned that the program was also stressful because of its one-size-fits-all approach. Clark himself had difficulty with the religious aspects of some recovery groups. Julia addressed the issue of program length, and, like Clark, believed that a more individualized approach would be beneficial:

I don’t think it needs to be the same for every single person. I don’t mean you have to change the whole program around necessarily. I don’t think the time period maybe doesn’t need to be the same for every person.

Within the theme of the overwhelming nature of the program, three subthemes emerged. The first centered on the cost of treatment and drug screenings. As Melissa described:

The program itself is expensive. If you’re not making decent money, you’re gonna spend \$300.00 a month to screen... The tests themselves cost different amounts. The travel to get there and your gas.

Rebecca concurred with this experience stating, “Our average is \$300.00 a month. Think about that. That’s an electric bill. I’m looking forward to not having that cost in my life.”

Harriet also found the financial cost very stressful. According to Julia, HPMP changed drug screening companies, claiming that the new company would be less expensive. “It’s not,” she explained, “it’s way more expensive and they test you more frequently; yet, they claim it’s random.”

A second subtheme that emerged concerned returning to the workforce. An initial program requirement was for the nurse to discontinue working. The monitoring program will grant permission to begin applying for employment after approximately three months

into the program. Two participants were able to return to their past employer; however, the other three participants struggled to obtain employment. Harriet applied to approximately one hundred jobs. She believed another program rule where HPMP does not allow a nurse to administer narcotics for the first ninety days of hire played a significant role in her inability to obtain employment:

When I started applying, I couldn't do the narcotics so everybody (said), 'Oh well, if you can't do narcotics then that's what a nurse does.' I felt it was because I was in the monitoring program (be)cause as soon as I told them I was in the monitoring program, the whole tone of the interview changed.

Julia experienced a similar issue, as she applied for fifty to one hundred jobs:

It's been challenging and discouraging because... I've just been applying and most of the time...I either hear...nothing back at all or I would get a rejection letter. Or every now and then I would get a call back for an interview, and on those occasions I would go in for the interview and then get nothing or a rejection letter after the interview.

Upon her return to work, Melissa could not administer narcotics for 90 days. Melissa explained, "I needed and wanted to get back to work. As far as pride, or being embarrassed, it wasn't a perfect set up, but I was glad to be getting back to work."

Conversely, in Rebecca's experience, she was completely supported by her work place:

They wanted me back, and they wanted me healthy. They were willing to do anything that they had to- to offer me a position, to make sure I had steady income coming in, to make sure I didn't feel like my life was over. Yeah, they were wonderful.

Clark also returned to his former employment; however, it took months for him to obtain the necessary contract from HPMP, delaying his return to work. The participants experienced frustration as communication with their case workers was delayed.

Participants needed approval from HPMP in order to make changes to their work schedule, counseling attendance, etc. In order for this change to occur, a new contract

had to be approved by HPMP. The delayed response on behalf of HPMP, often left the participants feeling overwhelmed and with a sense of powerlessness. As Clark stated:

It was probably another three weeks to a month before I actually got my contract, and then it was another week or two before they said you're good to return to work...that was frustrating because since I'd maintained my employment, I have a manager asking, 'When are you coming back?' I had to tell them (for) over two-three months, 'I don't know.' I think that's difficult on the employers that HPMP doesn't communicate that with them.

The third subtheme to emerge was the participants' relationships with their case managers. Overall, Clark had a positive relationship with his case manager and felt encouraged and supported by her. This was not the case for the other four participants who, unbeknownst to the researcher prior to the interviews, had the same case manager. They experienced poor communication that was discouraging, disrespectful, and often condescending. Harriet commented:

(The counselor) talks to you very condescending and sarcastic all the time. ...One time she talked to me so bad, very degrading. You know, like I was a child and it messed me up for a whole month.

Similarly, Julia found the case worker to be discouraging. She indicated that while she did not need a reward for never missing check-in or for never testing positive, she would have liked some positive affirmations from her case worker. Melissa felt the same:

It put me down...Never encouraging me. Never uplifting me. I've never had a negative screen, and I'm not looking for a pat on the back for being clean. That's not it at all. It's the fact that you are supposed to be on my support team... You're in a program that's supposed to be helping you to get back to work and get your life back. My case manager wasn't helping me at all....I never felt at all that she respected me.

Rebecca's experience with the case manager was similar. She was reprimanded by the case worker for asking a question in a telephone call. The caseworker indicated that an email should have occurred instead. "I felt like a little puppy in a corner being shouted at

or being hit over the nose with the newspaper. ...and that's why I limit my contact with her to as much as I have to," Rebecca commented. Clearly these four participants had similar issues of poor communication, lack of respect, and discouragement from this particular case worker. Rebecca attempted to make sense out of her experiences stating, "I even try to make myself feel better about her attitude towards me. I think, she's probably stressed out. I'm sure she's got a huge caseload because it's an epidemic."

Thus, the first theme indicated that the participants felt overwhelmed by the HPMP process. Several sub-themes emerged including cost of treatments and screenings, returning to the workforce, and relationships with the caseworkers. Participants in this study noted that they have to find a personal way to maintain integrity and self-sufficiency as they work through the HPMP program.

Theme Two: Acceptance is the Answer

The second theme that emerged was the understanding of the importance of acceptance. In *Alcoholics Anonymous: The Story of How many Thousands of Men and Women Have Recovered from Alcoholism*, the author states, "Acceptance is the answer to all my problems today" (Wilson, 2001, p 417). Participants cited this as the mantra that enabled them to cope with the HPMP experience. Clark related that while there were many aspects of the program he would like to change, he recognized that it is not within his power to do so. Clark stated, "If I'm practicing...serenity and acceptance, it makes everything in the monitoring program manageable." Harriet stated in a raw and open way:

Where I'm at and what's going on –it is what it is-ain't nothing I can do about it. It's going to be what it's going to be. The only thing I can do is go through what I'm going through knowing that I'll be okay in the end.

The participants affirmed that acceptance was the opposite of powerlessness. It was not giving into despair. Rather, according to the participants, it was an important aspect of recovery. As Julia believed, “I know I’ve always said that everything happens for a reason, and sometimes I don’t always understand, and that use to frustrate me. But now I just don’t let it frustrate me anymore.” Rebecca described her sense of acceptance as more of an epiphany when she stated, “Now, I don’t really know the exact date of when everything changed... This is about getting (my) life better and getting (me) back on track.” For Melissa acceptance centered on taking responsibility:

When I get called out on something I’ve done in the past, then I just say, ‘Yes, I own it, because I’m not gonna be put down or made to feel ashamed of myself. I know what I’ve done. ...If you’re gonna finish the program, you’re gonna follow HPMP’s rules, and you’re gonna do what you need to do on that-through the program. ... I had to accept that I had to do what they wanted me to do. When I did that, my mental status got a lot better.

From the theme of acceptance, subthemes emerged that illustrated the use of coping skills, both through internal and external support systems. These coping skills took the form of self-talk, personal affirmations, prayer, meditation, and building a support network. Melissa used prayer and personal affirmations stating, “I pray a lot. I look at the positive things in life, and the good things that are gonna come. I’m not going to let anyone defeat me... You know, I’ve been-I had to learn to forgive myself.” Rebecca, too, found prayer and staying present- centered helpful as coping skills. She also commented on her outside support system noting:

I pray probably more than- they may be small prayers... God is my main lean-on... To not worry about what’s coming up in two hours or tomorrow and just worry about what I’m doing in the moment ... I also have a great support system that has helped me- my husband and my family... I start my day and try to keep my mind clear for the day. I wake up, it’s gonna be a good day. I’m gonna go to work. We’re gonna get some things done. If I start my day with a positive attitude, it usually trickles through the rest of the day.

Rebecca did not enjoy attending AA/NA meetings, even though she attended as a requirement of the HPMP program. What she and her family found to be most helpful was Celebrate Recovery, a Christian based support program, and she used this as a coping mechanism. “Celebrate recovery is my favorite because it’s family oriented,” she indicated. “I can take my kids... to a class. My husband can go to a men’s group.” For Clark, meditation helped him early on in the HPMP program. He used meditation to mentally escape from the stresses of the program. For Harriet affirmations meant learning to trust herself and using self-talk to keep going. She told herself to “just do it...do what you’ve gotta do and it’ll be over sooner rather than later. And that’s what kind of kept me going.” With her past abuse history, Harriet was a survivor who persevered through many trials in her life, including HPMP. Like Harriet, Julia had experienced much self-doubt and utilized personal affirmations to help herself realize that “I am not worthless.”

Coping skills also came from outside of the family. Four out of five participants had positive experiences with counseling and considered their current therapist and therapy groups as part of their support network. Clark indicated that his experience with his professional group meetings were more helpful than Caduceus meetings:

My group therapy, which are the same people every two weeks... (are) all healthcare professionals. I get so much professional support...more so out of that than going to Caduceus meetings where people are cycling in and out... different people at different meetings.

Unfortunately, Harriet found counseling and groups to be a waste of money. She was initially hopeful about counseling, but was unable to bond with her counselor. She found

more support with her sister-in-law, aunt, and cousins. Julia, on the other hand, had two counselors and her parents offered financial support.

Julia also dealt with the sense of guilt and shame that accompanied the financial support her parents afforded. “I try not to focus on emotion,” Julia mentioned, “I mean honestly, I’m working on so many other things in counseling right now and I don’t focus on the shame and guilt so much so anymore, really because I can’t. It would just eat at me.” Melissa also discussed the shame and guilt caused by her addicted behavior and how she has overcome this with the help of her support system:

I’m very lucky to have my sister, my Mom and my husband...My daughter... I wouldn’t be here, had they not supported me and kept loving me through this. Not just discarding me... I’m very lucky to be alive.

Melissa learned not to allow others to shame her stating, “I’m just as worthy as the next person. Nobody’s perfect. You’d better love everybody, because this is a disease that does not discriminate.”

Acceptance was the belief/attitude that aided each participant in coping with the perceived overwhelming demands of the HPMP program. Each participant learned to use internal and external coping skills towards acceptance.

Theme Three: Accountability

Personal accountability developed as the third theme. Within it, four subthemes emerged: taking personal responsibility, working through shame, resilience, and trust in self. Participants indicated that learning to take responsibility for their actions was a huge step in their recovery. Melissa noted:

I am grateful that there is such a program, because honestly, when I admitted I had a problem, I thought that would be the end of my career...it keeps you accountable...The therapy helps to document someone else’s opinion. That’s

good. It's good to be accountable to someone until you learn to be accountable to yourself.

Rebecca believed the monitoring program was a lifesaver:

In some ways, if it wasn't for HPMP, I don't know where I'd be today...the groups are helpful, it's helpful in keeping you accountable. Pretty much all of their policies are helpful, because they all just keep you on track...keep structuring your life-There's no getting around it...you are held accountable and responsible, and things are made much tougher on you because of the program.

Harriet agreed that personal accountability was key to the HPMP program. She believed that by taking personal responsibility for her substance abuse, she learned how to be grateful for her sobriety. Clark added that accountability grew from his own personal acceptance and the monitoring program itself. He believed that HPMP was a valuable resource and a tool in his recovery efforts:

The monitoring program provides some consequences that long-term may be helpful, but can be a bit painful in the moment...I also think it helps add some objectivity to my recovery in that it keeps me honest.

Out of the five participants, Julia was in the monitoring program the shortest amount of time. She continued to struggle with the rules and requirements of the monitoring program, but saw the importance of being accountable:

It keeps (me) accountable...I mean everything happens for a reason-maybe that's just what it took. I wasn't willing to lose... (my) license...I just didn't realize that my life was so unmanageable. I didn't, it's kind of crazy when I look back, not to have realized that I didn't have these terms that I have now... surrender, powerlessness, you know, giving up control.

Working through shame became the second subtheme for personal accountability. Each participant openly shared the pains of childhood trauma, family of origin beliefs, and mental health issues that created shame. Several participants experienced significant childhood abuse; thus, rendering a sense of shame at an early age. Participants grew up feeling inadequate and unable to meet adult expectations. For some, this led to

depression in adulthood. The four participants who shared the same case manager, felt shamed in their interactions with her and in what they perceived was disrespectful contact. Rebecca noted that the interactions she had with her case manager brought on a sense of shame:

I don't have a lot of positive things to say about her, just for the simple fact of how she's approached me. My question is does she approach everyday people in her life like that or is it just me? Or is it just the people that are in the program? Because we already feel...badly.

Harriet concurred that the case worker evoked feelings of shame. She stated, "I think so much with her is just how she comes across, like I'm the scum of the earth." Each participant worked diligently in their recovery program to learn to cope with their issues of shame. Melissa transformed the case manager's disrespect into personal motivation.

In doing so, Melissa regained a sense of self-worth:

(I) have some sense of pride built back in (my) life. If it comes through...career, from home. Your family trusts you again, and looking at you with love instead of worried about where you're at and what you're doing. Or worried about you. Just worried about me. They're relaxed and happy. My work is better. This is who I've always been, I just hit a rough spot in life.

Each participant used their negative experience with the case manager to boost self-esteem and motivate them to complete the program.

Resiliency became the third subtheme of personal accountability, as each participant persevered through the stressors of the program. Harriet discussed how being resilient began with the start of her day:

I log in and if it shows red, I'll get anxiety...because that means I have to work my day around going to drug test, but that part is getting better...So I take full control over what it is that I have to do in regards to this (drug testing).

Clark developed resiliency with a change in attitude and perspective about the HPMP program. He stated, "I would say accepting the things I cannot change, being

appreciative and having gratitude for what the program does for me as opposed to dwelling on the negatives.” Julia shared Clark’s approach as she recognized that being frustrated with the program “is just pointless for me. I don’t always have to understand the why of everything anymore, because I could drive myself crazy with that if I let myself focus on that every moment of every day.” Being resilient helped each participant navigate through HPMP.

The fourth subtheme that emerged out of taking personal accountability was trust in self. Through acceptance of personal responsibility, working through issues of shame, and being resilient, each participant developed a sense of trust in their abilities to persevere. Melissa observed:

The healthcare professionals that I have been around that are in the program, you can see these phases that they go through. In the beginning it’s ‘this is stupid.’ Well it’s not always going to be-feel stupid, but you’ve got to do it. They (HPMP) don’t understand. They’re asking you to do this, this, this, and this and I’ve got to work. I’ve got a child. I’ve got 40 hours-there’s just not enough time, it’s not possible to do it. The frustration of trying to juggle it all. You can see that in the beginning. It’s almost like I’m making excuses for not wanting to do it- to a certain degree. I don’t have time to do that. Well, I do. I did. I am still... (HPMP) it’s helped getting your routine back. That would be my goal at the end of this program, it would be that everything would just be routine again. As normal as it’s going to be.

Rebecca found that HPMP kept her structured and accountable which helped her build self trust. She stated, “The HPMP rules have become...a part of my life, my life kind of revolves around it.” Julia continued to work on gaining trust in herself. She believed,

I may understand little bits and pieces as time goes on. And I already do understand more than I use to, but I may never understand the why of all of it. So I just don’t focus on that. I just don’t.

Clark agreed that HPMP gave him confidence and reaffirmed his ability to stay sober.

He commented, “(HPMP) definitely does affirm, ‘Am I doing this right?’ or ‘Are these

steps or changes in my life productive?’ ... So (I know) I’m doing that right.” Harriet learned how to trust herself by setting healthy boundaries with others. Her motto was “don’t forget” in order to avoid repeating past behaviors. Harriet learned to listen to her instincts.

The final theme of personal accountability illustrated a turning point in the recovery process for the participants. While they may not have agreed with the rules, regulations, and impersonal approach of the HPMP, they were encouraged by the process that led to taking responsibility for their substance abuse and, subsequently, their lives.

Summary

In conclusion, three themes emerged from the rich descriptions given by the participants during the interviews and the themes proceed from one to another: the overwhelming nature of HPMP, acceptance of the program’s requirements, and the act of being accountable for one’s journey in recovery. This flow can occur on a day-to-day basis and as an overall process. Utilizing the phenomenological method brought the phenomenon “back to the things themselves” (Husserl, 1970, p. 252) through giving voice to the participants in the HPMP program. The result of the shared phenomenon indicated that the participants made meaning of the phenomenon through the integration of past experiences, internal coping processes, and support from family. The essence of meaning for the participants evolved into a belief in the resiliency of self and the determination to live a life of sobriety and accountability.

Chapter 5 Discussion and Conclusions

This chapter summarizes the results of the study, discusses the findings and implications, connects those findings to literature, focuses on the limitations of the study, and offers recommendations for further research. The purpose of this phenomenological study is to describe participants' experiences in a monitoring program for impaired nurses in Virginia, determine what beliefs and attitudes underscore the participants' abilities to cope with the program, and uncover what meaning is made of the experiences. Only a few studies have explored the lived experiences of participants in a monitoring program.

Summary of Results

There were five participants used in this study, four females and one male. All of them fit the criteria for the research: (1) participants had participated in HPMP for at least a year; (2) participants had not used substances since entering HPMP; (3) participants were all licensed nurses eligible to return to work; and (4) participants were residents of Virginia. Initially, a pre-interview was held on the phone. Then, two interviews were conducted in the participants' hometowns spaced one week to ten days apart. The researcher used phenomenology to conduct the analysis, looking for emerging themes using horizontalization from participant descriptions as she immersed herself in the data. After data was analyzed, textural descriptions and structural descriptions were written.

Three themes emerged from the data. The first theme indicated that participants found the lived experience of HPMP to be overwhelming. From this, three subthemes surfaced involving the cost of the monitoring program, difficulties in returning to the workforce, and stressful relationships with the case managers. For the second theme, all

participants acknowledged the importance of acceptance. The subthemes that surfaced included the use of external and internal coping skills such as self-talk, prayer, meditation, personal affirmations, and building a support network. The third theme focused on accountability. Taking personal responsibility, working through shame, resilience, and self-trust developed as the subthemes.

These themes and their subthemes emerged from the primary research questions in this study: (1) What has been the lived experience of the participant in HPMP?; (2) What beliefs/attitudes are used by the participants to cope with the monitoring experience?; (3) What meaning do the participants give to their experiences in the HPMP? The discussion of the findings answers these questions.

Discussion of the Findings

The findings in this study add rich, thick meaning to the lived experiences of substance use nurses who are participating in a monitoring program. Each participant explored what policies were effective and ineffective, and what beliefs/attitudes helped them cope with HPMP. It is this researcher's belief that the participants were eager to discuss their experiences in the HPMP and to also have their stories heard and validated. The findings emerged from the analyzed data and from the researcher's reflective journal. Contemplating the journal and the words of the participant brought the findings into view. As an instrument in this study, this researcher recognized the impact of giving space to the participant in order to explore their HPMP experiences. What unfolded were the answers to the three primary research questions.

What Has Been the Lived Experience of the Participants in HPMP?

The central lived experience was the overwhelming nature of the program due to the intensity of the program's requirements. For participants, this led to anxiety as they worried about their ability to complete the required monitoring tasks, including the financial strain of the program. Paying for drug screens, treatments, and gasoline to get to-and-from required functions caused anxiousness. Several HPMP study participants had been financially supported by family members during the transition back to work. The researcher herself had previous clients who resigned from the HPMP program due to financial issues, or who had obtained retail jobs in order to ease the financial burden. Julia, Harriet, and Melissa also had to find supplemental jobs and struggled to regain their positions as nurses.

Furthermore, participants felt stress over their relationships with their case managers who held power over the participants' professional licenses. The participants deemed the relationship with their case managers as unequal and degrading, as they believed that they had been prejudged by them. Each participant experienced anxiety over interactions with the caseworker. Details, such as lost paper work and lack of positive acknowledgements, were also causes of participants' trepidations. Four out of the five participants with the same case worker experienced disrespect and an intense sense of dread due to the negativity of the case manager's attitude.

Attending the required number of support sessions also became overwhelming for the participants. Coupled with their regular life demands, such as family and friends, these meetings became overpowering. Participants cited the frequency of the meetings as a burden. Several participants hoped the amount of weekly attendance to support group

meetings would eventually be reduced and that the types of approved support groups would be diversified.

For several participants, the anxiety of not finding employment was daunting. Three participants struggled to find new employment, while two returned to their employers. All participants believed the HPMP needed to have contact with employers in a more open, less complicated, and timely way. All of the participants shared the frustration of HPMP's lengthy decision-making process, and their tendency to misfile or lose paperwork.

Shame was a lived experience from participants' childhoods that carried over into their HPMP participation as each had underlying childhood traumatic issues that had been left untreated. All HPMP participants felt a deep sense of shame concerning their addiction and what it meant to be an addicted nurse. Three nurses recognized their use of drugs was harmful to their patients and felt tremendous shame. One nurse was in recovery prior to beginning her nursing career, and one believed mental health issues played a large part in his inability to care for patients. While several of the HPMP nurses had experienced shame through the childhood trauma, it was also the initial shame of being caught, as well as their contact with their case manager, that reinforced their sense of shame.

What Beliefs/Attitudes Are Used by Participants to Cope with the Monitoring Program?

The implementation of coping skills allowed the participants to accept program policies and procedures. The use of internal and external coping skills led them to make meaning of their HPMP experience through acceptance of the program's policies and

procedures. The lived experience of HPMP required participants to reframe their thought processes and accept the program. For participants, acceptance was a process that remained a daily issue involving not only recognition of substance use issues, but of mental health issues, past childhood abuse issues, and chronic pain. Reframing their lived experience from overwhelming to acceptance was a turning point in their recovery.

Participants developed both internal and external coping skills. Poor coping skills for stress and traumatic life events were indicated by Julia, Harriet, Clark, Rebecca, and Melissa. Participants in this study often referred to learning internal coping skills as “tools to put in their tool box.” The learning and reframing occurred in initial treatment, whether inpatient or outpatient, and continued throughout the participants’ counseling, except for Harriet who did not have a trusting relationship with her outpatient therapist. The internal coping skills that were developed enabled participants to live in the present moment. Dealing with the HPMP on a daily basis was a challenge for the participants, and all used meditation and prayer as an internal coping skill. The use of the internal coping skills and staying present-centered, led each participant to the acceptance of their inability to change the program and adjust their day-to-day thinking. This helped the participants go from feeling powerless to being empowered.

External coping skills consisted of group counseling, individual counseling, support group attendance, and family/friends. Participants indicated the value placed on these external support systems. Clark and Rebecca had a positive and trusting relationships with their therapist. Melissa and Julia also found support in individual therapy. Harriet found that family, friends, and support group attendance (AA/NA) helped her the most. Although research indicates Caduceus meetings are helpful, (Wile

& Jenkins, 2015), these HPMP participants did not support this. The participants did participate in Caduceus, as required by the HPMP, but found this group to be less impactful for recovery. Several participants attended peer counseling groups with other HPMP participants and found peer support invaluable. Rebecca used a Christian based support group and indicated this was important for her husband and children. Whatever the means, these participants gained awareness of their thoughts and behavior using a restructuring of beliefs that helped them gain awareness of what led them into substance use.

What Meaning Do the Participants Give Their Experience in HPMP?

The meaning that the participants gave to their HPMP experience was accountability. The participants took personal responsibility for their recovery and, with treatment and support group attendance, worked through shame. The initial feeling of being overwhelmed, counseling and group attendance, and even drug testing helped the participants to show not only themselves but to others that they were being accountable for their recovery. This was of significance to each nurse as it gave them a sense of renewed pride and self-trust. Each participant had recalled that while using substances, he or she had lost respect in themselves. The participants acknowledged the ways in which their addictions had led them to make poor choices. Two participants, Julia and Rebecca, displayed significant regret and shame for taking drugs from their patients.

By following the rules and regulations of the HPMP, the participants began to trust themselves and found resiliency in their ability to handle life situations and positively participate in HPMP. The paper-trail of negative urine screens, monthly counseling reports, monthly work-site reports, and their own monthly check-in reports

indicated to the HPMP that they were in recovery and following the established policies. Moreover, participants realized that dealing with HPMP procedures and caseworkers meant that they had to change their own response to the program. In doing so, the participants gained trust in themselves. Through acceptance of the HPMP policies, each participant gained personal responsibility, trust in self, and personal acknowledgement of their own resiliency.

Connection to Literature

Studies have shown that the financial strain of a monitoring program negatively impact a nurse's recovery. A comparison study of substance use physicians and nurses by Shaw, McGovern, Angres, & Rawal (2003) found families who depend on the nurse's salary have smaller financial savings which will lead to greater strain and less money for treatment (p.568). The financial cost of the program's requirements worried all of the participants. Also of note in this study were the concerns of the nurse having to take time off from work, transportation issues, and finances. Interestingly, Shaw, et al., (2003) found their data supported their hypothesis that

...nurses would experience harsher professional and work sanctions, because their professional organizations are often less established than physicians' organizations...Nurses are placed on probation and sanctioned more commonly than physicians, both at presentation and follow-up. Therefore, the group who can least afford to miss work appears to be most likely to be reprimanded and may be least likely to seek costly legal representation (p.568).

Most nurses do not have excessive savings and several HPMP participants were offered financial assistance from their parents. Others obtained employment in retail to help them financially when they were not allowed to work in their profession.

In an analysis of focus groups for substance use nurses participating in Indiana State Nurses Assistance Program, Horton-Deutsch, McNelis, & O'Haver (2011) found

financial issues and costs were of concern to the participants. This was described as a “hindrance” to recovery (p.452). Horton-Deutsch, et al., (2011) state, “Group participants agreed that the financial burden of treatment was significant. Complicating this burden were periods of unemployment, lost income, withering savings, and lack of financial support from unemployed spouses” (p.454). Financial concerns, as seen in this study, can be overwhelming and a deterrent for nurses to participate in a monitoring program.

Participants in the Indiana monitoring program also had similar experiences with case management issues involving poor communication, lost paperwork, and confusion. These had a “negative effect” on the participants (Horton-Deutsch, et al., 2011, p.451). A study by Melvin, Koch, & Davis (2012) indicates that when a treatment participant is employed upon entering treatment and remains employed after treatment discharge, the employment rate is higher than having been unemployed (p. 35). This was affirmed in this study as the two participants, Rebecca and Clark, did not struggle with finding employment, while the other three participants applied for over one hundred postings each.

The struggle for Rebecca, Clark, Julia, Harriet, and Melissa centered on the length of required time off, the delay in case managers’ paperwork, and the length of time HPMP needed to obtain clearance to return to work. Melvin, Koch, & Davis (2012) state, “Securing and maintaining employment may be difficult for persons with substance abuse issues. Barriers such as lack of employment history, stigma, and the possibility of criminal justice involvement are just a few barriers one may face when seeking

employment” (p. 35). Employment has been indicated as a positive aspect of successful recovery for the substance abuse population (Melvin, et al., 2012).

Participants indicated that they initially used substances as a stress reliever. All participants in the HPMP study related abnormal stress from family of origin or spousal abuse. Early life stress has been found to negatively influence the brain, in particular the prefrontal cortex, which is associated with complex cognitive behaviors and the expression of appropriate social behavior (Sinha, 2008). This could result in changes to the brain and an inability to deal with stress in an appropriate manner.

The use of internal coping skills led to greater self-care and sustained recovery for the participants. As with the Burton (2014) study, all HPMP participants felt a deep sense of shame concerning their addiction and what it means to be an addicted nurse.

Witkiewitz, Marlatt, & Walker, (2005) used mindfulness in their study on relapse prevention and found, with continued practice, participants could learn to tolerate and work through stressful situations. All participants believed stress management needed to be part of the student nurses curriculum, and their own continued sobriety.

Furthermore, chronic medical issues and pain added another layer of stress to daily living, as participants were not allowed to use narcotics for pain relief. Higher rates of chronic pain and physical issues were found in impaired nurses, as it was with Julia. Rojas, Jeon-Slaughter, Brand, & Koos (2013) assert that chronic medical issues may be due to poor self-care and inappropriate boundaries, which would create a need to self-medicate and lead to substance use issues (p.105).

In studying differences between nurses, physicians, and pharmacists, Rojas, et. al., (2013), found that nurses reported a higher rate of family addiction, and an increased

comorbidity of psychiatric disorders. Comorbidity adds additional stress to the participants since they not only have to cope with the daily requirements of the HPMP, but also balance their mental health and substance use issues. Mental health diagnoses were given to all participants including depression, anxiety, and bipolar disorder. Clark believed his mental health disorder impacted his work significantly. His treatment group and individual counseling helped restructure his negative thoughts. Clark's lived-experience is supported by Smith & Hukill (1996) who had similar findings in nurses with mental health issues.

Group, individual counseling, and support group attendance can be external supports for the recovering nurse. The findings in this study are similar to the study conducted by Pardini, Plante, Sherman, & Stump (2000) in which they stated that:

...among recovering individuals, religious faith and spirituality is associated with several positive mental health outcomes. In particular, higher religious faith and spirituality was associated with increased coping, greater resilience to stress, an optimistic life orientation, greater perceived social support, and lower levels of anxiety (p.351).

Prayer and meditation were used by the HPMP participants to calm anxiety and let go of their need to control situations. Integrating spirituality and religious beliefs into recovery became a valuable coping skill. Another study indicated that counselors needed to pay attention to individual needs while honoring clients' preferences in utilizing spiritual and religious coping skills (Lietz, & Hodge, 2013).

Hansen, Ganley, & Carlucci (2008) explored recovery in participants with at least ten years of sobriety. Recovery began with an acceptance of past behavior and taking responsibility for recovery. All participants in this study recognized the policies, although difficult at times to deal with, ultimately held them accountable (Horton-

Deutch, et. al, 2011). Personal accountability is the foundation for maintaining recovery and is written into the Alcoholics Anonymous twelve steps as acceptance of addiction and making amends (Wilson, 2001). To be a healthy and functioning self is to accept personal responsibility for thoughts, feelings, and behavior (Crocker, 1999).

Accountability was the identifier that each HPMP participant used to make meaning of their participation in the monitoring agency.

Limitations

The researcher identified five limitations to this study. First, this study only included nurses from the state of Virginia who participated in the HPMP. Secondly, the study was based upon self-reported data. Third, the transferability of findings was a limitation. Fourth, the sample size, although adequate for a phenomenological study, was low. Finally, four out of five participants had the same case manager. The researcher acknowledged that these limitations were created by issues of both internal and external validity.

According to Connelly (2013), “Internal validity addresses the rigorous conduct of the study, while external validity focuses on applicability of the findings to larger populations (generalizations)” (p. 325). The researcher addressed credibility issues to this study by gathering rich descriptions, acknowledging the voluntary nature, and using self-reported data. Thus, the researcher noted that the internal validity concerns of this qualitative study focused on the “credibility” of research (Morrow, 2005, p. 252).

However, the researcher asserted that focusing on such a narrow group allowed specific questions to be answered and common threads to unfold. One way this researcher found

to increase credibility for this study was in gathering rich descriptions of participants' experiences.

The final internal validity limitation that arose was the use of self-reported data. According to Connelly (2013), "People may have selective memories and may get timing of events wrong (telescoping), attribute positive events and outcomes to external forces, and exaggerate the significance of actions and events" (p. 325). Each participant participated in counseling and support group attendance and, thus, engaged in reflection of past and present experiences/beliefs. This allowed for clarity of memory since participants were engaged in the phenomenon on a daily basis, so no time had passed between the experiencing of the phenomenon for telescoping to occur. The use of member checking was used to abate this limitation (Creswell, 2013; Morrow, 2005).

The external validity issue that the researcher experienced in this study dealt with "transferability" (Morrow, 2005, p. 252). Since only Virginia nurses were interviewed, unheard voices of nurses in other states and in other monitoring programs exist. This will be an area for future study. Awareness of these limitations were monitored by the researcher through the use of researcher reflexivity. As stated above, with reflection on this issue after each interview and with the knowledge of clients from private practice, it became clear early on in the data gathering phase that Virginia nurses participating in the HPMP shared similar experiences. The use of member checking and the review of this dissertation by the dissertation committee served as the final external audit.

In combining Seidman's three interview technique in the design of this study, the first interview was made 30-minutes longer than the second. During the first interview, it was difficult to stop the client at the end of ninety minutes as the interview would have

stopped in the middle of the second research question. Each participant was asked if they wanted to continue and all agreed. Understanding the context of the HPMP participant was important, yet this could have been completed with a longer pre-interview or with maintaining the integrity of the three interview technique in its original form. This researcher recognized the value of maintaining the integrity of Seidman's procedures as the length of the first interview was arduous. In reviewing the interview questions, a more concise verbiage needed to be used. The questions at times directed the participant in a particular direction which was not on point and resulted in obtaining information from participants that was not useful.

The use of a pilot study would have been helpful in molding a more succinct interview guide. According to Van Teijlingen and Hundley (2001), there are many reasons for conducting a pilot study. The benefit of a pilot study would (1) focus on the design of the study and research questions; (2) assess whether the interview questions are adequate; (3) identify whether or not adequate time has been given to the interviews; (4) assess the proposed data analyses techniques to uncover potential problems. Pilot studies help to make certain the design and method used in the research is sound. This would have aided in any changes needed and to expand or limit the design. Also, this researcher chose to not use a computer program to aid in theme analysis due to the small sample size. This researcher valued the aspect of data analysis of immersing into the data by reading and re-reading the paper transcripts. Statistical analysis may have been enhanced through the use of a computer program.

Four of the five HPMP participants had the same case manager and each shared the same experience of feeling shamed, disrespected, and demeaned. Their participation

in the study may have been motivated by their frustrations over the case manager. The researcher counsels other HPMP participants in her private practice. During the interviews for this study, it was difficult for bias to be bracketed. The researcher had clients who experienced similar issues with the same case manager. This was not expressed to the participants during the HPMP interviews. It was interesting to experience this issue as a researcher and time was taken after the interview to personally reflect on the bracketing process.

Implications

The findings of this study indicate that counselor education programs need to train counselors to recognize the needs of participants in a monitoring program, as well as familiarize students with the programs themselves. Counselors must be aware of the overwhelming stress produced by participation in a monitoring program, for participants not only struggle with sobriety, but with the intensity of the program itself. The counselor must be competently trained to help build a repertoire of techniques and to assist the participant as she navigates through complex issues. Furthermore, counselor education programs should recognize the importance of a deeper examination into the root of the participant's concerns, which could be physical, mental, or sexual abuse that occurred in childhood. In doing so, counselors will identify the underlying issues that perpetuate a dysfunctional, learned sense of being.

This study also reveals implications for the Health Practitioners' Monitoring Program. While the rightful goal of HPMP is to protect the public from an impaired nurse, a balance should exist so that the program itself treats the nurse with more

empathy and compassion. Caseworkers need to build an awareness of the stressfulness of the program and approach the participants in a more understanding and less punitive way. Participants in this study indicated that HPMP's one-size-fits-all approach discourages success and that, perhaps, a more individualized treatment plan would be appropriate, especially when defining the number of meetings that must be attended. The financial cost of the program coupled with the lengthy employment process, puts additional stressors on the participant that hinder a successful recovery. Communicating with potential employers about the monitoring program would help the employers understand the program. Finally, this study revealed a need for an exit interview by HPMP in order to gain valuable information about the program and reflect upon what policies work and which do not.

Implications from this study also exist for hospital administrators and nursing education programs. For hospital administrators, working with a person in HPMP offers a safety net as participants are screened on a weekly basis. Extensive screenings mean that the sobriety of the participant is unquestionable. More knowledge of the HPMP program will encourage administrators to fully utilize the monitoring program as a system that will benefit their organization. Nursing educators can also take from this study the need to include stress management and coping skills into their curricula, which all participants indicated were needed.

Future Studies

Areas of further study can range from the exploration of monitoring programs in other states to understanding internal coping skills utilized by the recovering nurse. Certainly, a follow-up study of nurses who have completed the HPMP would yield

valuable feedback, as this population may feel less restricted in giving voice to their experiences in the monitoring program. Comparing the experiences of nurses in HPMP with those in other state monitoring programs may offer an understanding of which policies and procedures promote the best results. Additional comparative studies between monitoring programs for other healthcare professionals and nurses would add to the acknowledgement of what policies work and which policies are least effective. All participants in this study related difficulty with the financial cost of the program, in particular the cost of drug screens. Further studies might investigate how other state monitoring agencies deal with this issue and if any state agency has addressed the cost of their program.

This researcher acknowledged the use of the term “acceptance” in theme two, which is an important concept in the substance use field. However, the term *coercion* could also apply. Monitoring programs, including the HPMP, hold power over the nurse and other participating healthcare professionals. Further research into the difference between acceptance and coercion as it relates to agency and program power would yield important information for monitoring programs (Dabro, 2009).

Identifying the interconnectedness, or lack thereof, of the monitoring programs and hospital administration and staff is vital to the recovering nurse. Future research could focus on how monitoring programs and hospital administrations might work together in support of the recovering nurse and what impact the use of a vocational rehabilitation manager could have for everyone involved. Also, the recovering nurse may reenter the workplace by gaining employment in a position that did not require the administration of narcotics; thus, allowing the nurse to return to work faster and more

safely. Further research on this important workplace topic would add tremendous value to the lived experience of the substance use nurse and healthcare professionals.

Additional research concerning the requirement of support group attendance would enhance the efficacy of continued practice. Future research that focused on the individualization of program requirements, such as a reduction of support group attendance by year four or five, would provide value, as would the investigation of how an atheist or agnostic nurse is supported. Furthermore, researching the types of training given to case managers and exploring the demands of their workload in a monitoring program would add valuable feedback toward understanding the complexities involved in assisting the recovering nurse.

Research that focuses on recovering nurses will further highlight their needs. Investigating utilizing peer nurses, who successfully completed a monitoring program, as mentors to nurses new to the program would offer insight into the role of positive relationships in recovery. Also, of interest to future research, would be the relationship between the monitored nurse and co-workers during the ninety-day narcotic suspension. Participants suggested that stress management education should become part of the nursing program. Further research might investigate the impact of stress management studies on nurses and the techniques used to manage stress. Moreover, this study brought out concerns of how to cope with chronic medical issues and pain management while in a monitoring agency, since most monitoring agencies operate on a zero tolerance for the use of any narcotic by the participant. Research into how this issue is dealt with in the general substance use field and within a specific subset of the substance use population is important.

Childhood abuse and trauma was experienced by four of the HPMP participants. Further research might focus on whether this is a predictor of substance abuse in the profession and whether early intervention with a student nurse may help mitigate substance use issues. Safety of patients is the utmost concern and future studies that can discover ways to help the addicted nurse in recovery will be vital.

Summary

This research study is of value to substance use counselors, nursing supervisors, educators, hospital administration, professional licensing boards, state legislators, and monitoring agencies. The findings can be used to implement changes in monitoring programs' policies and procedures. This study indicates a wealth of lived experiences in a population that is valuable and deserving of a voice.

Three themes surfaced as a result of this study. First, the requirements of the HPMP program are overwhelming. Secondly, the participants learned how to use both internal and external coping skills to transcend the overwhelming experiences as a result of the program's procedures. Third, these coping skills helped the participants move towards accountability and acceptance as they learned to navigate their way through the steps of the HPMP. Despite the policies, case manager issues, financial costs, difficulty obtaining employment, shame, stress, and frustrations of the program, participants developed a sense of accountability for their behavior. What evolved from the themes is an understanding that no matter what was asked of the participants, they persisted in their quest for recovery.

Participants in this study voiced concerns over the cost of the program, poor communication with their case managers, and difficulties in reentering the workforce.

Hearing these lived experiences of the participants can become part of the monitoring agency's evaluation of best practices. Furthermore, the participants in this study indicated that nurses in training must be educated on stress-management prior to entering the profession. In doing so, nurses will be better prepared to face the stressors of their daily lives. In conclusion, understanding the lived experiences of HPMP participants can enhance the awareness of important issues surrounding recovery, and restore the healthcare systems' greatest commodity, its nurses.

References

- Abbott, C. (1987). The impaired nurse part I: Description of chemical dependency. *Association of Perioperative Registered Nurses Journal*, 46(5), 870-876.
doi: 10.1016/S0001-2092(07)67409-2
- Abraham, A. J., Riekman, T., Kovas, A. E., & Roman, P. M. (2011). Counselors attitudes toward the use of naltrexone in substance abuse treatment: A multi-level modeling approach. *Addictive Behaviors*, 36(6), 576-583.
doi: 10.1016/j.addbeh.2011.01.030
- American Nurses Association. (1984). *Addictions and psychological dysfunctions in nursing: The profession's response to the problem*. Kansas City, MO: Author.
- American Nurses Association. (1985). *Code for nurses with interpretive statements*. Washington, DC: Author.
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental health disorders* (5th ed.). Arlington, VA: Author.
- American Society of Addiction Medicine. (2011). *Public policy statement: Definition of addiction*. Chevy Chase, MD: Author.
- Anton, R. (2010). Substance abuse is a disease of the human brain: Focus on alcohol. *The Journal of Law, Medicine & Ethics*, 38(4), 735-744.
doi: 10.1111/j.1748-720X.2010.00527.x
- Barr, M., & Lerner, W. (1984). The impaired nurse: A management issue. *Nursing and Economic*, 2, 196-201.
- Baker, T. L. (1994). *Doing Social Research* (2nd ed.). New York, NY: McGraw-Hill.

- Baum, A. (1990). Stress, intrusive imagery, and chronic distress. *Health Psychology*, 6, 653-675.
- Beckstead, J. (2002). Modeling attitudinal antecedents of nurses' decisions to report impaired colleagues. *Western Journal of Nursing Research*, 24(5), 537-551.
doi: 10.1177/019394502400446405
- Bissell, L., & Jones, R. (1981). The alcoholic nurse. *Nursing Outlook*, 29, 96-101.
- Brennan, S. (1991). Recognizing and assisting the impaired nurse:
Recommendations for nurse managers. *Nursing Forum*, 26(2), 12-16.
doi: 10.1111/j.1744-6198.1991.tb00876.x
- Brinkmann, S., & Kvale, S. (2015). *InterViews: Learning the craft of qualitative research interviewing* (3rd ed.). Thousand Oaks, CA: Sage.
- Buck, J. A. (2011). The looming expansion and transformation of public substance abuse treatment under the affordable care act. *Health Affairs*, 30(8), 1402-1410.
Thousand Oaks, CA: Sage.
- Bugle, L., Jackson, E., Kornegay, K., & Rives, K. (2003). Attitudes of nursing faculty regarding nursing students with a chemical dependency: A national survey. *Journal of Addictions Nursing*, 14(3), 125-132. doi: 10.1080/10884600390245703
- Burns, L. (1991). *An investigation of risk indicators for substance abuse among nurses* (Doctoral dissertation, University of Pennsylvania). Retrieved from <http://repository.upenn.edu/dissertations/AAI9125605/>
- Burton, K. (2014). Emerging from the darkness and stepping into the light: Implementing an understanding of the experience of nurse addiction into nursing education. *Journal of Nursing Education and Practice*, 4(4), 154.

doi: 10.5430/jnep.v4n4p151

Carpenter, M. (1994). The impaired nurse. *Nursing Ethics*, 3(2), 139-141.

Casey, E. (1978). History of drug use and drug users in the United States.

Facts about Drug Abuse-Participant Manual-The National Drug Abuse Center for Training Resource and Development. Retrieved from <http://druglibrary.org/schaffer/history/casey1.htm>

Church, O. (1985). Sairey Gamp revisited: A historical inquiry into alcoholism and drug dependency. *Nursing Administration Quarterly*, 9(2), 10-21.

doi: 10.1097/00006216-198500920-00004

Commonwealth of Virginia, Department of Health Professions. (2009). *Regulations governing the health practitioners' monitoring program*. Retrieved from

<http://www.dhp.virginia.gov>

Connelly, L.M. (2013). Limitation section. *MEDSURG Nursing*, 22(5), 325-336.

Creswell, J. (2014). *Qualitative inquiry and research design: Choosing among five traditions*. Thousand Oaks, CA: Sage.

Creswell, J. (2013). *Research design: Qualitative, quantitative, and mixed methods approaches* (4th ed.). Thousand Oaks, CA: Sage.

Crocker, S. F. (1999). *A Well-Lived Life: Essays in Gestalt Therapy*. Cambridge, MA: GICPress.

Damrosch, S., & Scholler-Jaquish, A. (1993). Nurses' experiences with impaired nurse coworkers. *Applied Nursing Research*, 6(4), 154-160.

doi: 10.1016/s0897-189(05)80113-2

- Darbro, Nancy (2009). Overview of issues related to coercion and monitoring in alternative diversion programs for nurses: A comparison to drug courts: Part 2. *Journal of Addictions Nursing, 20*, 24-33.
doi: 10.1080/10884600802693256
- Durrant, R., & Thakker, J. (2003). *Substance use & abuse: Cultural and historical perspectives*. Thousand Oaks, CA: Sage.
- Epstein, P., Burns, C., & Conlon, H. (2010). Substance abuse among registered nurses. *American Association of Occupational Health Nurses, 58*(12), 513-516.
doi: 10.3928/08910162-20101116-03
- Farley, P., & Hendrix, M. (1993). Impaired and nonimpaired nurses during childhood and adolescence. *Nursing Outlook, 41*(1), 25-31.
- Fenner, R. M. (2012). Women for sobriety: 35 years of challenges, changes and continuity. *Journal of Groups in Addiction, 7*(2-4), 142-170.
doi: 101080/1556035x.2012.705662
- Fletcher, C. (2004). Experience with peer assistance for impaired nurses in Michigan. *Journal of Nursing Scholarship, 36*(1), 92-93.
doi: 10.1111/j.1547-5069.2004.04019.x
- Genung, V. (2012). Understanding the neurobiology, assessment, and treatment of substances of abuse and dependence: A guide for the critical care nurse. *Critical Care Nursing Clinics of North America, 24*(1), 117-130.
doi: 10.1016/j.ccell.2012.01.007
- Goffnett, C. (1985). Dealing with the impaired nurse. *Michigan Hospitals, 21*(2), 35-40.
- Hall, W. (2016). Evaluating the public health impacts of legalizing recreational cannabis

- use in the United States. *Addiction*, 111(10), 1764-1773.
- Hanson, D. (2015). Alcohol: Science, policy and public health. *Oxford Scholarship*
Retrieved from <http://www.oxfordscholarship.com>
- Hansen, M., Ganley, B., & Carlucci, C. (2008). Journeys from addiction to recovery.
Research and Theory for Nursing Practice: An International Journal 22(4), 256-272. doi: 10.1891/0889-7182.22.4.256
- Hastings, J., & Burns, J. (2007). Addiction: A nurse' story. *American Journal of Nursing*, 107(8), 75-79.
- Health Practitioners' Monitoring Program. (2013). *Report of the monitoring program committee on program performance*. Retrieved from
<http://www.dhp.virginia.gov/hpmp/reports/2013HPMPAnnualReport.pdf>
- Health Practitioners' Monitoring Program. (2014). *Report of the monitoring program committee on program performance*. Retrieved from
<http://www.dhp.virginia.gov/hpmp/reports/2014HPMPAnnualReport.pdf>
- Health Practitioners' Monitoring Program. (2015). *Report of the monitoring program committee on program performance*. Retrieved from
<http://www.dhp.virginia.gov/hpmp/reports/2015HPMPAnnualReport.pdf>
- Heise, B. (2003). The historical context of addiction in the nursing profession: 1850-1982. *Journal of Addictions Nursing*, 14(3), 117-124. doi: 1080/jan.14.3.117.124
- Henninger, A., & Sung, H. (2014). History of substance abuse treatment. *Encyclopedia of Criminology and Criminal Justice* (1st ed.), 2257-2269. New York, NY: Springer.
- Horton-Deutsch, S., McNelis, A., & O'Haver Day, P. (2011). Enhancing mutual

- accountability to promote quality, safety, and nurses' recovery from substance use disorders. *Archives of Psychiatric Nursing*, 25(6), 445-455.
doi: 10.1016/j.apnu.2011.02.002
- Husserl, E. (1970). *Logical investigations*. London, England: Routledge.
- Jain, V., & Lall, R. (1996). Nurses' personality types based on the Myers-Briggs Type Indicator. *Psychological Reports*, 78(3), 938-938.
- Johnson, J. A. & Roman, P. M. (2002). Predicting closure of private substance abuse treatment facilities. *Journal of Behavioral Health Services and Research*, 29(2), 115-125.
- Kalivas, P., & Volkow, N. (2005). The neural basis of addiction: A pathology of motivation and choice. *American Journal of Psychiatry*, 162(8), 1403-1413.
doi: 10.1176/appi.ajp.162.8.1403
- Kincheloe, J. L., & McLaren, P. (2008). Rethinking critical theory and qualitative research. In Denzin, N. & Y. Lincoln (Eds.), *Landscape of Qualitative Research* (pp. 403-455). Thousand Oaks, CA: Sage.
- Koob, G., & Kreek, M. (2007). Stress, dysregulation of drug reward pathways, and the transition to drug dependence. *American Journal of Psychiatry*, 164(8), 1149-1159. doi: 10.1176/appi.ajp.2007.05030503
- Kunyk, D. (2013). Substance use disorders among registered nurses: Prevalence, risks and perceptions in a disciplinary jurisdiction. *Journal of Nursing Management*, 23(1), 54-64. doi: 10.1111/jonm.12081
- Lietz, C., & Hodge, D. (2013). Incorporating spirituality into substance abuse counseling: Examining the perspective of service recipients and providers.

- Journal of Social Service Research*, 39, 498-510.
- doi: 10.1080/01488376.2012.676023
- Lillibridge, J., Cox, M., & Cross, W. (2002). Uncovering the secret: giving voice to the experiences of nurses who misuse substances. *Journal of Advanced Nursing*, 39(3), 219-229. doi: 10.1046/j.1365-2648.2002.02268.x
- Luttrell, W. (2010). *Qualitative educational research: Readings in reflexive methodology and transformative practice*. New York, NY: Routledge.
- Lynch, M. (2012). Theorizing the role of the 'war on drugs' in US punishment. *Theoretical Criminology*, 16(2), 175-199. doi: 10.1177/1362480612441700
- Mark, T. L., Levit, K. R., Vandivort-Warren, R., Buck, J. A., & Coffee, R. M. (2011). Changes in US spending on mental health and substance abuse treatment, 1986-2005, and Implications for policy. *Mental Affairs*, 30(2), 284-292.
- Markel, H. (2011). *An anatomy of addiction: Sigmund Freud, William Halstead, and the miracle drugs of cocaine*. New York, NY: Pantheon Books.
- Marshall, C., & Rossman, G. (2011). *Designing qualitative research* (5th ed.). Thousand Oaks, CA: Sage.
- Monroe, T. B., Kenaga, H., Dietrich, M. S., Carter, M. A., & Cowan, R. L. (2013). The prevalence of employed nurses identified or enrolled in substance use monitoring. *Nursing Research*, 62(1), 10-15. doi: 10.1097/NNR.0b13e31826b3ca
- Morrow, S. L., Castaneda-Sound, C., & Abrams, E. (2012). Counseling psychology research methods: Qualitative approaches. *APA Handbook of Counseling Psychology* (1st ed.), 93-117. Washington, DC: American Psychological Association.

- Morrow, S. L. (2005). Quality and trustworthiness in qualitative research in counseling psychology. *Journal of Counseling Psychology, 52*(2), 250-260.
- Moustakas, C. (1994). *Phenomenological research methods*. Thousand Oaks, CA: Sage.
- Myrick, H., Anton, R., Li, X., Henderson, S., Drobos, D., Voronin, K., & George, M. (2003). Differential brain activity in alcoholics and social drinkers to alcohol cues: Relationship to craving. *Neuropsychopharmacology, 29*(2), 393-402.
doi: 10.1038/sj.npp.1300295
- O'Connor, P., & Robinson, R. (1985). Managing impaired nurses. *Nursing Administration Quarterly, 9*(2), 1-9.
- Pakdaman, S., Wilcox, R., & Miller, J. (2014). Theories and treatment of drug dependency: A neurochemical perspective. *Current Molecular Pharmacology, 7*(1), 52-66.
- Pardini, D., Plante, T., Sherman, A., Stump, J. (2000). Religious faith and spirituality in substance abuse recovery determining the mental health benefits. *Journal of Substance Abuse Treatment 19*, 347-354.
doi: 10.1016/S0740-5472(00)00125-2
- Patrick, P. (1984). Self-preservation: Confronting the issue of nurse impairment. *Journal of Substance Abuse Treatment, 1*(2), 99-105. doi: 10.1016/0740-5472(84)90032-1
- Priest, A. (1986). The impaired nurse: One person's story. *Vancouver Registered Nurses' Association of British Columbia News, 18*(6), 23-25.
- Rojas, J. I., Jeon-Slaughter, H., Brand, M., & Koos, E. (2013). Substance abuse patterns


- and psychiatric symptomology among three healthcare provider groups evaluated in an out-patient program for impaired healthcare professionals. *Journal of Addictive Diseases*, 32, 99-107. doi: 10.1080/10550887.2012.759857
- Rossman, G., & Rallis, S. (2017). *An introduction to qualitative research: Learning in the Field* (4th ed.). Thousand Oaks, CA: Sage.
- Schoenfield, H. (2012). The war on drugs, the politics of crime, and mass incarceration in the United States. *Journal of Gender, Race and Justice*, 15(2-3), 315-352.
- Seidman, I. (2013). *Interviewing as qualitative research: A Guide for Researchers in Education & the Social Sciences* (4th ed.). New York, NY: Teachers College Press.
- Shaffer, S. (1988). Attitudes and perceptions held by impaired nurses. *Nursing Management*, 19(4), 46-51.
- Shaw, M. F., McGovern, M. P., Angres, D. H., & Rawal, P. (2004). Physicians and nurses with substance use disorders. *Journal of Advanced Nursing* 47(5), 561-571. doi: 10.1111/j.1365-2648.2004.03133x
- Sinha, R., (2008). Chronic stress, drug use, and vulnerability to addiction. *Annals of the New York Academy of Sciences* 1141, 105-130. doi: 10.1196/annals.1441.030
- Smith, G. B. & Hukill, E. (1996). Nurses impaired by emotional and psychological dysfunction. *Journal of the American Psychiatric Nurses Association*, 2(6), 192-200. doi: 10.1177/107839039600200603
- Stolberg, V. B. (2006). A review of perspectives on alcohol and alcoholism in the history of American health and medicine. *Journal of Ethnicity in Substance Abuse*, 5(4), 39-53. doi: 10.1300/J233v05n04_02

- Tanga, H. (2011). Nurse drug diversion and nursing leader's responsibilities. *Journal on Nursing Administration, 13*(1), 13-16.
doi: 10.1097/nhl.0b013e31820bd9e6
- Trinkoff, A., & Storr, C. (1998). Substance Use Among Nurses: Differences between specialties. *American Journal of Public Health, 88*(4), 581-585.
- Trossman, S. (2003). Nurses' Addictions: Finding alternatives to discipline. *American Journal of Nursing, 103*(9), 27-28.
- Turner, L., Kruszewski, S. P., & Alexander, C. G. (2015). Trends in the use of buprenorphine by office-based physicians in the United States. *The American Journal of Addictions, 24*(1), 24-29.
- Van Manen, M. (1990). *Researching lived-experience: Human science for an action sensitive pedagogy*. London, England: Althouse.
- Van Teijlingen, E. R., & Hundley, V. (2001). The importance of pilot studies. *Social Research Update (35)*, 1-7.
- Virginia Health Practitioners Monitoring Program. *Orientation Handbook*. Retrieved from <http://www.dhp.virginia.gov/hpmp/forms/OrientationHandbook.pdf>
- West, M. (2002). Early risk indicators of substance abuse among nurses. *Journal of Nursing Scholarship, 34*(2), 187-193. doi: 10.1111/j.1547-5069.2002.00187.x
- White, W. (2014). *Slaying the dragon: The history of addiction treatment and recovery in America* (2nd ed.). Bloomington, IL: Chestnut Health Systems.
- Wile, C., & Jenkins, K. (2013). The value of a support group for medical professionals with substance use disorders. *Australasian Psychiatry, 21*(5), 481-485.
doi: 10.1177/1039856213498289

- Wilson, W. (2001). *Alcoholics Anonymous: The story of how many thousands of men and women have recovered from alcoholism* (4th ed.). New York, NY: Alcoholics Anonymous World Services, 2001.
- Witkiewitz, K., Marlatt, G. A., & Walker, D. (2005). Mindfulness-based relapse prevention for alcohol and substance use disorders. *Journal of Cognitive Psychotherapy: An International Quarterly*, 19(3), 211-228.
doi: 10.1891/jcop.2005.19.3.211
- Wright, E., McGuinness, T., Moneyham, L., Schumacher, J., Zwerling, A., & Stullenbarger, N. (2012). Opioid abuse among nurse anesthetists and anesthesiologists. *American Association of Nurse Anesthetists Journal*, 80(2), 120-127.
- Zavala, S. K., French, M. T., Henderson, C. E., Alberga, L., Rowe, C., & Liddle, H. A. (2005). Guidelines and challenges for estimating the economic costs and benefits of adolescent substance abuse treatments. *Journal of Substance Abuse Treatment*, 29(3), 191-205.
- Ziegler, P. P. (2015). *The Virginia health practitioners' monitoring program* [Power Point Lecture]. Retrieved from Virginia Commonwealth University
<http://www.medschoolvcu.edu/contentassets/images/professional/VAHealthPMP.ppt>

Appendix A

MEMORANDUM

DATE: June 1, 2017 

TO: Nancy E Bodenhorn, Patricia Ann Owens, Penny Burge, Lisa L Onega

FROM: Virginia Tech Institutional Review Board (FWA00000572, expires January 29, 2021)

PROTOCOL TITLE: The experiences of substance use nurses participating in the Health Practitioners' Monitoring Program in Virginia.

IRB NUMBER: 17-162

Effective June 1, 2017, the Virginia Tech Institution Review Board (IRB) Chair, David M Moore, approved the Amendment request for the above-mentioned research protocol.

This approval provides permission to begin the human subject activities outlined in the IRB-approved protocol and supporting documents.

Plans to deviate from the approved protocol and/or supporting documents must be submitted to the IRB as an amendment request and approved by the IRB prior to the implementation of any changes, regardless of how minor, except where necessary to eliminate apparent immediate hazards to the subjects. Report within 5 business days to the IRB any injuries or other unanticipated or adverse events involving risks or harms to human research subjects or others.

All investigators (listed above) are required to comply with the researcher requirements outlined at:

<http://www.irb.vt.edu/pages/responsibilities.htm>

(Please review responsibilities before the commencement of your research.)

PROTOCOL INFORMATION:

Approved As: **Expedited, under 45 CFR 46.110 category(ies) 6,7**
Protocol Approval Date: **March 15, 2017**
Protocol Expiration Date: **March 14, 2018**
Continuing Review Due Date*: **February 28, 2018**

*Date a Continuing Review application is due to the IRB office if human subject activities covered under this protocol, including data analysis, are to continue beyond the Protocol Expiration Date.

FEDERALLY FUNDED RESEARCH REQUIREMENTS:

Per federal regulations, 45 CFR 46.103(f), the IRB is required to compare all federally funded grant proposals/work statements to the IRB protocol(s) which cover the human research activities included in the proposal / work statement before funds are released. Note that this requirement does not apply to Exempt and Interim IRB protocols, or grants for which VT is not the primary awardee.

The table on the following page indicates whether grant proposals are related to this IRB protocol, and which of the listed proposals, if any, have been compared to this IRB protocol, if required.

Invent the Future

Appendix B

VIRGINIA HPMP NURSES

PARTICIPANTS NEEDED IN A DOCTORAL RESEARCH STUDY

CONCERNING THE EXPERIENCES OF NURSES IN THE HPMP

The purpose of this doctoral research study is to describe the experiences of nurses participating in the Health Practitioners' Monitoring Program. The voice of nurses participating in a monitoring program has been seldom reported.

Participants must have participated in HPMP for at least one year, be a licensed nurse, eligible to return to work, and be a resident of Virginia.

Study participants will be asked to engage in a pre-interview telephone call and two face-to-face interviews, with the second interview occurring one week after the first. Interviews will be conducted in your area so travel required will be limited. Each interview will be ninety minutes in length.

Confidentiality will be of utmost importance. Pseudonyms will be used and identifiable markers will be changed.

No compensation will be given for participation.

Please feel free to inform other nurses who might be interested and to make additional copies of this flyer. If interested, please contact Patsy Owens at powens@vt.edu or text 276-356-3650.

Appendix C

4/24/2017

Virginia Polytechnic Institute and State University
Ms. Patricia Owens
101 War Memorial Hall
Blacksburg, VA 24061

Dear Ms. Owens,

Enclosed is the Confidentiality Certificate, protecting the identity of research subjects in your single-site/single-protocol project entitled "The Experiences of Substance Use Nurses Participating in The Health Practitioners' Monitoring Program in Virginia".

We are providing one more year of Certificate coverage than you requested because it has been our experience that many studies take longer to complete than initially projected. Providing an extra year will ensure coverage for subjects, and may spare you the need to formally submit a request for an extension. Please note that the Certificate expires on 05/31/2019.

Please be sure that the consent form given to research participants accurately states the intended uses of personally identifiable information and the confidentiality protections, including the protection provided by the Certificate of Confidentiality with its limits and exceptions.

If you determine that the research project will not be completed by the expiration date, 05/31/2019, you must submit a written request for an extension of the Certificate three (3) months prior to the expiration date. If you make any changes to the protocol for this study, you should contact me regarding modification of this Certificate. Any requests for modifications of this Certificate must include the reason for the request, documentation of the most recent IRB approval, and the expected date for completion of the research project.

Please advise me of any situation in which the certificate is employed to resist disclosure of information in legal proceedings. Should attorneys for the project wish to discuss the use of the certificate, they may contact the Office of the NIH Legal Advisor, National Institutes of Health, at (301) 496-6043.

Correspondence should be sent to:

Christina J. Page, Certificate Administrator
6001 Executive Blvd., room 4228
Bethesda, MD 20892
(301) 827-5821

Sincerely,



Approved Date: 04/19/2017

Hiromi Ono
Scientific Review Officer/NIDA COC Coordinator
National Institute on Drug Abuse

Enclosure

CONFIDENTIALITY CERTIFICATE

CC-DA-17-067

issued to

VIRGINIA POLYTECHNIC INSTITUTE AND STATE UNIVERSITY

conducting research known as

"THE EXPERIENCES OF SUBSTANCE USE NURSES PARTICIPATING IN THE HEALTH PRACTITIONERS' MONITORING PROGRAM IN VIRGINIA".

In accordance with the provisions of section 301(d) of the Public Health Service Act 42 U.S.C. 241(d), this Certificate is issued in response to the request of the Principal Investigator, Ms. Patricia Owens, to protect the privacy of research subjects by withholding their identities from all persons not connected with this research. Ms. Patricia Owens is primarily responsible for the conduct of this research, which is currently unfunded.

Under the authority vested in the Secretary of Health and Human Services by section 301(d), all persons who:

1. are enrolled in, employed by, or associated with Virginia Polytechnic Institute and State University and its contractors or cooperating agencies, and
2. have in the course of their employment or association access to information that would identify individuals, who are the subjects of the research, pertaining to the project known as "The Experiences of Substance Use Nurses Participating in The Health Practitioners' Monitoring Program in Virginia",
3. are hereby authorized to protect the privacy of the individuals, who are the subjects of that research, by withholding their names and other identifying characteristics from all persons not connected with the conduct of that research.

The purpose of this study is to explore the experiences of impaired nurses participating in the Health Practitioners Monitoring Program (HPMP) in Virginia, as well as the beliefs and attitudes that underlie these nurses' abilities to cope with the program. Information collected includes stresses experienced and substance use patterns based on audio-recorded interviews.

A Certificate of Confidentiality is needed because sensitive information will be collected during the course of the study. The certificate will help researchers avoid involuntary disclosure that could expose subjects or their families to adverse economic, legal, psychological and social consequences.

Audio recorded interviews will be transcribed. Pseudonyms will be utilized per participant. Participant identifying information will be stored separately from interview data as hard copies

6001 Executive Blvd. Bethesda, MD 20892

will be in two different file cabinets and computer data under protected password. Participant data will be kept in a locked file for three years, after which all paper files will be shredded and re-cycled, voice recordings deleted, and USB drives destroyed. The PI will be the only person to have identifying information and stored at the PI's home office. This research begins on 04/03/2017, and is expected to end on 05/31/2019.

As provided in section 301 (d) of the Public Health Service Act 42 U.S.C. 241(d): "Persons so authorized to protect the privacy of such individuals may not be compelled in any Federal, State, or local civil, criminal, administrative, legislative, or other proceedings to identify such individuals."

This Certificate does not protect you from being compelled to make disclosures that: (1) have been consented to in writing by the research subject or the subject's legally authorized representative; (2) are required by the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 301 et seq.) or regulations issued under that Act; or (3) have been requested from a research project funded by NIH or DHHS by authorized representatives of those agencies for the purpose of audit or program review.

This Certificate does not represent an endorsement of the research project by the Department of Health and Human Services. This Certificate is now in effect and will expire on 05/31/2019. The protection afforded by this Confidentiality Certificate is permanent with respect to any individual who participates as a research subject (i.e., about whom the investigator maintains identifying information) during the time the Certificate is in effect.

Sincerely,

Signed Date: 5/18/2017

for

Nora Volkow M.D. Director National Institute on Drug Abuse

Appendix D

Participant Data Form

Name: _____ Birthdate: _____

Address: _____

Email: _____ Phone: _____

Criteria for the study

Check all that apply:

_____ The participant has been in the HPMP for at least one year.

_____ The participant has not used substances since entering the HPMP.

_____ The participant is a licensed nurse.

_____ The participant is eligible to return to work.

_____ The participant is a resident of Virginia.

Family history of substance use

Mark an X indicating this person's relationship with substance use:

	Alcohol Abuse	Drug Abuse	Social Drinker	No issue with use	Comments
Grandmother					
Grandfather					
Mother					
Father					
Brother					
Sister					
Other relatives					
Spouse					

Family of origin beliefs concerning alcohol and/or drug use:

Childhood experiences concerning alcohol/drugs:

Appendix E

VIRGINIA POLYTECHNIC INSTITUTE AND STATE UNIVERSITY

Informed Consent for Participants in Research Projects Involving Human Subjects

Title of Project: The Experiences of Substance Use Nurses Participating in the Health Practitioners' Monitoring Program in Virginia

Investigator(s):	Patricia Owens, LPC, CADC	powens@vt.edu	(276) 356-3650
	Penny Burge, PhD	burge@vt.edu	(540) 231-9730
	Nancy Bodenhorn, PhD	nanboden@vt.edu	(540) 231-8180

I. Purpose of this Research Study

The purpose of this phenomenological study is to describe participants' experiences in a monitoring program for impaired nurses in Virginia, determine what beliefs and attitudes underscore the participants' abilities to cope with the program, and uncover what meaning is made of the experiences. This study will focus on nurses who participate in the Virginia Health Practitioners' Monitoring Program (HPMP). Results of this dissertation may be used for publication and presentations.

II. Procedures

Participants will be recruited through a website *allnurses.com* and by the distribution of a flyer at Virginia hospitals and Caduceus groups. After recruitment, participants will be contacted via telephone for a pre-interview (20 to 30 minutes) that will cover confidentiality, procedures, and consent. The sampling size will be ten to fifteen nurses from the state of Virginia who have been enrolled in the HPMP for a minimum of one year. Each nurse must be licensed and eligible to return to work. Furthermore, each nurse may not have used a substance since entering HPMP. Participants will each engage in two ninety minute interviews, with the second interview occurring one week after the first. The interviewer will ask participants to discuss experiences with HPMP. Family of origin, past and current work experiences, stress, substance use, entry into HPMP, and continued involvement with the HPMP will be explored during the interviews. Each interview will be audio recorded and transcribed. The interviews will be held in the participants' home town areas in a private setting.

III. Risks

Participants may experience emotional distress caused by remembering unpleasant experiences. If a stressful issue arises during the interview, the researcher will ask the participant to discuss the issue(s) with his/her counselor. The researcher will give additional referral if needed. Any expense accrued for seeking or receiving treatment will be the responsibility of the participant and not that of the research project or Virginia Tech.

During the interview process, if a participant reveals suicidal or homicidal ideation, the researcher is required by Virginia state law to notify appropriate authorities. Also, if it is revealed that the participant is currently engaging in substance use, HPMP will be notified.

IV. Benefits

While no direct benefit may be experienced by the participants, the results of the study will hopefully benefit future nurses by providing an understanding of the issues involved. No promise or guarantee of benefits has been made to encourage participation.

V. Extent of Anonymity and Confidentiality

Every attempt will be made to ensure confidentiality through the use of pseudonyms and changing identifiable markers (i.e. drug of choice, area of living, age, type of work). Identifiable information will be obtained, stored separately in the researcher's home under lock, and kept securely away from data. Only the dissertation committee and the researcher will have access to identifiable and/or de-identifiable data.

The Virginia Tech Institutional Review Board (IRB) staff may view the study's data for auditing purposes. The IRB staff is responsible for the oversight of the protection of human subjects involved in research.

VI. Compensation

No compensation will be given for participation in this study.

VII. Freedom to Withdraw

The participant is free to withdraw from this study at any time without penalty. Furthermore, the participant is free to refuse to answer questions or respond to what is being asked without penalty.

Please note that there may be circumstances under which the investigator may determine that a participant should not continue as a subject.

VIII. Questions or Concerns

For questions or concerns relating to this study, contact Patricia Owens, LPC, CADC powens@vt.edu, or (276) 356-3650.

For questions or concerns about the study's conduct, the rights of the research participant, or to report a research-related injury or event, contact the VT IRB Chair, Dr. David M. Moore at moored@vt.edu or (540) 231-4991.

IX. Participant's Consent

I have read the Consent Form and conditions of this project. I have had all my questions answered. I hereby acknowledge the above and give my voluntary consent.

_____ Date _____
Participant's signature

Participant's printed name

Appendix F

Interview Guides

Interview One

Primary research questions to be explored in this interview are (1) What has been the lived experience of the participant in HPMP; and (2) What beliefs/attitudes are used by the participants to cope with the monitoring experience?

1. What led you to become a nurse?
2. What type of work do you do as a nurse?
3. How many years of experience as a nurse?
4. Tell me your substance use history?
 - When did you first use drugs/alcohol?
 - For what reason did you begin to use alcohol/drugs?
 - When do you believe drugs/alcohol became an issue?
 - What is your drug of choice?
 - Was coping with stress a factor in your alcohol/drug use?
 - How did your drug/alcohol use lead you into the HPMP?
 - Do you have any charges/reprimands on your nursing license?
 - Did/do you participate in inpatient care, IOP, and/or counseling?
5. What was entering HPMP like for you?
 - Is this your first experience with HPMP?
 - How did you experience your first contact with HPMP?
 - What was orientation to the HPMP like for you?

-What was your initial experience like with your assigned caseworker?

6. Since entering HPMP, what have been your experiences with the program?

-How has your relationship developed with your caseworker?

-What issues concerning HPMP have been the most impactful in your life?

BREAK

1. How do you make sense out of those experiences with the HPMP program?

2. What coping skills have you used or developed in your experience with HPMP?

-Which coping skills have been most helpful and which ones have been the least?

-How do you cope with the stress of the HPMP?

3. If you've returned to work, what have been the reaction of peers to your participation in the HPMP?

-How did you experience the initial job search?

-What have been your experiences with interviews for employment?

-How did you experience the restriction concerning administering narcotics?

-Tell me if you've experienced work stress and how you are coping.

4. Is there anything I haven't asked about your HPMP experience that would be important for me to know?

Interview Two

Primary research question to be explored is: What meaning do the participants give to their experiences in the HPMP?

1. Based on your experiences with HPMP, what has been or become your belief about the program?
2. Given what you have said about your life prior to HPMP participation, and what you've said about your life since HPMP, how do you make sense of your participation in HPMP?
3. What HPMP program policies have you found helpful?
4. What HPMP program policies would you like to change or see added?
5. When/if speaking to a group of nursing students concerning substance use, and participation in HPMP, what advice would you share?
6. What would you like your colleagues to know about the HPMP program?
7. What would you like hospital administration to know about your experience with HPMP?
8. What, if anything, do your colleagues misunderstand/understand about you, a nurse in recovery from substance use?
9. Is there anything I haven't asked about concerning your experience with HPMP that would be important for me to know?