

CODEPENDENCY AMONG NURSES: A COMPARISON BY SUBSTANCE USE
DISORDER AND OTHER SELECTED VARIABLES

by

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A DISSERTATION

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ABSTRACT

Previous studies have shown that the profession of nursing has inherent risk factors that may contribute to Substance Use Disorder among nurses. One of those risk factors may be codependency.

This study explored the relationship between codependency and self-reported history of treatment for SUD among nurses. It also compared nurses' codependency scores by gender, race, birth order, having experienced or witnessed physical violence in the family of origin, having a parent or primary caregiver with SUD, and having a parent or primary caregiver with a history of mental illness.

One thousand nurses with active licensure in a southeastern state were mailed survey packets which included the Spann-Fischer Codependency Scale and a demographic questionnaire. Two hundred and two surveys were returned.

The results indicated that the nurses' codependency scores differed significantly when compared by history of treatment for SUD. Nurses who reported treatment for SUD had higher codependency scores than nurses who reported no treatment for SUD. The nurses also differed significantly in their codependency scores when compared by their having witnessed or experienced physical violence in their family of origin. Those who reported a history of witnessing or experiencing physical violence in their family of origin had higher codependency scores than those who did not. The third significant finding was that nurses who reported having a parent or primary caregiver with a history of mental illness had higher codependency scores than those who did not.

DEDICATION

This endeavor is dedicated to the memory of my parents, L. B. and Alyne Simmons who taught me to value learning.

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CHAPTER I INTRODUCTION

Substance Use Disorder (SUD) is one of the nation's major public health problems and a growing client population for mental health professionals, including counselors. Data from the Bureau of Labor Statistics (BLS) showed that the addiction counselor workforce will grow by 31% between 2006 and 2016. According to the BLS, employment prospects for substance abuse counselors will grow much more rapidly than the average for other occupations because of the nation's greater awareness of SUD (Bureau of Labor Statistics, 2008).

In 1997, SUD was identified by the National Council of State Boards of Nursing as the most prevalent health problem in the United States among nurses. It has also been reported as the most preventable health problem in this country (Robert Wood Johnson Foundation, 1993). Substance Use Disorder has reached epidemic proportions in the United States (Hansen, Ganley, & Carlucci, 2008). Americans represent 5% of the world's population and consume more than 60% of the world's illicit drugs (Shrum, 2004).

The National Household Survey on Drug Abuse (2002) reported that 15.9 million Americans age 12 years and older admitted to using an illicit drug in the month before the survey. Twelve percent of those surveyed also reported illicit drug use in the past year, and 41.7% had used illicit drugs at least once during their lifetime. In 2006, according to the Substance Abuse and Mental Health Services Administration (SAMHSA) (2007), an estimated 22.6 million Americans were diagnosed with SUD. Of that number, only 2.5 million received treatment in a SUD facility in that year. One half or less of those who complete treatment for SUD remain abstinent after one year of sobriety (Friedmann, Saltz, & Samet, 1998).

Approximately one half of all patients admitted to trauma centers in America are under the influence of alcohol or other drugs. The economic costs of healthcare, lost productivity, and crime in the United States have been estimated at over \$500 billion annually. The burden of SUD spares no segment of society. Substance Use Disorder occurs in people of all ages, races, and levels of socioeconomic status, as well as both genders (Gorelick, 2008).

The *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR) (2000) collectively refers to substance dependence and substance abuse as Substance Use Disorder. Substance dependence is a cluster of cognitive, behavioral, and physiological symptoms which indicate the individual continues to use a substance despite significant consequences. Substance abuse is a maladaptive pattern of substance use that is characterized by recurrent and significant adverse consequences that are related to the continuous taking of the substance (DSM-IV-TR, 2000).

Substance Use Disorder is described as encompassing both dependence on and the abuse of drugs, usually taken voluntarily for the purpose of their effect on the central nervous system or to prevent or reduce withdrawal symptoms. Both substance abuse and substance dependence are related to the taking of a drug or chemical, such as alcohol, amphetamines, cocaine, opioids, sedatives, hypnotics, and anxiolytics (American Psychiatric Association, 2000).

Substance Use Disorder is characterized by the excessive use of alcohol, other drugs, or both; a genetic disposition to the disorder; and progressive deterioration of the user because of the use (Calkins, 2001). The disorder is progressive, and during the course of the disorder the person with SUD loses control over the use of psychoactive substances (SAMHSA, 2005). The consequences of SUD can include interpersonal difficulties, interference with work or school,

legal problems, and even death (Mueser, Noordsy, Drake, & Fox, 2003). Rarely is only the individual affected by impairment resulting from SUD. Family, friends, and colleagues are frequently drawn into the circle of difficulties because they depend on the individual or because they desire to help (Calkins, 2001).

Substance Use Disorder can be a costly disease to an individual (Malliarakis & Lucey, 2007). When that person is a healthcare professional, the cost can be measured in more than dollars. Healthcare professionals who are impaired by SUD are hazardous to public safety. Nurses who practice while impaired from SUD put their health and the lives of their patients at risk (Church, 2000). They also put themselves at risk for unemployment and loss of health benefits. Numerous related costs are posed to the employing agency, which include lower productivity resulting from greater use of sick time and absenteeism, as well as increased strain and tension among staff. Nurses who are impaired by SUD not only jeopardize public safety, they also lower the standards of the profession (Church, 2000).

Contrary to the public's opinion that healthcare professionals are immune to substance use disorders, SUD affects the professions of medicine, dentistry, nursing, and pharmacy (Coombs, 1997). While it is difficult to estimate the number of nurses impaired by SUD in the United States (Wisconsin Nurses Association, 2001), estimates of the occurrence of SUD among nurses vary from 6% to 32% (Griffith, 1999; Trinkoff & Storr, 1998). A recent conservative estimate is that 253,000 of the 2.7 million registered nurses in the United States are affected by SUD (Fogger & McGuinness, 2006). Even with unreliable estimates of occurrence, recent data from state nursing boards indicate that SUD is a serious issue in the nursing profession (Clark & Farnsworth, 2006).

Nurses are more likely than the general public to use prescription drugs and to have access to their drug of choice (Domenighetti, Tomamichel, Gutzwiller, Berthoud, & Casabianca, 1991; Hughes et al., 1999; Lloyd, 2002; Myers & Weiss, 1987; Rosvold, Vaglum, & Moum, 1998; Trinkoff & Storr, 1994, 1998). Nurses also tend to monitor their personal use of prescription medication themselves, rather than relying on the objective judgment of other healthcare professionals (Shaw, McGovern, Angres, & Rawal, 2004), thus exacerbating the problem. Research focused on disciplinary action taken by state boards of nursing showed that 67% to 90% of all disciplinary actions taken were related to substance abuse (Haack & Yocum, 2002; Smith & Hughes, 1996). In response to the problem, 39 states have developed programs to channel nurses impaired by SUD into treatment, to monitor their return to work, and to prevent revocation or suspension of their licenses (Sloan & Vernarec, 2001).

Research on SUD among Nurses

Research on SUD among nurses has existed since the 1960s, with most of the early research focusing on narcotic addiction (Poplar, 1969), cross addiction (Levine, Preston, & Lipscomb, 1974), and alcohol addiction (Bissell & Haberman, 1984; Bissell & Jones, 1981). In the late 1980s, researchers began to concentrate mainly on the profession's attitude toward impairment from SUD (Hendrix, Sabritt, McDaniel, & Field, 1987). West (2003) reported an increased focus on the nurse with SUD into the 1990s. This focus, however, has lessened in the last five to seven years.

Research focused on the prevalence of SUD among nurses has offered a variety of approximations of incidence. In 1984, the American Nurses Association estimated that 8% to 10% of nurses were affected by dependence on alcohol, while 2% to 3% were dependent on

other drugs. Later research estimated SUD in nursing to be as low as 2% and as high as 20% (Finke, Hickman, & Miller, 1993; Lippman, 1992; Rigby, Virgo, Russell, & Cormack, 1992; Sullivan, Bissell, & Williams, 1988; Virdin, 1992). Some of the research supported the claim that nurses may be at higher risk for SUD than the general population (Bissell & Jones, 1981; Clark, 1988; Coombs, 1996; Gelfand, Long, McGill, & Sheerin, 1990; Sullivan et al., 1988). The rationale for this claim is grounded in the nature of the profession itself. Nursing is a stressful and demanding profession. The demands include required frequent contact with serious illnesses and with death, shift work, and variable working hours associated with unpredictable sleep patterns. Erratic sleep patterns may contribute to the use of both sedatives and stimulants in order to function. Nurses are also expected to focus on the needs of their patients to the exclusion of their own needs. This expectation can contribute to work habits that are detrimental to personal health, such as working overtime in highly stressful environments (Lillibridge, Cox, & Cross, 2002).

Another reason nurses may be susceptible to SUD is accessibility to controlled substances in the workplace (Caroselli-Karinja & Zboray, 1986). Nurses have easy access to prescription medication and can divert drugs from their patients (Shaw et al., 2004). Along with accessibility to controlled substances, the attitude of pharmacological optimism has been cited as a contributor to the development of SUD among nurses. Pharmacological optimism describes the belief that drugs are available to promote healing and that they are valuable, useful tools of nursing practice (Bissell & Jones, 1981; Clark, 1988; Coombs, 1996; Gelfand et al., 1990; Sullivan et al., 1988). This belief is inculcated throughout nursing education and practice because pharmacology is viewed as an essential part of medical treatment. Nursing students are also

taught that drugs solve problems. Therefore, in their practice, nurses see that drugs alleviate pain, cure infection, and alleviate anxiety (Ellis, 1995). With this in mind, nurses also tend to feel confident that they can safely use drugs because of their education and experience (Martinez, 2001).

West (2003) reported that one predominant contributing factor to SUD among the nursing population is a history of addiction in the family of origin. A family history of chemical dependency has been suggested as a significant risk factor toward developing SUD among nurses (Bugle, 1996; Mynatt, 1996; Sullivan, 1987). Moreover, Coombs (1996) speculated that health-care professions attract people who are vulnerable to drug abuse (i.e., vulnerability often stems from being reared in a family with alcoholic and emotionally abusive parents). To illustrate, in a study of chemically-dependent nurses, 62% reported having an alcoholic family member which compared with 28% of nonchemically dependent nurses (Sullivan, 1987).

Codependency

The literature suggests that the profession of nursing is also affected by another disorder that has its roots in the field of SUD (Arnold, 1990). Codependency, a term used to describe a dysfunctional pattern of living, is believed by some researchers to be rampant in the nursing profession (Beattie, 1987; Friel & Friel, 1987; Snow & Willard, 1989; van der Wal, 1996). The term itself lacks a consistently applied definition, and few authors adhere to the same definition (Harper & Capdevila, 1990). When used in reference to nursing, codependency has been called counterfeit caring. Nurses who practice counterfeit caring have lost their sense of professional identity through overidentification with the role of caretaker (Allison, 2004).

Introduction of the concept of codependency without a standardized definition has created confusion in the field of SUD. It has also raised questions about the relationship between codependency and SUD. Researchers have found that approximately 60% of all chemically-dependent persons entering their first treatment program and 90% of all chronically relapse-prone individuals could have a dual diagnosis of chemical dependency and codependency (Gorski, 1992). Codependent nurses can struggle with self-neglect, perfectionism, the need to control, and improper boundaries. Nurses are often rewarded for overcommitment to the job and avoidance of errors, which exacerbates the codependent's lack of boundaries and need for perfectionism (Barr & Lerner, 1984).

Statement of Problem

The cost of SUD in nursing cannot be easily analyzed. The healthcare system is certainly impacted by the turnover and retention rates of nurse employees, the morale of nursing staff, and the quality of patient care. SUD among nurses erodes the public's confidence in one of the oldest helping professions (Ellis, 1995). Individuals with the potential to productively contribute to nursing are being lost to the profession for reasons directly or indirectly related to SUD (Kornegay, Bugle, Jackson, & Rives, 2004). Because of SUD, many well-educated and highly experienced nurses lose their families, careers, and their futures. Some lose their lives. One of the most disturbing consequences of SUD among nurses occurs when the nurse begins to view his or her job as a means to acquire drugs for personal use or for selling. Nurses who are impaired from the use of easily acquired drugs endanger or even injure the lives of patients entrusted to their care.

Nurses who experience codependency may be at increased risk for SUD. With this problem, it is important to explore the relationship between codependency and SUD, as well as the relationship between codependency and other variables which have been associated with SUD.

Purpose of the Study

The purpose of this study was to examine the relationship between codependency and SUD among nurses, as well as to explore the relationship between codependency and other selected variables that have been associated with SUD. Determining if nurses who have been treated for SUD differ in their codependency scores when compared with nurses who report no history of treatment for SUD can lead to early identification and intervention of nurses who may be susceptible to SUD. Prevention, education, and early intervention could be initiated once identification has occurred (West, 2003).

The monitoring programs designed by the boards of nursing in 39 states require counseling as part of the effort to reclaim the careers of nurses affected by SUD (Sloan & Vernarec, 2001). Professionals who counsel nurses will benefit from research that examines codependency and treatment for SUD among nurses. This study also provides useful information for counselors working in assistance programs for hospital employees, as well as counselors who work with student nurses in academic settings. Nurses who have been diagnosed with SUD are often referred to counselors in private practice who may also benefit from the results of this study.

Research Question

The following research question was answered:

Do nurses differ in codependency scores when compared by (a) self-reported history of treatment for SUD, (b) gender, (c) race, (d) birth order, (e) having witnessed or experienced physical violence in family of origin, (f) having a parent or primary caregiver with SUD, and (g) having a parent or primary caregiver with a history of mental illness.

Null Hypothesis

The following null hypothesis was tested:

Nurses will not significantly differ in codependency scores when compared by (a) self-reported history of treatment for SUD, (b) gender, (c) race, (d) birth order, (e) having witnessed or experienced physical violence in family of origin, (f) having a parent or primary caregiver with SUD, and (g) having a parent or primary caregiver with a history of mental illness.

Definition of Terms

The following terms are defined for this study:

Birth Order: The location in the family of origin which refers to the four basic positions of oldest, middle, youngest, and only child (Dreikurs, 1999).

Boundary: A dynamic line of demarcation separating an individual's internal and external environment and varying in permeability and flexibility (Scott, 1993). Boundaries are established by a series of successful developmental experiences, which contribute to formation of a clear self-identity (Hoover & Norris, 1996).

Codependency: The learned behavior that is expressed by dependencies on people and things outside the self; these dependencies include the neglecting and diminishing of one's own identity (Whitfield, 1991).

Counterfeit Caring: The codependent behavior of nurses which masquerades as professional nurse caring. The behavior limits growth in the care receiver by maintaining dependence on the caregiver and encouraging feelings of guilt in the care receiver (Allison, 2004).

Family of Origin: The family in which an individual was reared (Dreikurs, 1999).

Intimate Partner Violence: Physically abusive behavior between partners in an intimate relationship (Bedi & Goddard, 2007).

Mental Illness: The spectrum of cognitions, emotions, and behaviors that interfere with interpersonal relationships, in addition to functions required for work, at home, and in school (Johnstone, 2001).

Physical Violence: The intentional use of physical force against another person or against oneself, which either results in or has a high likelihood of resulting in injury or death (Rosenberg, O'Carroll, & Powell, 1992).

Substance Use Disorder: A term that includes diagnostic criteria for substance abuse and substance dependence. Substance abuse refers to the impairment and continued use of psychoactive substances in a 12 month period in spite of negative consequences in social occupational, psychological, physical, or legal arenas. Substance dependence connotes compulsive and continued use of alcohol or drugs despite negative consequences and extends the criteria within the same time frame to include three or more symptoms from a

list of seven symptoms. The seven symptoms include tolerance, withdrawal, taking increased amounts of the substance over time, unsuccessful efforts to control use, spending a great deal of time obtaining, using or recovering from the substance, demonstrating losses of social, occupational, or recreational activities and the continued use of substances in spite of serious physical or psychological problems or a combination of both (DSM-IV-TR, 2000).

Limitations of the Study

The present study had the following limitations:

1. The study included only nurses registered in one state in the southeastern United States. Therefore, the generalizability to nurses in other states may be limited.
2. The study used self-report information to collect data. It is assumed that participants were honest in their responses rather than responding in a manner that they believed to be socially desirable.

Assumptions

The following assumptions were made:

1. All of the participants received the survey packet in a timely manner.
2. All participants were honest when responding to the questions in the survey packet.

Summary

Substance Use Disorder is a major problem in the United States. It affects every segment of society as well as all ages, races, levels of socioeconomic status, and both genders. Substance Use Disorder is a progressive disease that can be extremely costly to an individual. When that individual is a health-care professional, the cost can be measured in more than dollars, and the safety of the public can be jeopardized.

The profession of nursing has inherent risk factors that may contribute to SUD among nurses, including codependency. This study explored the relationship between codependency and history of self-reported treatment for SUD among nurses, as well as the relationship between codependency and other selected variables linked to SUD. Specifically, this study compared nurses' codependency scores by self-reported history of treatment for SUD, gender, race, birth order, having experienced or witnessed physical violence in the family of origin, having a parent or primary caregiver with SUD, and having a parent or primary caregiver with a history of mental illness

CHAPTER II REVIEW OF THE LITERATURE

Codependency is a concept that has been written about extensively since 1987. Exactly what the term means has been widely disputed (O'Brien & Gaborit, 1992). Morgan (1991) found six different conceptualizations of the term: (a) an emotional, psychological, and behavioral condition; (b) an obsession with interpersonal control; (c) learned self-defeating behaviors; (d) a form of suffering associated with attending to others; (e) an addictive disease; and (f) a preoccupation with others that is characterized by extreme dependency.

The classic characteristics of codependency include (a) the powerful need to take care of others; (b) the inability to identify, express, manage or clarify feelings; (c) secret feelings of powerlessness; (d) difficulty in setting limits; (e) identity confusion; (f) dependence on others for approval; (g) difficulty with authority figures; (h) a prolonged relationship with a person who suffers from an addiction or dysfunction; and (i) any addictive behavior, whether the addiction be to substances such as alcohol, narcotics, or food, or to a process such as controlling or fixing others (Cauthorn-Lindstrom & Hrabe, 1990; Zerwekh, 1989). Gorski (1992) identified the personality characteristics of the broadly-defined term of codependency as low self-esteem, obsessive involvement with others in order to raise self-esteem, and extreme caretaking behavior that results in lack of self-care.

The work of Hughes-Hammer, Martsolf, and Zeller (1998) found that codependency is a construct comprised of five concepts. The core concept is focus on others or self-neglect which is

a compulsion to help or control events or others through manipulation or advice giving. This concept involves boundary issues and the need to control. Associated with the core concept are four symptoms that include (a) family of origin issues, (b) low self-worth, (c) hiding self, and (d) medical problems.

Family of origin issues result from growing up in a family that was troubled, chemically dependent, or overwhelmed by problems. In such a family, thoughts and feelings are not expressed and discussed and affection is not openly displayed. Low self-worth involves self-criticism, self-hatred, and feelings of shame and humiliation. The hiding self symptom is the use of a positive front to cover negative emotions while repressing feelings. Medical problems denote a sense of current bad health when compared with family and friends. This symptom is also accompanied by preoccupation with real or imagined health difficulties (Hughes-Hammer et al., 1998).

Originally, codependency referred to a view of human behavior that was formed in the Twelve Step culture of Alcoholics Anonymous and Al-Anon (Stude, 1990; Tournier, 1979). The idea of codependent behavior arose when attention shifted from the person with SUD to the impact the disorder had on loved ones (Weegmann, 2006). This idea was linked to family system theories that embraced the concept that no one gets sick alone. The founding principles of Al-Anon, the support group for those who are affected by another person's SUD, suggested that in time the family of the addict or alcoholic became as sick as the person with the disorder.

At the heart of codependent behavior is *enabling*. Enabling connotes aiding and abetting the behavior of a person with SUD through overzealous helping (Asher & Bissett, 1988; Harper & Capdevila, 1990). The term *enabler* describes a person who unwittingly supports the addict or

alcoholic in their SUD. People with enabling tendencies may become involved with partners who are unreliable, needy, or abusive, and then try to provide and control everything within the relationship (Weegmann, 2006).

In 1991, Lyon and Greenberg examined the enabling dimension of codependency by randomly assigning codependent and non-codependent female college students to interact with males who were playing either exploitive or nurturing roles. Compared with the control group, codependent women preferred the exploitive male to the male who was nurturing. They described the exploitive man as more intelligent and offered him more help when his role was exploitive.

The concept of codependency has historically been linked to the chemical dependency field and is rooted in the treatment of families of alcoholics (Kowal, 1994). Originally, it was thought that codependency evolved from being emotionally involved with a person with SUD. In the 1940s, wives of alcoholics formed a group later known as Al-Anon. The purpose of the group was to give these women an opportunity to discuss the problems inherent in living with an active alcoholic (O'Brien & Gaborit, 1992). In 1979, the term codependency was coined and referred to dysfunctional behavior resulting from living in a committed relationship with an alcoholic (Beattie, 1987).

Codependency has been defined in various ways and has been referred to as a personality disorder (Cermak, 1986) as well as relationship addiction (Weegmann, 2006). The concept itself remains difficult to define, and a single operational definition has yet to be embraced by the mental health professions (Martsolf, 2002). Use of the concept has been criticized because it is ill-defined and may tend to pathologize traditional female roles. Feminist scholars have argued

that women are told they are suffering from a disease when they fulfill society's expectation to focus on caring for the needs of others (Martsof, 2002). Feminist authors have criticized the concept because they claim it stigmatizes caring and feminine traits in general (Anderson, 1994; Brown, 1990; Malloy & Berkery, 1993). Weegmann maintained that a complex debate surrounds the codependency movement. There are those who view it as liberating for women trapped in caring roles. Others argue that pathologizing the individual and the power of patriarchal relations is overlooked. One criticism is the portmanteau manner in which the term is used. There is a risk that in our culture, we are too keen to diagnose our ills and find remedies (Weegmann, 2006).

Caring is the central concept of nursing, and the profession of nursing is built around this concept (Herrick, 1992). The practice of nursing has a codependency risk due to its nature. Being a nurse requires being sensitive to the needs of others. Caffrey and Caffrey (1994) compared the history of the profession of nursing with the developmental history of a codependent. The comparison highlighted characteristics such as hiding feelings, diminishing self-value, attempting to control everything in an often difficult working environment, and accepting peer group values. Nurses are also required to follow rules, but are frequently not involved in the decision-making process.

The nursing literature has sought to explore the differences and similarities between professional nurse caring, professional and personal boundaries, and codependency (Martsof, 2002). Feminist nurse authors suggest that the concept of codependency in nursing represents oppressed group behavior that stems from the exploitation of nurses by the patriarchal and profit-based healthcare system (Caffrey & Caffrey, 1994; Klebanoff, 1991; van der Wal, 1996; Watson, 1999).

The estimates of codependency among nurses vary. Holder, Farnsworth, and Wells (1994) reported that almost 70% of nursing students in their study came from families with histories of sexual molestation, chemical dependence, or physical violence. The nursing profession appeals to some individuals because it offers opportunities to care for people in need. However, those who choose to enter the profession must often practice in a healthcare system that contributes to the development of codependent traits (Covello, 1991). This dynamic has created the problem of differentiating professional nurse caring from codependency masquerading as caring (Quinn, 1989). Professional nurse caring has been defined as spontaneous, nonjudgmental, and stemming from a solid basis of self-esteem (Caffrey & Caffrey, 1994). This definition is in contrast to the most common conceptualization of codependency, which includes characteristics of ill-defined boundaries, limited emotional expression, nonassertiveness, and external locus of control (Caffrey & Caffrey; van der Wal, 1996). Nurse codependency is characterized by an inability to distinguish others' responsibilities from one's own, a false sense of duty to others that has a basis in fear, and a dependency on others for feelings of self-worth (Allison, 2004).

A review of the literature suggests that nurses, perhaps more than any other helping professional group, are at high risk for codependency (Ryan, 1991). Snow and Willard (1989) claimed that as many as 80% of practicing nurses are affected by codependency, and many psychosocial experts agree that a high incidence of codependency exists in nursing (Bissell & Jones, 1981; Clark, 1988; Coombs, 1996; Gelfand et al., 1990; Kowal, 1994; Sullivan et al., 1988). One of the reasons that nurses are strongly attracted to their profession is their need to take care of others. Many who choose nursing do so to satisfy a role they learned as children.

These learned roles centered on carrying out adult functions at an early age, such as caring for a sick sibling or an alcoholic parent (Snow & Willard, 1989). Some nurses grow up in chaotic families where abuse and neglect are common. The learned behaviors from such backgrounds can overpower an individual's ability to find balance (Hemfelt, Minieth, & Meier, 1989).

In the work environment, codependent behaviors of one individual may damage the morale and motivation of the entire healthcare team (Davidhizar & Eshleman, 1992). Nurses who enter the profession with unresolved issues that negatively affect their relationships are more susceptible to burnout, SUD, and problems in the workplace (Parker, Faulk, & LoBello, 2003).

Several approaches are available for nurses who seek recovery from codependency. Participation in therapy has been shown to mitigate the effects of relating in a codependent manner (Collins, 1993; Luff, 1990; Webster, 1990). Treatment based on the concept of codependency has also been helpful in decreasing emotional pain (Hands & Dear, 1994). Many individuals choose twelve-step recovery programs for support and help with changing undesirable patterns of behavior. This approach is often used in conjunction with the assistance of a professional counselor. Counselors can help individuals discover the origin of their dysfunction. They can also teach appropriate ways to develop new attitudes and make healthier choices (Kowal, 1994).

Substance Use Disorder

Substance Use Disorder is a progressive, chronic, and relapsing disorder that cannot be cured, but it can be treated (Malliarakis & Lucey, 2007). This disorder creates a major drain on the personal, social, economic, and professional resources of the American population. In 2001,

the director of the National Institute on Drug Abuse called substance abuse the most destructive health and social problem facing the United States (Leshner, 2001). The burdens on the healthcare delivery system and the social services system posed by SUD are immense (Abbott, 2002). Approximately one half of all patients admitted to trauma centers in America are under the influence of alcohol or other drugs (Gorelick, 2008). Between 20% and 40% of hospitalized patients have illnesses that are directly related to or exacerbated by the abuse of alcohol. It has been estimated that over 100,000 lives are lost each year due to alcohol abuse (National Institute on Alcohol Abuse and Alcoholism [NIAAA], 2000). Abuse and diversion of prescription drugs, including pain medications, is on the rise in the nation (Chandra & Ozturk, 2004). Community-based studies in the United States estimate that more than 22 million adolescents and adults abuse or are dependent on alcohol or other drugs (Gorelick, 2008). Clearly, SUD is a problem in this country.

The causes of SUD are multifaceted. One aspect of the disorder is the familial predisposition of individuals that makes them susceptible. Substance Use Disorder appears to be highly transmissible from one generation to the next (Pears, Capaldi, & Owen, 2007). The predominant theories regarding the development of SUD suggest that along with familial predisposition, other factors are involved. In an effort to explain the etiology of the disorder, the developmental model emphasizes the interplay between characteristics of the individual and his or her social environment (Pears et al., 2007), including peer pressure and financial status. Substance Use Disorder is not simply a problem of poor decision making and lack of willpower. Substance Use Disorder is a medical disease with social consequences, which is not different from other chronic diseases (Chandra & Ozturk, 2004).

Substance Use Disorder is also a topic that is fraught with emotion. Initially, most people emotionally react to the topic and then cognitively respond to it. By definition, SUD has negative consequences that affect almost every area of a person's life. It is common for those consequences to include ruined relationships, financial disaster, deterioration of personal health, and erosion of the person's spirituality. Substance Use Disorder is a chronic, relapsing disease, and the implications for the individual are significant and costly if left unchecked (Malliarakis & Lucey, 2007).

Persons with SUD are affected in all areas of their lives. As a result of SUD, serious medical problems may develop that affect job performance and occupational roles. Individuals with SUD are at greater risk of developing chronic health conditions, such as cirrhosis of the liver and autoimmune deficiency disorders. They are also at higher risk for cardiovascular disease, hypertension, cerebrovascular accidents, diabetes, and depression (NIAAA, 2001). The abuse of alcohol and other drugs increases the risk of death from automobile accidents as well as injuries received from recreational activities (Thompson, 2007).

As the population of the United States ages, the incidence of SUD in the elderly population is expected to double from 2.5 million to 5 million in the next two decades (Gfroerer, Penne, Pemberton, & Folsom, 2002). With increasing health problems due to the aging process, more individuals will be likely to misuse alcohol, prescription medications, and illicit drugs (Thompson, 2007).

In order to address the national health problem posed by SUD, it is essential to understand that SUD is biopsychosocial in nature: It is the result of biological, psychological, and social influences. Recent technological developments support the theory that SUD is a

disorder of the brain and not a moral issue (National Institute on Drug Abuse [NIDA], 2007). Historically, the public has been confused by the moral degradation of the person as the disease progresses. Substance Use Disorder directly affects the brain, and the result is negative behavior. Often, this behavior is viewed as lack of self-will and self-control instead of symptoms of the disease (Malliarakis & Lucey, 2007). People affected by SUD are often considered to be suffering from a moral defect or failure of willpower rather than a chronic, relapsing health condition with biological, psychological, and environmental components (Gorelick, 2008). One of the reasons the disorder is viewed as a lack of self-control is the impairment of inhibitory control in the person with SUD. Inhibitory control refers to the ability to inhibit one's impulses and responses. Impairments in inhibitory control as well as problems with self-regulation, impulsivity, and behavioral control have been documented in persons with SUD (Martin, Lynch, Pollock, & Clark, 2000).

The biological basis of SUD emphasizes genetics and neurobiology, which include brain structure and neurotransmitters. Research has found that substances of abuse engage systems in the motivation and pleasure pathways of the brain. The dopamine pathways are the principal pleasure areas in the brain's limbic system (NIDA, 2007). Elevated levels of dopamine increase sensations of pleasure. Substances of abuse multiply the dopamine levels in the brain to a level that sometimes causes shutdown. The use of an addictive substance floods the brain with dopamine, and the user experiences the extreme pleasure of a high. When the effect of the substance wears off, the dopamine levels drop significantly, and the individual is then subject to abject misery. Following the course of SUD, the individual then chases another high to recreate the positive feelings or to offset the ensuing misery. Over the course of time, the number of

dopamine receptors lowers, and the result is that more substances are needed to achieve the extreme pleasure of the high (Malliarakis & Lucey, 2007). The research that supports the role of genetics on SUD comes primarily from family, twin, and adoption studies (Griffith, 1999). These studies revealed a genetic predisposition to alcoholism (Anthenelli & Schuckit, 1998).

Psychological theories support the premise that some people are born with personality traits that make them more susceptible to SUD. The addictive personality tends to have excessive dependency needs, a strong need for success or power, the inability to provide adequate self-care, lack of tolerance for painful feelings, and a background of dysfunctional family dynamics (Kaufman, 1994). Other behavioral characteristics associated with the development of SUD include religiousness, emotionality, depressed mood, low self-esteem, and self-derogation (Faltz, 1998).

Social factors also play a role in SUD. One such factor is peer interaction (Faltz, 1998). Women with SUD are influenced in their frequency and amount of substance abuse by their male sexual partners (Mynatt, 1996). Environmental factors, such as place of residency, are also influential in the development of SUD. Residents of poverty-stricken urban areas are at high risk for substance abuse problems (Kaplan, Sadock, & Grebb, 1994).

Substance Use Disorder among Nurses

One of the earliest documented cases of a substance-impaired nurse is the story of Jane Gibson. Ms. Gibson accompanied Florence Nightingale, the “mother” of professional nursing, to the battlefield in the Crimean war. Gibson was fired from her postwar position in a London hospital when she came to work under the influence of alcohol and was unable to perform her nursing duties (Monahan, 2003).

Nurses are among the group of trusted professionals who are believed to have immunity to SUD. A common misperception exists that nurses and other healthcare professionals with SUD will somehow overcome their problems before they become too serious (Coombs, 1997). To the contrary, early research indicated that healthcare professionals, including nurses, experienced impairment from SUD at a disproportionate rate of 30% to 50% (Bluestone, 1986; Caroselli-Karinja & Zboray, 1986; Hendrix et al., 1987; Talbot, Gallegos, Wilson, & Porter, 1987). However, the belief that nurses have a higher rate of SUD was challenged (Bissell & Haberman, 1984; Sullivan et al., 1988), and later studies reported that the prevalence rate among nurses was similar to the general population (Haack, 1988; Smardon, 1998; Trinkoff, Eaton, & Anthony, 1991). In 2001, the National Council of State Boards of Nursing estimated that approximately 15% of healthcare professionals struggle with some form of SUD in their careers.

Difficulty in estimating the number of nurses impaired from SUD in the United States is due in part to the fear of reprisal, denial, and lack of agreement on the operational definition of impairment (West, 2003). Identification of the nurse with SUD is hampered by a conspiracy of silence among coworkers. Collegiality among nurses in the work setting appears to play a major role in not reporting suspected substance abuse (Shumaker & Hickey, 2006). Historically, in the workplace, the common reaction to a nurse impaired from SUD was either dismissal or discipline. This response contributed to the stigma of SUD and to the consequence of nurses hiding or denying their symptoms to avoid punitive action (Darbro, 2005). Nurses also tend to believe that they are invulnerable to SUD, and that they are incapable of becoming addicted (Gold, Byars, & Frost-Pineda, 2004). This belief contributes to their reluctance in eliciting help for themselves (Griffith, 1999).

The problem of SUD among nurses has been largely ignored by professional associations because of the slow movement toward facing the issue (Torkelson, Anderson, & McDaniel, 1996). Church (1985) conducted a historical search of SUD among nurses from 1900 to 1985 and found only three studies between 1900 and 1955 that related to impairment from SUD. The topic appeared occasionally from 1955 to 1980, when the focus on impairment from SUD increased. A review of the literature revealed that the evolution of research progressed from identifying the prevalence of SUD among nurses and attitudes toward it to identifying risk factors and symptoms (West, 2003).

The American Nurses Association (ANA) defined the term *impairment* in 1984 and began working with state nurses associations in setting up assistance programs for impaired nurses (West, 2003). The ANA defined impaired nursing practice as a situation occurring when an 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. These conditions include psychological dysfunction or excessive use of drugs and alcohol (Church, 2000).

In 1990, following the action of the ANA, the National Council of State Boards of Nursing issued a position statement on issues regarding peer assistance and alternative programs. The council defined peer assistance programs as networks of peers who initiate intervention to assist into treatment, monitor progress, and offer continual support to chemically-dependent peers. These alternative programs were described as therapeutic, nondisciplinary, and rehabilitative. They are offered by state boards of nursing as an alternative to disciplinary action against a nurse's license to practice. There is a paucity of research on the effectiveness of these

programs. However, one study found that relapse among nurses in diversion programs was 41.7% as compared to a relapse rate of 75% for the general population (Baldwin & Smith, 1994). In the remaining 11 states without alternative programs, no clear path exists for nurses and employers to follow when faced with the complex issue of impaired practice. The lack of a formal program of assistance often results in the termination of the impaired nurse and the likelihood of that nurse moving on to another healthcare facility, increasing the risks to the public and the profession (Church, 2000). Although most disciplinary cases heard before boards of nursing nationwide involve SUD, the majority of nurses impaired from SUD are never intervened upon or identified (Gossop et al., 2001).

The conditions of the working environment can increase the likelihood of SUD among nurses. Stress associated with the demands of the nursing profession has been extensively documented. There is strong evidence that nurses experience symptoms of psychological distress, depression, and anxiety, which predisposes them for SUD (Shaw et al., 2004). Much of the literature since 1980 has focused on the factors related to the nursing shortage and the demanding job of nursing (Simoni & Paterson, 1997; Tsai, 1993; Tyler, Carroll, & Cunningham, 1991; Tyler & Cushway, 1995). Clark (1988) identified seven risk factors as instrumental in contributing to SUD among nurses: (a) role strain, (b) problems of daily living, (c) enabling by peers and managers, (d) attitudes toward drugs, (e) lack of education regarding SUD, (f) lack of controls, and (g) the prescribing practices of physicians. Bianchi (2004) identified the major job stressor for nurses as insufficient time to complete assigned duties. The stress of working in the nursing profession is a hazard in itself. Alcohol and drugs are often used as a coping mechanism (Shaw et al., 2004). To add to the risk factors is the discovery that some nurses consider the use

of drugs or alcohol an acceptable means of coping with problems (Darbro, 2005). Darbro also found that nurses also believe they are competent to self-medicate and that their professional training gives them immunity from SUD. An earlier study by McAuliffe (1984) noted that nurses are highly knowledgeable about drugs, they discount their own personal risk, and they believe that they can use drugs without negative consequences.

The work environment and declining job satisfaction have been identified as two major factors that have contributed to the current shortage of nurses (Ma, Samuels, & Alexander, 2003). Nurses must cope with time pressures and fast-paced working environments (Shaw et al., 2004). They face insufficient resources, lack of administrative and managerial support, long hours, and fatigue (Bianchi, 2004). Inadequate staffing, work overload, awareness of the tremendous responsibility they carry, feelings of incompetence, and interpersonal conflicts have been commonly identified as work stressors in nursing (Boey, 1999). Nurses who are overworked and deprived of sleep are also immersed in a work setting that provides access to drugs within a professional culture that views pharmacological agents as beneficial. An additional risk factor includes limited information about SUD problems and treatment approaches for SUD during their student experience (Monahan, 2003).

Additionally, Darbro (2005) found that common workplace issues among nurses include a stressful work environment, an increased work load with a higher acuity of patients, expectations to work overtime, and demands from administration and the medical staff. The workplace issue mentioned most frequently was availability of narcotic drugs in most areas of practice. Even the nurses who did not take drugs from the workplace noted that they were easily

accessible (Darbro, 2005). Constant exposure to drugs in the workplace can desensitize nurses to the danger of abusing them (Gold et al., 2004).

One model used to explain drug abuse among nurses theorized that drug dependence would be higher in people who have access to medications, have no fear of reprisal for their actions, and experience job stress. Nurses who have access to prescription drugs are far more likely to abuse them than are those who do not have access (Shaw et al., 2004). To examine this phenomenon, a study that analyzed 3,600 nurses determined that nurses with easier access to medications reported greater substance abuse. The social network of the work setting was found to provide a sanctioned atmosphere for drug access and substance abuse (Trinkoff, Zhou, et al., 2000). Nurses and their colleagues often support each other with a conspiracy of silence in order to avoid putting their own or another's career at risk (Field, 2004).

There are several reasons for the silence. One reason nurses who are affected by SUD find it difficult to ask for help or even admit they have a problem is the idealized public image of healthcare professionals. Other factors are the eventuality of sanctioning by their board of licensure (Lewis, 2006) and the highly negative view the profession has of substance-impaired nurses (Monahan, 2003).

Variables Associated with SUD

Family History of SUD. In 2000, more than 2.5 million children in the United States younger than 18 years were estimated to be living with a mother who had used illicit drugs in the past year (Shulman, Shapira, & Hirshfield, 2000). Parental SUD is believed to affect children emotionally, cognitively, and socially, and to contribute to behavioral problems that will continue into adulthood (Peleg-Oren, Rahav, & Teichman, 2008). Parents with SUD tend to

monitor their children poorly (Chassin, Pillow, Curran, Molina, & Barrera, 1993), have poorer control of their children's behaviors (Kandel, 1990), and have poorer quality of interactions with their children (Brook, Whiteman, Balka, & Cohen, 2001). Goodwin (1981) found that children of alcoholics often marry alcoholics and are at greater risk for SUD themselves.

Studies of adult children of alcoholics indicated that they are at increased risk for emotional problems, including depressive symptoms, anxiety disorders, and post-traumatic stress disorder (Domenico & Windle, 1993; Moss, Baron, Hardie, & Vanyukov, 2001; Oravec, 2002; Sebre et al., 2004; Velleman & Orford, 1990; Windle & Searles, 1990). Parents with SUD apparently do not set limits, do not have clear expectations, or do not establish clear standards of behavior for their children. They also have little consistency in discipline. The unpredictability in parental approach may explain the findings of several studies that these children manifest problem behaviors as early as preschool (Fitzgerald et al., 1993; Kuperman, Schlosser, Lidral, & Reich, 1999). Paradoxically, children of parents with SUD can also be described as adopting patterns of behavior precociously mature for their age. They often assume excessive responsibility, internalize guilt, rationalize, and exhibit compliance while simultaneously feeling weak and dependent. Their emotional and social functioning may be impaired when they grow up (Glover, 1994; Wegscheider-Cruse, 1981).

The incidence of familial history of SUD has been found to be significant among nurses. In the 1980s, the literature supported the recognition that there were 12 million children of alcoholics in the United States and that nurses were overrepresented in this group (Finley, 1982). At the same time, the nursing literature also began to reflect a growing concern for the nurse impaired by SUD (West, 2003), and the research began to focus on identifying risk factors

involved in nurses with SUD. Sullivan (1987) studied characteristics of SUD in a national sample of 139 nurses and found that nurses who were impaired from SUD had (a) a family history of alcoholism and depression, (b) a history of sexual abuse, (c) extensive medical histories, and (d) a history of academic and professional success. Other studies also found that a family history of SUD was a potent factor among impaired nurses. For example, family studies of 407 recovering health-care professionals showed that nurses had the highest percentage of alcoholic relatives (Bissell & Haberman, 1984; Kenna & Wood, 2005). Kenna and Wood found that a family history of drug and alcohol use was one of the predictors of lifetime substance abuse by both nurses and pharmacists.

Haack and Hartford (1984) suggested that nurses who were the children of alcoholics accepted the role of caretaker and assumed responsibility for the alcoholic parent. It is possible that as children, these nurses assumed a nursing role toward an alcoholic parent and later played out this responsibility in their choice of profession. Sullivan (1987) reported that 48% of 139 impaired nurses said that family difficulties had forced them to assume parental roles during childhood. Nurses who grow up in households made dysfunctional from SUD may find gratification in continuing their nurturing role as healthcare providers (Coombs, 1996).

Family History of Mental Illness. Mental illnesses take an enormous toll on individuals and on their families, friends, and society as a whole (Murray & Lopez, 1997). In July, 2003, the President's New Freedom Commission on Mental Health recommended enhanced efforts in screening for mental disorders in primary care settings. Time constraints, lack of reimbursement, and the lack of an easily administered, inexpensive screening instrument have made widespread screening in primary care settings impractical. Rohrer, Rohland, Denison, Pierce, and Rasmussen

(2007) suggested that an alternative approach could be identifying risk factors for poor mental health and targeting that population with health promotion materials. Their study found that individuals with a family history of mental disease or SUD were nearly twice as likely to report mental distress, such as depression and SUD.

A family history of SUD coexisting with a mental illness, such as depression or anxiety, low self-esteem, poor coping skills, chronic pain, and a history of victimization, such as child abuse or sexual traumatization, were also identified as personal risk factors among healthcare professionals (Rohrer et al., 2007). The significance of family history of mental illness was observed in a study of 236 nurses. The findings indicated that the nurses came from chaotic families with SUD, suffered victimization, and had low self-esteem (Mynatt, 1996).

Family History of Physical Violence. In recent years, there has been considerable and increasing interest in the effects of trauma on children (Saunders, 2003). The traumatic experience of witnessing violence within the home has been recognized as a potential contributor to long-term difficulties (Mabanglo, 2002). Although limited data exists on the number of children who witness domestic violence, it has been estimated that between 3.3 million (Carlson, 1984) and 17.8 million children are exposed to violence between intimate partners (Holden, 1998).

Intimate partner violence (IPV) includes behaviors that range from verbal assaults and insults to severe or fatal physical aggression (Carlson, 1984; Jaffe, Wolfe, & Wilson, 1990). Estimating the prevalence of the different types of violence within families is difficult due to underreporting and the consequences of disclosure (Herman, 1992; Jaffe et al., 1990). In the United States, approximately one in four women reported experiencing physical assault by an

intimate partner at some point in their lives (Tjaden & Thoennes, 2000). In developed countries such as Great Britain (Mirrlees-Black, 1999) and Australia, 23% of the women studied reported violence between themselves and an intimate partner (Bedi & Goddard, 2007).

Recently, research addressing the overlap between IPV and child abuse has found that the incidence of co-occurrence ranged from 6% to 100%. The lack of consistency in estimates was attributed by Appel and Holden (1998) to methodological issues. Appel and Holden also reported a median of 40% of children living with IPV who experienced directly-targeted physical abuse.

Numerous studies have documented a relationship between adverse developmental experiences, such as witnessing parental aggression or family conflict, and SUD (Bassuk, Dawson, & Huntington, 2006). Childhood trauma in the form of domestic violence has been linked with a wide range of negative outcomes in adulthood, including psychological problems and substance abuse (Bryer, Nelson, Miller, & Kohl, 1987; Kendler et al., 2000). Covington and Kohen (1984) found that adult women who abused alcohol and other drugs experienced higher rates of physical, sexual, and emotional abuse during childhood than women who were nonabusers. As many as 62% to 81% of adult women in treatment centers for SUD were victims of child abuse or neglect (Gil-Rivas, Fiorentine, Anglin, & Taylor, 1997; Liebschutz et al., 2002; Teets, 1995). In comparison, 26% to 30% of women who had not been treated for SUD reported child abuse or neglect (Kendler et al., 2000; MacMillan et al., 2001).

Birth Order. Birth order is the location in a family and refers to the four basic positions of oldest, middle, youngest, and only child. The family environment into which a person is born is different for each child, and each child essentially has a different family (Dreikurs, 1999). Each birth position has tasks, characteristics, and demands that influence the child's view of his

or her place in the family and in life (Kalkan, 2008). The characteristics of the firstborn child are usually depicted as powerful and influential (Campbell, White, & Steward, 1991). As a rule, firstborn children usually adhere to rules, respect authority, and become leaders themselves (Kalkan). Firstborns are believed to enjoy structure and regular routines (Toman, 1993). They are more rigid than siblings who are born later (Leman, 1985).

The middle child may feel squeezed in between older and younger siblings. Middle children may perceive themselves as in a race to overtake the firstborn and take the privileged position of being first in the family (Kalkan, 2008). Middle children may not readily develop a role in the family and are often seen as good arbitrators who emphasize justice and fairness (Leman, 1985).

The youngest child is like the firstborn in having a special position in the family. Youngest children are often viewed as spoiled and pampered and tend to have a greater external locus of control (Falbo, 1981; Fraser & Nystul, 1983). Youngest children have been overrepresented among persons with alcoholism (Conley, 1980). They also abuse narcotics more frequently than people in other birth positions (Linder & Lemer, 1976).

Only children, like youngest children, are likely to be seen as pampered and spoiled because there are no other children to divert the parents' attention (Adler, 1927). Only children have also been viewed as more likely to abuse drugs than persons in other birth positions (Linder & Lemer, 1976).

Kenna and Wood (2005) suggested that research into birth order of nurses is important to consider because older siblings lend themselves to the role of caretaker and, subsequently, the profession of nursing. Firstborn children are often socialized to conform, achieve, behave, and

please others. They frequently take responsibility when parents are absent and often act as parent substitutes in large families (Gladding, 1996).

Gender. Men have consistently been reported to have higher rates of SUD than women in all age groups (Sannibale & Hall, 2001). This higher rate has been explained predominantly in terms of biological and social factors that influence women's exposure to substance use (Anthony & Helzer, 1991; Cloninger, Christiansen, Reich, & Gottesman, 1978; Helzer, Burnam, & McEvoy, 1991).

However, there is evidence that women may be more susceptible than men to the consequences of SUD. Women have a higher prevalence of alcohol-related problems (Bongers, van Oers, van de Goor, & Garretsen, 1997; Glenn & Parsons, 1989), and they progress more rapidly from first drink to regular intoxication (Helzer et al., 1991). Sannibale and Hall (2001) found that men were twice as likely as women to meet the criteria for substance abuse, and women were more than twice as likely as men to develop severe substance dependence, particularly opioid and sedative dependence.

The 2004 National Sample Survey of Registered Nurses reported 2.9 million nurses in the United States and that 88.4%, or 2.3 million, of those nurses were White females (HRSA, 2005). Men are a minority within nursing, and they leave the profession at almost twice the rate of females. Males leave at a rate of 7.5% and females at a rate of 4.1% (Evangelista & Sims-Giddens, 2008). Studies conducted in Missouri, Texas, and Louisiana also found that males received a disproportionate share of formal disciplinary action from the Boards of Nursing in those states (Booth & Carruth, 1998; Evangelista & Sims-Giddens).

Research that addresses gender as a risk factor among nurses with SUD must take into account that women tend to report a family history of alcoholism more frequently than men (Gomberg, 2003), and that there is a higher proportion of women than men in the nursing profession (Kenna & Wood, 2005). One composite review of the Idaho Program for Recovering Nurses found that 18% of those enrolled were male. This figure represented more than three times the number of male nurses licensed to practice in the United States (Clark & Farnsworth, 2006). Finke, Williams, and Stanley (1996) described the characteristics of 221 nurses in a peer assistance program and reported that the percentage of males in the program was four times higher than the percentage of males in the profession.

Gaps in the Literature

Early research on nurse impairment focused on narcotic addiction (Garb, 1965; Poplar, 1969); cross addiction, or addiction to more than one drug (Levine, Preston, & Lipscomb, 1974); and alcohol addiction (Bissell & Haberman, 1984; Bissell & Jones, 1981). These early studies focused on the prevalence of addiction in nurses. Later studies addressed the profession's attitude toward impairment from SUD (Hendrix, Sabritt, McDaniel, & Field, 1987) and began identifying characteristics of the nurse impaired from SUD (West, 2003). Ten years following the statement on nurse impairment by the American Nurses Association, the literature began to reflect the need for policies designed to assist nurses with SUD (Peery & Rimler, 1995). Much of the literature concerning policies focused on the need for developing professional assistance programs to identify and monitor nurses with SUD (West, 2003). The effort to identify early risk factors of nurses impaired from SUD included studies with students and faculty of nursing schools (Gnadt, 2006; Kornegay et al., 2004).

In the late 1980s, researchers began to study the prevalence of codependency in the nursing profession to determine whether nurse codependency overlapped with healthy caring described in nursing theories (Quinn, 1989). Both SUD and codependency have been subjects of extensive research in the nursing profession. A review of the literature revealed that codependency has not been studied as it relates to SUD among nurses. The current study not only investigated the relationship between codependency and history of treatment for SUD among nurses, it also examined the relationships between codependency and gender, race, and birth order, variables which have been associated with SUD.

Having a family history of SUD has been identified as a contributing factor in occurrence of SUD among nurses (West, 2003). Sullivan's study (1987) identified a family history of alcoholism, as well having a family history of mental illness. This study expanded upon previous research by exploring the relationship between these two variables and codependency among nurses.

Summary

The prevalence of codependency and its effect on the profession of nursing has been researched (Arnold, 1990). Substance Use Disorder has also been studied in relation to the profession of nursing. The studies currently available that focus on SUD among nurses have not examined the relationship between codependency and SUD, as well as the relationship between codependency and other variables associated with SUD (e.g., gender, race, birth order, witnessing or experiencing physical violence in the family of origin, having a parent or primary caregiver with SUD, having a parent or primary caregiver with a history of mental illness). This

study expands on previous research by providing a better understanding of codependence among nurses and its relationship to SUD and other selected variables.

CHAPTER III METHODOLOGY

Substance Use Disorder is a problem in the United States as well as in the profession of nursing. As a profession, nursing has inherent factors which contribute to SUD. One of these may be codependency. This study explored the relationship between codependency and history of treatment for SUD among nurses, as well as the relationship between codependency and gender, race, birth order, having experienced or witnessed physical violence in the family of origin, having a parent or primary caregiver with SUD, and having a parent or primary caregiver with a history of mental illness.

This study addressed the following research question:

Do nurses differ in codependency scores when compared by (a) self-reported history of treatment for SUD, (b) gender, (c) race, (d) birth order, (e) having witnessed or experienced physical violence in family of origin, (f) having a parent or primary caregiver with SUD, and (g) having a parent or primary caregiver with a history of mental illness.

Null Hypothesis

The following null hypothesis was tested:

Nurses will not significantly differ in codependency scores when compared by (a) self-reported history of treatment for SUD, (b) gender, (c) race, (d) birth order, (e) having witnessed or experienced physical violence in family of origin, (f) having a parent or

primary caregiver with SUD, and (g) having a parent or primary caregiver with a history of mental illness.

Research Design

The study used a survey design.

Participants

The population was 202 nurses with active licensure in a state in the southeastern United States. The licensure board for nursing in this state offers nurses the option of selecting a specialty. Only nurses who did not indicate a specialty setting were selected for the study because of the possible interaction of specialty setting (e.g., a nurse who works in a substance abuse or mental illness specialty setting) with codependence and SUD. Participation was voluntary and confidential.

Procedures

The nurses were mailed survey packets which included a form seeking demographic information (e.g., age, gender) and data specific to other variables being studied (e.g., history of treatment for SUD, birth order, witnessing or experiencing childhood physical, parent or primary caregiver history of SUD, parental history of mental illness). The nurses also completed the Spann Fischer Codependency Scale (see Attachment A).

Instruments

The study used the Spann-Fischer Codependency Scale (SFCS), which consists of 16 self-report items with responses assessed on a six-point Likert scale ranging from

1 (*Strongly Disagree*) to 5 (*Strongly Agree*) (Fischer, Spann, & Crawford, 1991). This instrument assesses codependency in terms of an extreme focus outside of self, a lack of open expression of feelings, and attempts to derive a sense of purpose through relationships. The total scores on the SFCS range from 16 to 96. Higher scores reflect greater codependency. The internal consistency as measured by Cronbach's alpha ranges from .73 to .80. In two administrations of the scale, stability estimates revealed a test-retest correlation of .87. The SFCS has demonstrated the most reliability and validity evidence of any of the codependency scales found in the literature (Allison, 2004).

Data Analysis

The data were analyzed using a 2 (history of treatment for SUD) X 2 (gender) X 2 (race) X 4 (birth order) X 2 (physical violence in family of origin) X 2 (parent or primary caregiver history of SUD) X 2 (parent or primary caregiver history of mental illness) ANOVA. The following variables were dichotomous (Yes/No): (a) history of treatment for SUD, (b) having witnessed or experienced physical violence in family of origin, (c) having a parent or primary caregiver with a history of SUD, and (d) having a parent or primary caregiver with a history of mental illness. Gender was categorized as male or female. Birth order had four categories: (a) first born, (b) middle child, (c) youngest child, and (d) only child. The results of this analysis can be found in Chapter IV.

CHAPTER IV RESULTS

This study examined the codependence scores of registered nurses. The following null hypothesis was tested:

The codependence scores of nurses will not differ when compared by self-reported history of SUD, gender, race, birth order, having witnessed or experienced physical violence in the family of origin, parent or primary caregiver history of SUD, and parent or primary caregiver history of mental illness.

Participants

One thousand registered nurses who did not indicate a specialty setting were chosen from the board of nursing roster of a southeastern state. Each nurse was mailed a survey packet which contained a letter of consent, the Spann-Fischer Codependency Scale, a form seeking demographic information (e.g., age, gender) and data specific to other variables being studied (e.g., history of treatment for SUD, birth order, witnessing or experiencing childhood physical, parent or primary caregiver history of SUD, parental history of mental illness), and a stamped envelope for returning the survey. Of the 1,000 surveys mailed, 202 were returned for a response rate of 20.2%.

The nurses ranged in age from 23 to 75 years ($M = 53.22$, $SD = 10.37$). The majority ($n = 185$) of the nurses were female; the remainder ($n = 17$) were male. Racial identification was as

follows: White ($n = 157$), African American ($n = 43$), Hispanic ($n = 1$), and one reported his or her race as other.

Seventy four nurses reported they were the first born child in the family. Sixty five nurses indicated that they were a middle child. Fifty nurses reported being the youngest child and 12 nurses indicated being an only child.

The nurses were asked if they had ever been treated for SUD. Ten reported having been treated and 192 reported no history of treatment. The nurses were also asked three questions about their family of origin. One question asked if they had ever witnessed or experienced physical violence in their family of origin. Sixty nine nurses reported witnessing or experiencing physical violence in their family of origin; 132 did not report in history of violence in their family. One nurse did not respond to this question.

The nurses were also asked if they had a family history of SUD. Fifty six nurses answered positively to a parental history of SUD; while 145 nurses responded negatively to this question. One nurse did not answer the question. The last question asked if the nurses had a history of mental illness in their family of origin. Thirty five nurses responded that they did and 165 nurses responded that they did not have a history of mental illness in their family. Two nurses did not respond to the question.

Data Analysis

The nurses' codependency scores ranged from 17 to 88 ($M = 48.49$, $SD = 16.52$). Mean codependency scores by SUD and the other independent variables of the study can be found in Table 1.

Table 1

Codependency Mean Scores by SUD and Other Selected Variables

Variable	<i>M</i>	<i>SD</i>
History of treatment for SUD		
Yes	58.90	5.27
No	47.95	1.18
Gender		
Male	43.58	4.22
Female	48.95	1.21
Race		
White	49.96	1.32
nonWhite	43.36	2.30
Birth Order		
First born	48.31	1.97
Middle child	47.23	2.11
Youngest child	50.86	2.32
Only child	48.50	3.19
Physical violence in family of origin		
Yes	53.57	1.96
No	45.62	1.38
Parent or primary caregiver with SUD		
Yes	51.50	2.28
No	47.32	1.35
Parent or primary caregiver with mental illness		
Yes	57.00	2.63
No	46.64	1.26

The hypothesis was tested using a 2 (history of treatment for SUD) X 2 (gender) X 2 (race) X 4 (birth order) X 2 (physical violence in family of origin) X 2 (parent or primary

caregiver history of SUD) X 2 (parent or primary caregiver history of mental illness) ANOVA.

The race variable was collapsed into two categories: White and nonWhite. The results of the analysis can be found in Table 2

Differences in Codependency Scores by SUD and Selected Variables

Source	<i>df</i>	<i>F</i>	η_p^2	<i>p</i>
SUD	2	3.82	.020	.05*
Gender	1	1.98	.011	.16
Race	1	2.97	.016	.09
Birth order	3	.41	.007	.75
Violence	1	4.43	.023	.04*
Caregiver SUD	1	.02	.000	.89
Caregiver MI	1	5.64	.029	.02*
Error	187			
Total	197			

* $p \leq .05$

Note: Violence = having witnessed or experienced physical violence in family of origin; Caregiver SUD = parent or primary caregiver history of Substance Abuse Disorder; Caregiver MI = parent or primary caregiver history of mental illness

The nurses' codependency scores differed significantly when compared by history of treatment for SUD. Nurses who reported having been treated for SUD had higher codependency scores than nurses reporting not having been treated for SUD. The nurses also differed significantly in their codependency scores when compared by their having witnessed or experienced physical violence in their family of origin. Those who had witnessed or experienced physical violence in their family of origin had higher codependency scores than those who had

not. Finally, the nurses' codependency scores differed significantly when they were compared by having a parent or primary caregiver with a history of mental illness. The nurses who had a parent or primary caregiver with a history of mental illness had higher codependency scores than those who did not. Discussion and implications of these findings are provided in Chapter V.

CHAPTER V DISCUSSION, IMPLICATIONS, AND RECOMMENDATIONS

In the United States, codependency is a common mental health problem. Over twenty years ago, forty million Americans were estimated to be diagnosed as codependent (Goff & Goff, 1988). It has also been suggested that the incidence of codependency is higher in the helping professions (Martsolf, Hughes-Hammer, Estok, & Zeller, 1999). Of these professional groups, nursing, more than any other profession, has been saddled with the stereotype of codependency (Arnold, 1990). Codependency in nursing is manifested by a loss of professional identity, an overidentification with the role of caretaker, an inability to distinguish one's responsibilities from the responsibilities of others, a false sense of duty to others that has a basis in fear, and a dependency on others for self-worth. Nurse codependency fosters dependency on the caregiver by the care receiver, encourages feelings of guilt in the care receiver, and is controlling (Allison, 2004). It is important to distinguish nurse codependency from healthy nurse caring which, in contrast to codependency, is empowering, nonjudgmental, spontaneous, and stems from a solid basis of self-worth (Caffrey & Caffrey, 1994). This study focused on the relationships between codependence scores and self-reported treatment for SUD, gender, race, birth order, family history of physical violence, history of SUD in a parent or primary caregiver, and history of mental illness in a parent or primary caregiver.

The study examined the codependency scores of nurses when compared by (a) self-reported history of treatment for SUD (b) gender, (c) race, (d) birth order, (e) having witnessed or experience physical violence in the family of origin, (f) having a parent or primary caregiver

with SUD, and (h) having a parent or primary caregiver with a history of mental illness.

Participants in the study were nurses with active licensure in a southeastern state in the United States.

The nurses differed in their codependency scores when compared by (a) self-reported treatment for SUD, (b) having experienced or witnessed physical violence in the family of origin, and (c) having a parent or primary caregiver who had a history of mental illness.

Discussion

Substance Use Disorder has been described as a serious problem in the nursing profession. Thirty-nine states have programs designed to monitor nurses who are impaired by SUD. The majority (67% to 90%) of all disciplinary action taken by state boards of nursing is related to SUD. Although it is recognized as a serious problem, estimating the incidence of SUD among nurses is difficult. In 1984, the American Nurses Association estimated that 8% to 10% of nurses were dependent on alcohol and 2% to 3% were dependent on other drugs. Later estimates ranged from 6% to 32% (Griffith, 1999; Trinkoff, & Storr, 1998). Some of the early research supported the claim that nurses may be at higher risk for SUD than the general population (Bissell & Jones, 1981; Clark, 1988; Coombs, 1996; Gelfand, Long, McGill, & Sheerin, 1990; Sullivan, et al., 1988). This study did not support the claim that the incidence of SUD among nurses is higher than the general population. Of the 202 surveys returned, ten participants reported having been treated for SUD, or less than 5%. It is possible that nurses who have been treated for SUD did not respond to the survey and had they responded, the differences may have been even more significant with a larger response rate.

Previous research has suggested that codependency and SUD are linked. Studies of chemically-dependent persons entering their first treatment programs have found that 60% of them and 90% of those who are chronically relapse-prone have dual diagnoses of SUD and codependency (Gorski, 1992). In this study, the nurses who reported a history of treatment for SUD had higher codependency scores. This was an expected finding.

Prior research into the effects of trauma on children indicated that witnessing physical violence within the family was a potential contributor to long-term difficulties (Mabanglo, 2002). This form of trauma was also linked with a wide range of negative outcomes in adulthood, including psychological problems (Bryer, Nelson, Miller, & Kohl, 1987; Kendler et al., 2000). The nurses in this study who reported a history of physical violence in their family of origin had higher codependency scores. This was an expected finding. Children who witness family violence can develop caretaking patterns at an early age. This sometimes evolves from the need to protect other siblings from physical harm. The powerful need to take care of others is a classic characteristic of codependency. This powerful need to take care of others may stem from the feelings of powerlessness to stop or control the physical violence in the family.

Mynatt (1996) found that nurses with a family history of mental illness suffered victimization and had low self-esteem. Rohrer et al. (2007) also found that individuals with a family history of mental disease were nearly twice as likely to report mental distress. In this study, the nurses who reported a family history of mental illness had higher codependence scores. This was an expected finding. Gorski (1992) identified low self-esteem as a core concept of codependency. Children who feel victimized and suffer low self-esteem from family of origin

issues such as mental illness are predisposed to codependency. The codependent personality obsessively seeks approval from others in an effort to gain higher self-esteem.

Coombs (1996) speculated that health-care professions attract people who are reared in families with alcoholic and emotionally abusive parents. Research conducted by Holder, Farnsworth, and Wells (1994) reported that almost 70% of nursing students in their study came from families with histories of sexual molestation, SUD, and physical violence. Children of parents with SUD can be described as sometimes adopting patterns of behavior precociously mature for their age. They often assume excessive responsibility and accept the role of caretaker for the alcoholic parent (Haack & Hartford, 1984). Such family situations can contribute to the learned roles centered on carrying out adult functions in childhood, such as caring for an alcoholic parent (Snow & Willard, 1989). These learned behaviors can overpower an individual's ability to find balance (Hemfelt, Miniherth, & Meier, 1989). The nurses in this study who reported a history of SUD in their families of origin did not have higher codependence scores. Given the dynamics of codependency and the findings from research into children of alcoholic parents, this was an unexpected finding. This was unexpected because the concept of codependency began with the belief that codependent behavior evolved from being associated with a person with SUD. Most treatment facilities include families in their treatment of patients with SUD because the concept that no one gets sick alone has been embraced by the professional community. It was expected that children who have been reared in an environment dominated by the behavior of a parent or guardian with SUD would have characteristics of codependency.

Previous research suggested that firstborn children lend themselves to the role of caretaker and are often socialized to conform, achieve, behave, and to please others (Kenna & Wood, 2005). They frequently take responsibility when parents are absent and often act as parent substitutes in large families (Gladding, 1996). Given the similarities between the characteristics of firstborn children and the characteristics of codependency, it was expected that birth order would be significant when making comparisons. In this study, however, order of birth was not significant in relation to codependency scores.

This was an unexpected finding because firstborn children are often people pleasers and can be dependent on others for approval. The need to please others and have their approval is central to codependency.

Implications and Recommendations

1. Nurses who reported treatment for SUD had higher codependence scores. This finding could be helpful to facilities that treat nurses with SUD. Along with treatment designed to address SUD, facilities could include lectures and psychoeducational groups that address codependency issues. Individual counseling sessions with these nurses in treatment, and following discharge from treatment could also be structured to include goals for recovering from codependency.
2. Nurses who have histories of physical violence in their families of origin have higher codependency scores. Counselors who work with registered nurses as well as counselors employed by universities with schools of nursing could use this finding in treatment planning. The trauma of witnessing or experiencing physical violence can have a negative impact on a

person's physical and emotional health well into adulthood, if left untreated. Nurses who have a family background of physical violence need to address this issue therapeutically.

3. Nurses who have histories of mental illness in their families of origin have higher codependency scores. This finding needs to be addressed in the curriculum of schools of nursing. The core of nursing education is the promotion of physical and mental health. Nursing students could be taught the importance of their own mental health as well as their patients. This finding could also benefit counselors who work with nurses and nursing students.

Future Research

1. The present study focused on nurses registered in one state. Future research needs to be conducted in other states or using a national random sample to increase generalization of the findings.

2. The findings from this study were based on a limited sample size without random selection. Future research needs to be with a larger, randomly selected sample.

3. This study did not address a history of childhood sexual abuse. Prior research has linked childhood sexual abuse and SUD. Incidence of childhood sexual abuse among women being treated for SUD is as high as 75%. Future research needs to explore this relationship.

4. The present study did not ask participants for their educational level. Future research could include this to determine if baccalaureate nursing programs are more successfully addressing the risk of codependency in nursing than associate degree schools of nursing.

5. This research focused on history of treatment for SUD, without asking the participant about current substance use. Future research should include a question addressing the participant's current use of mood or mind altering substances. It is possible that some of the

participants could be abusing substances and may not have yet been referred for treatment or come to the attention of their state board of nursing.

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Appendix A

Survey

Please answer the first question by recording your age. After carefully reading the remaining questions, select the answer which applies to you by circling your response.

What is your current age? _____

What is your gender: Male Female

What is your race: African American Caucasian Hispanic Asian Other

What was your birth order in your family? First Born Middle Child Youngest Child Only Child

Have you ever sought treatment for Substance Use Disorder? Yes No

Did you ever experience or witness physical violence in your family of origin? Yes No

Did either of your parents or a primary caregiver have a Substance Use Disorder? Yes No

Did either of your parents or a primary caregiver have a history of mental illness? Yes No

Please read the following statements and place the number that best describes you in the spaces provided. Use the following scale:

1 = Strongly Disagree 2 = Moderately Disagree 3 = Slightly Disagree 4 = Slightly Agree
5 = Moderately Agree 6 = Strongly Agree

___ It is hard for me to make decisions

___ It is hard for me to say “no.”

___ It is hard for me to accept compliments graciously

___ Sometimes I almost feel bored or empty if I don’t have problems to focus on

___ I usually *do not* do things for others that they are capable of doing themselves

___ I tell myself that things will get better when the people in my life change what they are doing

___ I *do not* worry very much

___ I don’t usually let others see the “real” me

___ I seem to have relationships where I am always there for them but they are rarely there for me

___ Sometimes I get focused on one person to the extent of neglecting other relationships and responsibilities

___ I seem to get into relationships that are painful for me

___ I often have a sense of dread or impending doom

___ I often put the needs of others ahead of my own

___ When someone upsets me I will hold it in for a long time, but once in a while I explode

___ When I do something nice for myself I usually feel guilty

Appendix B
Participant Letter

Dear Fellow RN:

Codependency has been described as a dysfunctional pattern of living which emerges from repeated exposure to stressful conditions. Research suggests that nurses are at risk of exhibiting codependency by the very nature of their profession. In nursing, codependency is characterized by a loss of professional identity and an over identification with the role of caretaker. It also results in an inability to distinguish others' responsibilities from one's own, a false sense of duty to others that has a basis in fear, and a dependency on others for self-worth. As a nurse who is now a practicing counselor, I am interested in codependency as it affects the nursing profession.

I am conducting a study exploring variables that may influence codependency among nurses. As a registered nurse in the state of Alabama, you have been randomly chosen to be invited to take part in this survey. Completing the survey will require that you answer questions about any family history of violence, mental illness, and Substance Use Disorder. You will also be asked if you have been treated for Substance Use Disorder. I anticipate that the survey can be completed in less than five minutes.

YOUR PARTICIPATION IS COMPLETELY VOLUNTARY. Your responses will be anonymous. The information that you provide will not be linked to your identity in any way; therefore, please do not place any identifying information on the survey.

There will be no direct benefits to you for participating in this survey. The results will be useful to professionals who counsel nurses, as well as nurse educators, for the purpose of prevention, education, and early intervention. It is possible that some of the questions may make you uncomfortable. You may skip any questions you do not wish to answer.

If you have questions about this study, please contact Jo Self, RN, at 205-515-7611 or by email at JoRebel205@aol.com. If you have questions about your rights as a participant, contact the University of Alabama Institutional Review Board at 205-348-5152.

Thank you in advance for your willingness to assist with this study. Please return the completed survey to me in the self-addressed, stamped envelope.

Sincerely,

Jo Self