THE CRITICAL FACTORS INFLUENCING THE ATTITUDES AND BEHAVIORS OF NURSES CARING FOR PATIENTS WITH SUBSTANCE USE DISORDERS

DISSERTATION

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Suzan Blacher

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by

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Abstract

Background: Nursing is known to be an ethical and caring practice discipline, yet there is some evidence that nurses may have negative attitudes and behaviors towards persons with substance use disorders. Few nurses realize these undesirable attitudes and behaviors negatively impact the very patients they are caring for (Can & Tanriverdi, 2015). These attitudes and behaviors are also considered unprofessional and may place nurses in violation of the Nursing Code of Ethics (American Nurses Association, 2015).

Purpose: The purpose of this qualitative constructivist grounded theory study is to develop a middle-range theory explicating the process of nurses caring for Substance Use Disorder patients. A substantive theory constructed from nurses' attitudes and behaviors may provide the framework needed to minimize the effects of stigmatization in the nursing care provided to this vulnerable and marginalized population.

Philosophical Underpinnings: This qualitative constructivist grounded theory study will be guided by the philosophical underpinnings of symbolic interactionism and pragmatism.

Methods: The research design selected for this study is the constructivist grounded theory approach as described by Charmaz (2014). Data were collected through semi-structured individual interviews and focus group interviews. The individual interviews were evaluated using coding procedures and placed into categories, which were then evaluated for associations and themes. Theoretical sampling was then used to further develop the concepts and themes until saturation occurred. A focus group of four nurse experts in substance use disorders and addiction was used to confirm the generated

theory of the registered nurses' role in caring for persons with substance use disorders. The focus groups participants were then asked to substantiate the generated theory.

Results: The basic social process that was co-constructed from the voices of nurses caring for patients with substance use disorders was *Achieving Understanding: Pathway to Care*. The four categories that emerged from the data that supports the theory are *avoiding, stigmatizing, and struggling with role and lacking education.* These categories represent the critical factors which lead the way to best practices in caring for patients with substance use disorders

Conclusions: The theoretical framework co-constructed from this study can be used to guide nursing education, research, and practice. Understanding the influencing factors of nurses who care for patients with substance use disorders is essential to providing the best patient care, as well as enhancing academic nursing curricula and healthcare institutional practices. This study augments the body of nursing knowledge.

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My classmates and colleagues who offered support and reassurance, thank you for your friendship and encouragement. To my friends who kept me sane by checking in on me, even when I disappeared for weeks on end, and insisted on taking me away from my computer to refresh my mind, I cannot thank you enough.

To Steve my best friend, partner, companion, supporter. You were always there encouraging me, cheering me on, boosting my spirit, providing a sounding board for ideas as well as listening to my grumblings. Thank you for not complaining about the countless hours I spent shut away in my office doing what I needed to do to accomplish this endeavor.

To all the nurses who participated in my study, thank you for sharing your feelings and knowledge about substance use disorders and addiction. You helped me to advance compassionate care to this much maligned population. Let's keep fighting the good fight!

DEDICATION

I dedicate this work to my father and mother. My father always encouraged my educational growth and encouraged me to reach beyond my current level. When in grade school, he would spend time practicing my reading and vocabulary skills with me. He paid for an endless parade of math tutors to get me through the "new math"! When I had a dark moment and considered dropping out of nursing school, my father flew to Boston to encourage me to stay in my nursing program. I am forever grateful for that support, encouragement, and love. He was so proud when I received my diploma in nursing. Although he did not live to see me graduate with my BSN or my MSN, and now my PhD, I know that he will be bursting with pride as he looks down and watches me cross the stage to receive my doctorate.

My mother has served as a role model for me as a strong and awe-inspiring woman. Mom returned to school when it was not fashionable for women to do so. She has been a staunch supporter of my continuing education throughout my life. Throughout all my educational trials and tribulations, she has offered unfailing support and encouragement. She has been selfless in understanding when I told her I could not visit with her because I had to work on my dissertation. She has always been in my corner cheering me on. She too will be bursting with pride as she sits in the audience and watches me cross the stage to receive my doctorate.

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CHAPTER ONE

PROBLEM AND DOMAIN OF THE INQUIRY

The most recent Gallup Poll once again recognizes nurses as the highest rated profession for honesty and ethical standards (Gallup Poll, 2018). Nursing is known to be a caring practice discipline, yet there is evidence that some nurses have negative attitudes and behaviors towards persons with substance use disorders (Chang & Yang, 2012; Neville & Roan, 2014; Nilsen, Stone, & Burleson, 2013). Few nurses realize these unfavorable attitudes and behaviors negatively impact the very patients they are caring for (Can & Tanriverdi, 2015). These undesirable attitudes and behaviors may also be considered unprofessional and may violate the ANA *Nursing: Scope and Standards* (2015b), the ANA *Code of Ethics* (2015a) and the ANA *Social Policy Statement* (American Nurses Association, 2015c).

A search of the literature has found that there is a deficit of substantive theories addressing nurses' attitudes and behaviors when caring for substance use disorder (SUD) patients. Despite the many attempts to improve attitudes and behaviors of nurses caring for patients with SUD through educational programs, negative attitudes and behaviors are still problematic (Chang & Yang, 2012; Neville & Roan, 2014; Nilsen et al. 2013). A substantive theory could be used as a framework for changing attitudes and behaviors and contribute to nursing knowledge to enhance practice, nursing education, and nursing research.

Background of the Study

The *Diagnostic and Statistical Manual of Mental Health Disorders* - (DSM-5)

(American Psychiatric Association, 2013) defines and describes substance use disorders (SUDs) as a group of disorders that encompasses alcohol and drug misuse. The term substance abuse is no longer used. SUDs are characterized as mild, moderate, or severe and are identified by a set of diagnostic criteria. SUDs are said to be present when repeated use of the substance(s) produce significant clinical and functional impairments to the individual. These may present as health problems or disability and/or the inability to meet one's responsibilities at home, work, or school. The individual may display impaired control, social impairment, and risky use (Substance Abuse and Mental Health Administration, 2013).

Substance use disorders are a ubiquitous problem that has become a national epidemic. The United Nations Office on Drugs and Crime (UNODC), World Drug Report (2017), notes that in 2015, "about a quarter of a billion people used drugs. Of these, around 29.5 million people, or 0.6% of the global adult population, were engaged in problematic use and suffered from drug use disorders" (p. 9). The World Health Organization (WHO) (2014) Global Status Report on Alcohol and Health reports that "globally, harmful use of alcohol causes approximately 3.3 million deaths every year (or 5.9% of all deaths), and 5.1% of the global burden of disease is attributable to alcohol consumption" (p. vii). In the United States, the National Survey and Drug Health (NSDUH) (2016), reported that an estimated 20.1 million individuals had a SUD in the past year. Of that total, roughly 15.1 million people had an alcohol use disorder and 7.4 million people who had an illicit drug use disorder (SAMHSA, 2017, p. 2). Of that total, roughly 15.1 million people had an alcohol use disorder and 7.4 million people who had an illicit drug use disorder (SAMHSA, 2017, p. 2). The comorbid health conditions that

often accompany substance misuse create substantial medical complications that compound the treatment for patients with substance use disorders (Hatzenbuehler & Phelan, 2013). These medical conditions range from withdrawal symptoms, multiple overdoses, alcoholic hepatitis, cardiovascular complications, lung disease, diabetes, liver ailments, infectious diseases (HIV, Hepatitis C), as well as psychological issues of depression, anxiety, posttraumatic stress disorder (PTSD) and suicide (Chang & Yang, 2012; Bradbury-Golas, 2013; Phelan, Lucas, Ridgeway &Taylor, 2014). The World Health Organization (WHO) examined 18 conditions (e.g., being homeless, being HIV positive, having a criminal record) in 14 countries (Canada, China, Egypt, Greece, India, Japan, Luxembourg, Netherlands, Nigeria, Romania, Spain, Tunisia, Turkey, and the UK) and found that of the most stigmatized conditions, alcohol SUD was classified as the fourth most stigmatized condition. Illicit drug SUD was rated as the most stigmatized condition (Room, Rehm, Trotter, Paglia, & Ustun, 2001. p. 276).

Bartlett, Brown, Shattell, Wright, and Lewallen (2013) identified that undesirable attitudes and behaviors of health care providers (nurses) negatively impact the care patients with SUDs receive, including the quality of the care, the health and well-being, and the recovery of patients with SUDs. Some studies also note that these attitudes and behaviors may be responsible for propagating stigma. Stigmatized individuals experience feelings of guilt and shame that lead to low self-esteem and low self-respect and may lead to feelings of anxiety, depression, and a lower quality of life (Barry, McGinty, Pescocolido & Goldman, 2014; Can & Tanriverdi, 2015; Chang & Yang, 2013). When caring for SUD patients, nurses may display avoidant care such as having decreased engagement, spending less time with the patients, being more

task-oriented, and having less empathy (Can & Tanriverdi, 2015; Van Boekel, Brouwers, Van Weeghel, & Garretsen, 2013). Nurses may also neglect to perform assessments and interventions that would identify SUD patients and their particular complications (Chang & Yang, 2013). This can have direct and harmful effects on patients. Can and Tanriverdi (2015) suggested that patients experiencing stigma often withdraw from society and feel alienated. They also stated that this translated into the patients experiencing adverse effects in obtaining employment and housing and seeking medical care.

Nursing's Social Responsibility

Social justice is a concept that calls for the righting of the unfair treatment of health conditions, as well as social conditions, particularly those that affect the disadvantaged, vulnerable, marginalized, and stigmatized populations (Grace & Willis, 2012). Thompson (2014) identified how nursing scholars have characterized social justice as (a) interventions that emphasize the social, political, economic, and environmental aspects that are detrimental to persons and groups and (b) the effects of race, gender, power, class, and other social relational arrangements that attempt to avoid the disparities, inequalities, and inequities for persons, groups, and communities (p. E18). Social justice is inherent in nursing practice.

Nursing has been involved in matters of social justice since the days of Florence Nightingale. Nightingale understood that actively advocating for changing social circumstances, the environment, and laws that contribute to what we now call the social determinants of health was just as vital as offering compassionate nursing care (Thurman & Pfitzinger-Lippe, 2016). Nurses have a professional and ethical responsibility to enjoin the principles of social justice in their practice. The ANA

asserts that nursing is dedicated to caring for the ill, disadvantaged, underprivileged, underserved, and vulnerable in society, as well as to social justice (ANA, 2017). This accountability derives from three guiding and foundational documents from the American Nurses Association (ANA). These documents provide guidance and direction for the practice of professional nursing in the United States. The first of these documents, the ANA *Nursing: Scope and Standards of Practice* (2015) delineate the expectations of professional nursing practice. Specifically, Standard 7 speaks of ethical practice and social justice. The application of this standard states "the nurse integrates principles of social justice into nursing and policy" (p. 68).

The second of the documents, the ANA *Code of Ethics for Nurses With Interpretive Statements* (2015) makes several references to social justice. Interpretive Statement 1.1 describes the essential principle that inspires the entirety of nursing: "respect for the inherent dignity, worth and unique attributes, and human rights of all individuals" (p. 1). Interpretive Statement 8.1 states that the ANA believes that "healthcare is a human right and that all persons are entitled to ready access to affordable, high-quality health care services" (p. 31). Interpretive Statement 8.2 states that "ethics, human rights, and nursing converge as a formidable instrument for social justice and human rights… ." The statement goes on to note that "nurses must address the context of health, including the social determinants of health … and healthcare disparities." The statement concludes that "human rights must be diligently protected and promoted…" (p. 32). Interpretive Statement 8.4 notes that nurses should highlight human rights violations and be responsive when these violations are confronted (p. 33). Interpretive Statement 8.4 also encourages nurses to emphasize the protection of

human rights, particularly safeguarding the rights of the vulnerable, marginalized, and stigmatized groups (p. 33).

The third document, the ANA *Social Policy Statement* (2015) conveys the considerations of a social contract that exists between nursing as a profession and to society and its health and health policies (p. 19). This document interweaves and explicates the *Nursing: Scope and Standards of Practice and Code of Ethics for Nurses with Interpretive Statements*. Society has certain expectations of the nursing profession. These expectations include "honesty, ethical standards, and competence" (p. 20). An expectation of society is that nursing will address social justice issues and issues of health disparities and will advocate for the resolution of these issues. The expectations of nursing's social contract with society originate from the ANA definition of nursing as "the protection, promotion, and optimization of health and abilities, prevention of illness and injury, alleviation of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, communities, and populations" (p. 23). The attitudes and behaviors of some nurses who care for patients with substance use disorders may be in direct conflict with the three foundational documents that serve to guide nursing practice.

Social justice is a value that is an important value to this researcher. Social justice is one of Barry University's (BU's) core commitments. This is clearly stated in the BU Mission statement:

> Barry expects all members of our community to accept social responsibility to foster peace and nonviolence, to strive for equality, to recognize the sacredness of Earth, and to engage in meaningful efforts toward social change. The

University promotes social justice through teaching, research, and service. (Barry University, 2008)

Stigma

Stigma was first described by the ancient Greeks who used "bodily signs designed to expose something unusual and bad about the moral status of the signifier" (Goffman, 1963, p. 1). In his seminal work, *Stigma: Notes on the Management of a Spoiled Identity*, sociologist Ervin Goffman, described stigma as "an attribute that is deeply discrediting," and this turns a person "from whole and usual to a tainted, discounted one" (p. 3). Goffman also stated that stigma "is really a special kind of relationship between attribute and stereotype…" (p. 4). He also noted that the stigmatized person "…is disqualified from full social acceptance" (Goffman, 1963). Goffman popularized the concept of stigma as dehumanization because of an individual's social identity, objectionable social state, or social identity and one's behavior in response to others expectations (Goffman, 1963). The consequence of the stigma, shame, disgrace, and humiliation became more significant than the actual "mark" (Streunkel & Wong, 2013). This mark or negative label has come to denote a connection to negative stereotypes or discrimination (Link & Hatzenbuehler, 2016). A person who is stigmatized is generally thought of as unimportant, devalued, and flawed in important ways.

Since Goffman's classic work, the areas of the behavioral sciences, public health, sociology, social psychology, and psychology have broadened and evolved the stigma research. There are now several more classifications of stigma that are known to impact persons with SUD: public stigma, self-stigma, perceived stigma, and structural or

institutional stigma, to name a few. Public stigma refers to the public support or encouragement of prejudice or discrimination against a specific group and may include stereotypes (Corrigan, Morris, Michaels, Rafacz, & Rüsch, 2012; Luoma et al., 2013).

Self-stigma is the negative feelings, thoughts, poor self-image, and feelings of devaluation that an individual acquires and internalizes by being part of a stigmatized group (Livingston, Lang & Amari, 2011; Luoma et al., 2013). Perceived stigma refers to the values that members of a stigmatized group have about the prevalence of stigmatizing attitudes and actions in society (Luoma, O'Hair, Kohlemberg, Hayes, & Fletcher, 2010). Structural or institutional stigma occurs when the policies and practices of private and governmental institutions intentionally limit prospects or when an institution's policies are not intended to discriminate but impede individuals' opportunities (Corrigan, Markowitz & Watson, 2004). These types of stigma have a variety of negative effects on persons with SUD. SUDs are regularly categorized as some of the most stigmatized conditions. In study undertaken by the World Health Organization (WHO) that examined 18 of the most stigmatized conditions, alcohol SUD was classified as the fourth most stigmatized condition. Illicit drug SUD was rated as the most stigmatized condition (Can & Tanriverdi, 2015; Livingston et al., 2011). Research on stigma is considerable but has not focused on the stigma of the substance using population, instead concentrating on mental health, HIV, and other stigmatized groups (Kulesza, Larimar, Rao, 2014; Luoma et al., 2010; Smith, Earnshaw, Copenhaver, 2016). Nurses, as members of society, hold attitudes and behaviors that tend to mirror those of the society around them. These may be based on cultural or religious ideologies from their upbringing.

Goffman (1963) observed that stigmatization is a social process that occurs within cultural relationships and develops from a social perspective of time and place. Stigmas are, therefore, fluid and subject to change with time and context. Pescosolido and Martin (2015) commented that "stigmas reflect the fault lines in a society at any one point and are as artificial and subject to change as national boundaries on a world map" (p. 91). If a society stigmatizes persons with SUD, nurses may also stigmatize persons with SUDs. In fact, nurses have been found to be more judgmental than other health care workers (Bartlett et al., 2013).

Statement of the Problem

Nurses have a duty to care for all patients with the same compassion, respect, and dignity, regardless of the patients' diagnosis (ANA, 2015). Substance use disorders are among the most stigmatized of all conditions (Phillips & Shaw, 2013; Van Boekel et al., 2013; WHO, 2014). Studies suggest that nurses' behaviors and language reinforce this stigma, which can negatively impact the health outcomes of patients with substance use disorders (SUDs) (Chang & Yang, 2013; Nilsen et al., 2013; Neville & Roan, 2014). Research exploring nurses' attitudes and behaviors in their role of caring for SUD patients is needed. Findings could generate a substantive theory that enhances nursing's understanding of how to minimize or eliminate the effects of stigmatization in the nursing care provided to this vulnerable and marginalized population.

Purpose of the Study

The purpose of this qualitative constructivist grounded theory study was to develop a middle-range theory explicating the process of nurses caring for substance use disorders (SUDs) patients. A substantive theory constructed from nurses' attitudes and

behaviors may provide the framework needed to minimize the effects of stigmatization in the nursing care provided to the vulnerable and marginalized population

Research Questions

The principal research question to be addressed in this study is, "What are the critical factors that influence the attitudes and behaviors of nurses caring for SUD patients?" Associated questions are, "How do nurses describe the experiences that influence their attitudes and behaviors while caring for SUD patients?" and "How do nurses describe their decision-making processes in choosing interventions when caring for the SUD patient?"

Philosophical Underpinnings

Paradigms are worldviews that create a backdrop for how the research investigation is undertaken. A researcher chooses the paradigmatic lens to view the exploration of the phenomena. Constructivist grounded theory methodology has several philosophical underpinnings. These include interpretivism, constructivism, constructionism, pragmatism, and symbolic interactionism.

Interpretivism

The interpretivist worldview came about as a critique of positivism. It is derived from the teachings of Max Weber who purported that the human or social sciences should have *Verstehen* (understanding) (Crotty, 2013). Crotty also noted that that "interpretivism 'entails an ontology in which social reality is regarded as the product of processes by which social actors together negotiate the meanings for actions and situations" (p. 11). This framework approach asserts that the social reality aspect is different than natural reality because the individuals are human beings and they interact

with each other. Lor (2011) noted that "…for interpretivists, knowledge of the world is the result of an intentional process, on the part of the researcher, of making sense of the world (p .4). Interpretivism highlights the way in which people understand how behaviors and actions are perceived by others (Weaver & Olson, 2006). The Interpretive tradition allows for studying social and human interactions. According to Creswell (2013), the qualitative researcher uses an "interpretive/theoretical framework that informs the study of research problems addressing the meaning individuals or groups ascribe to a social or human problem" (p. 44). Weaver and Olson (2006) noted that "the interpretive paradigm emphasizes understanding of the meaning individuals ascribe to their actions and the reactions of other" (p. 460). Interpretivism developed to "understand and explain human social reality" (Crotty, 2013, pp. 66-67). Interpretivist research "is guided by the researcher's set of beliefs and feelings about the world and how it should be understood and studied" (Denzin & Lincoln, 2005, p. 22). Interpretivists accept multiple meanings and ways of knowing and acknowledge "objective reality can never be captured. I only know it through representations" (Denzin & Lincoln, 2005, p.5). The interpretive paradigm focuses primarily on recognizing and narrating the meaning of human experiences and actions (Fossey, Harvey, McDermott, & Davidson, 2002).

Constructivism

Constructivism posits that knowledge and meaning are constructed by persons as they participate in their world (Crotty, 2013). In constructivism, meaning and truth are formed by how the participants interface with the world around them, unlike positivism, in which meaning is discovered. With constructivism, knowledge is individually constructed. In constructivism, each person constructs meaning in different ways. It is "the idea that people 'construct' their

own individual realities" (Rodgers, 2005, p. 154). These constructions of individual realities become understood as objective realities. Because people construct their own realities, there are then multiple realities—"there are as many realities as people" (Denicolo, Long, & Bradley-Cole, 2016). Knowledge is derived from an individual's personal constructive activities. Crotty (1998) described constructivism as "the unique experience of each of us. We each have our own way of looking at the world and each of these ways is legitimate" (p. 58).

Constructionism

Constructionism is a framework that is created internally from constructs. These constructions are the perceptions that are held and how the world is viewed. They are changeable and as such have a significant effect on the worldview (Berger & Luckmann, 1966). Constructionists hold the view that knowledge is not discovered, but rather it is created (Schwandt, 2003). People construct their realities within a social, cultural, and historical perspective. How an individual's worldview is created is informed by culture and language (Patton, 2002). Language and culture are social constructs created by individuals and the groups of individuals who define it. Social constructionism is a framework that espouses people create their own social realities by individual and shared action (Bryant & Charmaz, 2013). Berger and Luckmann discussed this in terms of social constructionism and how an individual's "social reality is constructed, managed and sustained" (Denzin & Lincoln, 2011). They believed that society has both objective and subjective realities (Berger & Luckmann, 1996). Crotty (1998) remarked that "social constructionism emphasizes the hold our culture has on us: it shapes the way we see

things (even in the way in which we feel things!) and gives us a quite definitive view of the world" (p. 58).

Qualitative Research

Qualitative research examines diverse social settings and the individuals who exist within them (Berg, 2009). Creswell (2013) noted that qualitative research is utilized when there is a need to understand the context of an issue, the process that people undergo, the thoughts and beliefs they hold, and their interaction. The qualitative approach is rooted in the interpretive worldview. This naturalistic lens is supported by the previously discussed worldviews. A qualitative research approach utilizes philosophical assumptions that are distinctive of this perspective.

The qualitative approach is the framework for the type of research, which allows the researcher to become an observer of life and its social context. Denzin and Lincoln (2011) describe qualitative research as:

> … a set of interpretive, material practices that make the world visible. These practices transform the world. They turn the world into a series of representations, including field notes, interviews, conversations, photographs, recordings and memos to self … qualitative researchers study things in their natural settings, attempting to make sense of or interpret phenomena interms of the meanings people bring to them. (p. 3)

Qualitative research examines diverse social settings and the individuals who exist within them (Berg, 2009). Creswell (2013) noted that qualitative research is utilized when there is a need to understand the context of an issue, the process that people undergo, the thoughts and beliefs they hold, and their interaction. Qualitative approaches

that may be employed are phenomenology, ethnography, narrative, case study, and grounded theory. Creswell (2013) described five philosophical assumptions that apply to all research endeavors. Ontology entails the nature of reality. In qualitative inquiry, the ontological assumption of relativism is that each individual has their own reality and therefore reality is seen through multiple views (Creswell, 2018). These multiple realities may be social or experientially based: local or specific (Guba & Lincoln, 2005). Epistemology asks how we know what we know and what is the role of the researcher to what is being researched. A subjectivist epistemology informs this study. The relationship between the researcher and the participants is fundamental in establishing how the knowledge is co-created. The epistemological assumption takes the form of how the researcher acquires the knowledge needed to inform the research question. Inquiring of the participants' subjective experiences and perceptions of their world, as well as the researcher's subjective experiences and perceptions, will inform this study. The relationship between the researcher and the participants is fundamental in establishing how the knowledge is co-created and shared. It is this interaction that appraises the search for knowledge.

Axiology describes the role of values in research. The axiological assumption encompasses the value of the study as well as the values the researcher brings to the study (Creswell, 2018). To be true to the method of inquiry chosen, the researcher must explore her own values and beliefs so as not to impose these onto the study. The researcher's values were constantly self-evaluated through the process of memoing and journaling. Rhetorical involves the language being used to describe the study, establish rigor and report the findings. The researcher uses the language of the research in which

she is engaged in. Qualitative researchers use the research language of qualitative research: confirmability, dependability, credibility, and transferability (Creswell, 2007). The researcher also ensures that the data comes from the voice(s) of the participants by using their words and descriptions. Methodology concerns the design of the study. Methodological assumptions will include using inductive processes so that the findings may emerge collectively from the participants and the researcher's experiences. If necessary, the questions asked may need to be amended to better answer the research question or to understand the problem (Creswell, 2018).

Grounded Theory

Grounded theory is a research method that employs an inductive methodology. The purpose of grounded theory is to generate a theory informed by the data (which is garnered from the participants), rather than using the data to test an existing theory (Glaser & Strauss, 1967). It is a method that is used to reveal a social process or social relationships (Creswell, 2013). Initial data is collected using purposive sampling. Coding of data identifies categories. The data is collected, and the categories are analyzed simultaneously using constant comparative analysis method. This allows the data to be compared and contrasted. Theoretical sampling occurs in order to extend the data collection so that new data can inform the previous data exploration (Engward, 2013; McCann & Clark, 2003).

Grounded theory has three main approaches to offer the researcher. Grounded theory was originally developed in 1967 by Barney Glaser and Anselm Strauss. This is now known as traditional or classical grounded theory. This method drew upon the positivist background of Glaser and his ideas of stringent coding methods and emphasis

on discovering emergent theories. Strauss drew upon the pragmatist/symbolic interaction perspective. His ideas emphasized emergent processes and social and interpretive meanings of action to grounded theory (Charmaz, 2006). Data is systematically collected and analyzed in order to generate theories about human behavior, with the intention of developing a theory that emerges from the qualitative data of the participants, rather than testing a hypothesis as in quantitative research (Charmaz, 2008; Corbin & Strauss, 2008; Glaser & Strauss, 1967). Glaser believed that theories emerge from core categories that are the products of basic social processes (BSP). Glaser (1978) wrote that "basic social processes are fundamental patterns in the organization of social behavior as it occurs over time, the BSP *conception* is a generic theoretical construct…" (p. 16). Glaser also stated that there are two types of BSP: a social psychological process (BSPP) and basic social structural process (BSSP) that may be discovered (p. 11). Glaser and Strauss used data collection, analysis, and constructing codes and categories from data, rather than from hypotheses. This is the constant comparative method, which is ongoing throughout the process. Theory development occurs throughout each step of data collection and analysis. Theoretical sampling is for theory construction.

In 1978, Strauss, and later, with his new partner, Corbin, shifted from classic grounded theory and towards a "verification" of theory, which included more systematized data coding procedures (Charmaz, 2008, 2015; Corbin & Strauss, 2008, 2015). This grounded theory method has been termed by some as "evolved grounded theory" (Ramalho, Adams, Huggard, & Hoare, 2015). The terminology, "evolved grounded theory" emanates from the metamorphosis in thinking about grounded theory. Strauss and Corbin "evolved" their methodology to include the variety of differing

perspectives and “truths;” their work became more about interpretation and inclusive of the voices of whom they were studying (Mills, Bonner & Francis, 2006). Strauss and Corbin’s evolved method permitted a limited literature review as long as it did not intrude on theory creation (Corbin & Strauss, 2015; Ramalho et al., 2015). The next grounded theory approach is the constructivist approach, which looks for meanings, as well as views, values, beliefs, and the interconnection of the society of both the participants and the researcher.

Constructivist Grounded Theory

Constructivist grounded theory was developed by Kathy Charmaz in the mid-1990s (Higginbottom & Lauridsen, 2014). Charmaz’s method embodies a constructivist-interpretive viewpoint, which incorporates relativist ontology and a subjectivist epistemology (Denzin & Lincoln, 2013). Charmaz (2014) describes constructivism as “a social scientific perspective that addresses how realities are made” (p. 342). Charmaz’s approach is rooted in the original methodologies of the founders of classic grounded theory, Barney Glaser and Anselm Strauss, and later, Strauss and Corbin (Charmaz, 2014). However, Charmaz’s constructivist approach has some significant differences. The main difference is that instead of “discovering theories,” she put forth that the theories are co-constructed (Hall, Griffiths, & McKenna, 2013).

According to Charmaz (2006), constructivist grounded theory addresses how “people’s actions affect their local and larger social worlds” (p. 132). Charmaz (2006) seeks to appreciate the variances and distinctions among the participants and to co-construct meaning with them. Constructivist grounded theory looks for meanings, as well as views, values, beliefs, and the interconnection of the society of both the

participants and the researcher. The researcher is an integral part of the process. Charmaz expressed that the researcher cannot detach themselves, their knowledge, or their experiences from the research process. The researcher is grounded in "their perspectives, privileges, positions, interactions and locations" (Charmaz, 2009). The researcher needs to inquire as to what is going on as the social process emerges: What actions, conditions, and processes are occurring as the processes occur? Charmaz (2014) recommended concentrating on the process as it occurs along with the words. The researcher is an integral part of the process.

The theory that is generated by constructivist grounded theory is a co-construction of the researcher's and the participant's constructions (Charmaz, 2006; Mills, Bonner, & Francis, 2006). Part of the researcher's experience is the use of literature. Glaser argues that any review of literature interferes with the emergence of theory. He then revised his position to permit literature to be used later in the process, in a limited manner, and then only non-professional material (Ramalho et al., 2015). Charmaz's constructivist approach allows "shared experiences and relationships with participants and other sources of data" (Charmaz, 2014, p. 239). Charmaz partners with the participants and infuses the researcher's knowledge and experience. Two theoretical frameworks are foundational to grounded theory: pragmatism and symbolic interactionism.

Pragmatism. In 1878, a philosophical perspective (later to become known as pragmatism) was put forth by C.S. Pierce, a sociologist (McCready, 2010). It was not until 20 years later that William James began discussing and expanding on Pierces original thoughts and actually termed it pragmatism (Maddux & Donnett, 2015;

McCready, 2010). Pierce referred to his work as practicalism (Maddux & Donnett, 2015). Although James wholly credited Pierce with the originating doctrine of pragmatism, Pierce did not care for James' "empirics-focused principles" and renamed his ideology as "pragmaticism" (McCready, p. 193, 2010). James is thought to be the co-founder of pragmatism and the leading influence of pragmatism (McCready, 2010). The perspective of pragmatism posits that practicality or worthwhileness of the phenomenon is superior to inductive knowing. It is a perspective that is based on action and the interaction of people. The truth is discovered through inductive methods via interactive interpretation (Munhall, 2012). The researcher attempts to understand the phenomena of interest through the experiences of the participants in order to explain the social processes being experienced (Creswell, 2013; Munhall, 2012; Patton, 2012,). The pragmatist's thinking is that if the knowledge that is produced offers practical experience and is valuable, it is worth pursuing (Corbin & Strauss. 2008; Munhall, 2012). Pragmatists believe that practicality is of the utmost importance and that theories are based on practical application and actions. This is how individuals come to understand their world. The meanings materialize from useful actions to resolve problems (Charmaz, 2014). Pragmatism maintains that findings may be reviewed and adjusted to create improvements using inductive means and reflection to garner ore of the human experience (Munhall, 2012). It is fluid in nature and may have many interpretations (Charmaz. 2014). There is a strong emphasis on the outcomes of the inquiry. William James writes "pragmatism is the attitude of looking away from first things, principles, "categories" supposed necessities; looking away towards last things, fruits, consequences, facts" (Crotty, 1998, p. 73). Pragmatists may use a variety of methods to collect data

using whatever works to achieve the goals. The problem, not the methodology, is important. Pragmatism informs symbolic interactionism (Charmaz, 2010).

Symbolic interactionism. Symbolic interactionism (SI) was an idea first developed George H. Mead, a sociologist, and later made known by Herbert Blumer, also a sociologist, when he coined the term (Berg & Lune, 2012). SI is a theoretical perspective that seeks to investigate what transpires within a person's world. Blumer (1969) stated that it is a term that "...has come into use as a label for a relatively distinctive approach to the study of human group life and conduct" (p. 1). Blumer based SI on three premises:

1. Human beings act toward things on the basis of the meanings that the things have for them.
2. The meaning of such things is derived from or arises out of, the social interaction that one has with one's fellows.
3. These meanings are handled in and modified through, an interpretive process used by the person in dealing with the things he encounters. (p. 2)

Symbolic interactionism (SI) is based on the societal interaction of people or groups of persons and the interpretation of the meanings of these interactions. Everything that individuals say or do is dependent upon how they understand their collective world (Berg & Lune, 2012). SI sees human beings as active participants in their social environment. In SI, people attach meanings to things, situations, or people. Those meanings derive from the actions or interactions of those involved. The meanings of things develop from the way people act towards the individual about whatever that thing is (Blumer, 1969). Symbols are germane to the very nature of SI: "language,

communication, interrelationships, and community" (Crotty, 1998). Symbols are how humans interact and communicate and know each other's activities and behaviors. Language is the most significant symbolic process used by people (Milliken, 2012). Crotty (1998) noted that it is language (dialogue) that permits the awareness "of the perceptions, feelings, and attitudes of others" (p. 75). How language is used and the meanings that people attribute to language are what shape social interaction—for better or for worse (Blumer, 1962). Those meanings may be transformed by interpreting those symbols or meanings to handle their domain of existence (Munhall, 2012). The meanings are created and shared and then become the reality (Patton, 2012). Changes to the language can also change the social reality.

These symbols are culturally and historically based. Various groups may use the same language but attribute a different meaning to the words (Milliken, 2012). SI seeks to describe the social interactions by analyzing the data revealed from the participants who have the first-hand experience with the phenomenon. According to Streuert Speziale and Carpenter (2007), individuals "…behave and interact based on how they interpret or give meaning to specific symbols in their lives, such as the style of dress, or verbal and nonverbal expressions" (p. 134). Charmaz (2014) remarked that "symbolic interactionism assumes that people can and do think about their lives and actions rather than respond mechanically to stimuli" (p. 9). The interpretive/constructivist philosophical perspective and pragmatic and symbolic interactionism viewpoints served to inform the research approach chosen for this study.

Relationship of Constructivist Grounded Theory to the Study

Constructivist grounded theory is an ideal research method to investigate the

social process nurses display about the attitudes, behaviors, misconceptions, specious stereotypes, and stigmas that surround the substance use disorders (SUDs) population. The constructivist grounded theory approach of Kathy Charmaz is the most effective method to answer the research question: What are the critical factors which influence nurses' attitudes and behaviors in caring for SUD patients? Selecting the constructivist grounded theory method was also chosen due to a priori knowledge experience, as well as a deep awareness of the literature that was brought to this study. These may serve to inform interpretations of concepts and theories that may be generated. Using constructivist grounded theory allowed the researcher to bring personal and professional experiences to the construction of the theory. Charmaz (2014) noted that "what we bring to the study also influences what we *can* see" (p. 27). It is, therefore, incumbent upon the researcher to practice reflexivity. Practicing reflexivity means the researcher self-examines "interests, positions, and assumptions" and how these may have influenced the study (Charmaz, 2014).

Significance of the Study

It was anticipated that the results of this study will have meaningful implications for disciplines outside of nursing such as psychology, social psychology, psychiatry, and social work since there are no known theories on nurse's attitudes and behaviors by these disciplines. This study may influence the overall scientific community in relation to the advancing of grounded theory method. Grounded theory is a method of discovery that embraces the views of the participants and may include the inquiry of a social process that will lead to the generation of a substantive theory. Grounded theory methodology is ideal for research areas that have limited or no well-developed theories. As Charmaz

indicated (2003), constructivist grounded theory speaks to "human realities and assumes the existence of real worlds" (pp. 272-273). It is hoped that this study will offer a new theory, which has been constructed from the participant data, concepts, and categories to explain nurse's attitudes and behaviors toward patients with substance use disorders.

Significance of the Study to Nursing

This study is significant in that nurses are often unaware of how their attitudes and behaviors influence the nursing care of patients with substance use disorders. The creation of a middle range theory regarding nurses' attitudes and behaviors toward caring for persons with substance use disorders will provide a foundation to improve nursing practice, education, research, and health/public policy. Smith and Parker (2015) noted that nursing theories guide advancement and direction for nursing. Nurses have an ethical obligation to incorporate theoretical knowledge into whatever their nursing role may be. The knowledge acquired by investigating this proposed study problem may lead to interventions being developed that identify and alter negative attitudes, behaviors, and perceptions that are held by nurses and other healthcare providers towards patients with SUDs. A better understanding of stigmatizing attitudes and behaviors by nurses could lead to positively changing the negative effects of stigma towards SUD patients and advance positive healthcare outcomes.

Implications for Nursing Education

Nursing education is ripe for current information about caring for patients who have substance use disorders. Substance use disorder education is not emphasized in undergraduate nursing education. This is evidenced by multiple studies where nurses indicate that they lack the knowledge and the requisite confidence and competence to

care for patients with substance use disorders. It is only very recently that a few graduate (nurse practitioner) programs are beginning to include some basic substance use education. Nursing educators are the first line for building an effective substance use curriculum. However, faculty will also need substantive education on substance use and addiction across the continuum to implement a patient-centered curriculum. Both didactic and clinical experience with substance use disorders patients are needed. De Vargas (2013) noted that when students have both didactic with clinical experience, students obtained higher scores on the knowledge assessment and had more positive attitudes towards these patients. A theoretical framework of the attitudes and behaviors of nurses caring for substance use disorder patients could furnish the structure needed for introducing substance disorder curriculum and faculty development into nursing education at all levels.

Implications for Nursing Practice

Nurses will encounter substance use disorder patients in all healthcare settings. The attitudes and behaviors nurses' exhibit while caring for these patients can have a significant and negative impact on the quality of their health and well-being (Can & Tanriverdi, 2015). A middle range framework regarding the attitudes and behaviors of nurses could serve to provide the knowledge to enhance nursing practice. Awareness of an individual's attitudes and behaviors and the effects and consequences is the first step in changing practice. Nursing theories guide nursing practice.

Implications for Nursing Research

Several studies exist on the attitudes and behaviors of nurses toward substance use disorder patients. However, there are no theories or inquiries that propose how a

theoretical framework on attitudes and behaviors of nurses toward substance use disorder patients may guide nursing research, education, practice, or health policy. Once a theoretical framework evolves from the data, it needs to have the concepts and constructs tested employing a quantitative method. This will generate the knowledge needed to then be able to use this middle range theory as a guide to the nursing care of substance use disorder patients.

Implications for Health and Public Policy

In the United States (U.S.), there is a long history of negative attitudes and behaviors towards persons who use/misuse chemical substances. This has a great impact on the health policies in the U.S. With the generation of a theoretical framework, nurses may be better able to understand the dynamics of caring for this patient population. A mid-range theory may also bring about a positive awareness of the policy issues impacting these patients. This framework may provide a foundation for nurses to have an increased involvement with public health issues of health disparities as well as advocacy for this group of patients.

Scope and Limitations of the Study

The scope of this study is limited to current working registered nurses in Florida. The aim of the study is to develop a constructive grounded theory of nurses' attitudes and behaviors who care for patients with substance use disorders. The limitations of the study include the sample selection. The sample was selected from registered nurses (RNs) who work with patients who have substance use disorders in any healthcare setting. The geographic location was limited to those RNs located in South Florida. The sensitive topic of nurses' attitudes toward this particular group of patients may discourage some

nurses from participating in the study or from being forthcoming about their attitudes and behaviors. Some participants may present experiences with a more positive portrayal so as not to be perceived as unethical. Researcher biases may be a limitation of the study. Another limitation was that the researcher is a novice researcher and not an expert in the use of grounded constructivist theory methodology.

Chapter Summary

The purpose of this qualitative constructivist grounded theory study was to develop a middle-range theory explicating the process of nurses caring for substance use disorders (SUDs) patients. This chapter discussed the background of nurses' attitudes and behaviors towards persons with substance use disorders and the ethical implications. This study was guided by the philosophical underpinnings of symbolic interactionism and pragmatism. The research question to be addressed is "What are the critical factors influencing nurses' attitudes and behaviors toward substance use disorder patients?" The significance of this study to nursing, nursing education, nursing practice, nursing research, and health/public policy was described. The scope and limitations of the study were also discussed. Chapter Two considered a literature review pertinent to the inquiry of nurses' attitudes and behaviors toward patients with SUDs. An experiential context is also provided.

CHAPTER TWO

REVIEW OF THE LITERATURE

The purpose of this qualitative constructivist grounded theory study was to develop a middle-range theory explicating the process of nurses caring for SUD patients. A substantive theory constructed from nurses' attitudes and behaviors may provide the framework needed to minimize the effects of stigmatization in the nursing care provided to this vulnerable, marginalized population. The traditional grounded theorist Glaser (1967) does not subscribe to performing a literature review. He believes the researcher should approach the research with a *table rasa* or a blank slate. Charmaz (2014) argued that a literature review is necessary to be informed on the topic and to place the study in context. To accomplish this, a review of the literature was conducted seeking research published between 2009 and 2016.

The literature review began with the broad topics of a general search of nurses' perceptions, attitudes, values, beliefs, and stigma towards patients with substance use disorders. A more specific review of general hospital nurses' perceptions, attitudes, values, beliefs, and stigma toward hospitalized patients with SUD was then undertaken. A review of stigma follows. The search approach involved using electronic databases using CINAHL, ProQuest, PsychInfo, Medline, and PubMed. These databases were utilized to identify English, full-text, peer-reviewed articles relating to the phenomena of interest. Manual investigation of article references and specialty journals broadened the literature search. Keywords included: *substance abuse, substance use disorders, addiction, attitudes, nurses, and stigma. substance abuse, substance use disorders, addiction, attitudes, nurses,* and *stigma.* The topics in the review comprise nurses'

perceptions, stigma, discrimination, caring, and ethics. The content areas in this review comprise three categories: (a) historical context, (b) stigma, and (c) nurses' perceptions. The chapter begins with a historical review of drugs and alcohol, the researcher's experiential background, and the literature review.

Historical Context

People have been using drugs and alcohol since prehistoric times. Saah (2005) noted that several early civilizations have left archaeological evidence of their use of betel nut (Thailand), nicotine (indigenous populations of Australia and North and South America), khat (Ethiopians and North Africans), and cocaine (Ecuadorians). Fermented brews (wines, beers, and ales) have been known to be consumed worldwide for thousands of years (Hanson, 2013; Room, Babour, & Rehm, 2005). These plant and alcohol substances were believed to have a sacred function and were used to connect with the spiritual world (Guerra-Doce, 2014). In Hanson's (2013) historical review of alcohol, he noted the ancient Egyptians believed beer was an essential part of daily life. Hanson also described alcohol use by the ancient Hebrews, Mayans, Babylonians, Chinese, Greeks, Romans, and Persians. Some of the imbibings were for religious ritual, celebrations, and medicine. In ancient Greece, drinking alcohol was thought to be a civic duty. Plato wrote in his treatise, Republic, that the youth should be encouraged to drink so they can learn moderation (2013). It was in Aristotle's *Nichomachean Ethics* that "addiction" was first examined (Franzwa, 1998). Aristotle defined four views or types of addiction behaviors:

> …the self-indulgent person; one who participates in harmful behaviors intentionally, the incontinent person; has passions that are too strong to resist, the

> physically ill or damaged person; one not to be held accountable, and the badly habituated person, who might actually be "curable." (p. 93)

Franzwa contends that Aristotle's "types" may have been the forerunner of the modern-day sin/moral vs. sickness/medical model of addiction. Drinking alcohol has persisted as an important part of all societies and in all countries, even becoming an economic source. In the 16th-century version of the Oxford English Dictionary defines, addiction as the devotion to someone or something (Franzwa, 1998). It was not until the 1880s that words referring to addiction or persons with an addiction took on a completely different meaning. Heise (2003) wrote that addiction began to be known as "habituation" and those persons with "habitués" were "weak-willed and moral failures but were generally considered harmless" (p. 117). In the late 1800s, the Massachusetts State Hospital for Dipsomaniacs and Inebriates declared inebriety as a disease. Inebriation (alcoholism) had been medicalized (Heise, 2003, p. 119).

Medical personnel were becoming concerned over the level of addiction they were seeing. It was believed that nearly a quarter of a million people were believed to now be addicted to the popular medications of opium, cocaine, heroin, and morphine (Heise, 2003; Scott, 1998). An increase in crime was being blamed on the fears of the public and minorities (Blacks, Chinese, and Mexicans) were being accused of corrupting the young and pushing women into prostitution (Heise, 2003). In 1910, Bellevue Hospital in New York admitted its first patient for heroin addiction. By 1915, 425 heroin addicts had been admitted, and most of these were thought to be members of gangs (Scott, 1998).

Scott (1998) Argued that in order to control the spread of immoral behavior, violence, and corruption, a series of laws were enacted. The most significant of these was the Harrison Narcotic Tax Act of 1914. While under the guise of a tax, the Harrison Narcotic Act absolutely banned the sale and nonmedical use of opium and cocaine, as well as using for maintenance for persons with addiction (Scott, 1998). By prohibiting prescriptions for treating persons with heroin, a black market was created. This became a lucrative business for drug dealers. An associated underworld of drugs and prostitution developed both domestically and internationally (Scott, 1998). It was during this time that the term 'junkie' came to be known. The term 'junkie' is thought to have originated among addicts who got together to support themselves by gathering scrap metal from junkyards and selling it. The label 'junkies' was created (Scott, 1998).

Stigma

According to Goffman's seminal work (1963), stigma is "an attribute that is deeply discrediting," and this turns a person "from whole and usual to a tainted discounted one" (p. 3). Goffman further stated that stigma "is really a special kind of relationship between attribute and stereotype…" (p. 4). A person who is stigmatized is generally thought of as unimportant, devalued, and flawed in important ways. This mark or negative label has come to denote a connection to negative stereotypes or discrimination (Link & Hatzenbuehler, 2016). Stigma is a multifaceted social process that serves to marginalize and subjugate people with substance use disorders and mental illness (Kennedy Forum, 2015).

In a systematic review, Van Boekel et al. (2013) reviewed 28 articles that assessed health professionals' attitudes towards patients with substance use disorders and

examined the consequences of these attitudes on healthcare delivery for patients in Western countries. PsycINFO, PubMed, and Embase were the databases reviewed. Some perceived factors impeding health care for these patients are violence, manipulation, and poor motivation. Health professionals reported they did not have adequate training with to work with this patient group. Health professionals may have an avoidant approach to the delivery of care with substance use disorder patients compared to other patient groups, which may result in shorter visits, expression of less empathy, and less patient engagement and retention. The findings revealed that negative attitudes of health professionals towards patients with substance use disorders are common and contribute to suboptimal health care for these patients. However, few studies have evaluated the consequences of health professionals' negative attitudes towards patients with substance use disorders. Future research suggested were studies that explore the consequences of the negative attitudes of health professionals on the delivery of healthcare and studies that are observational. Studies that include the perceptions from the patients' perspective are also needed. Recommendations propose that healthcare facilities and educational organizations provide educational opportunities and that the administrative echelons offer support to the frontline professionals.

Kelly and Westerhoff (2010) conducted a randomized, between-subjects, cross-sectional design study. The objective of the study was to determine if words used to describe a person (substance abuser vs. having a substance use disorder) cause different judgments to be made about behaviors (self-regulation, social threat, treatment vs. punishment). The sample consisted of 516 subjects, attending two mental health conferences (63% female, 81% White, age 51; 65% doctoral-level) completed the study

(71% response rate). A Likert-scaled questionnaire using three subscales ["perpetrator-punishment" (= .80); "social threat" (= .86); "victim-treatment" (= .64)] assessed the perceived causes of the problem, whether the character was a social threat, able to regulate substance use, and should receive therapeutic vs. punitive action. After reading a vignette using one of two terms (substance abuser or having a substance use disorder), subjects rated their agreement with related statements.

The findings indicated that when using the term "substance abuser," stigmatizing attitudes may be produced and perpetuate stigmatizing attitudes. When referring to an individual as a "substance abuser," negative judgments about the person are made about their behavior, indicating that he or she may be a social threat and that punishment is indicated versus treatment. When referring to the person in the vignette as having a "substance use disorder," the person was seen more as a victim and less responsible and in need of treatment. The authors suggested that future research using different questions and vignettes may reveal different outcomes. Recommendations from the authors include avoiding the label of "abuser" as it may cause and enforce stigma. They also recommended that health care policies emanating from national organizations, criminal justice institutions and other policy creating bodies associations eliminate stigmatizing language.

El Rasheed, El Sheikh, El Missiry, Hatata, and Ahmed (2016) conducted a cross-sectional design study. The aim was to test whether there was stigma and negative attitude toward patients with substance abuse among mental health professionals, medical students, psychiatrists, and psychiatric nurses and to test whether stigma varies according to the used substance (alcohol, cannabinoids,

heroin, and tramadol) and compare whether stigma varies among the mental health professional: psychiatrist, psychiatric nurse, medical student. The sample consisted of $N = 467$: 351 graduating med students, 65 psych nurses, and 51 psychiatrists who worked at the Dept. of Neuropsychiatry at University Hospital, Ministry of Health Hospital, Mental Health & Addiction Treatment Centre. Addiction stigma was measured by four scales (Level of Familiarity Scale, Perceived Dangerousness scale, Fear scale, and Social Distance scale).

Statistical analysis used was SPSS version 15. Fisher exact probability was calculated if <5 observations were encountered in any of the table cells. Student *t*-test was used to test differences between two interval variables if parametric, if nonparametric Mann-Whitney U test was used. The *p*-value was set at 0.05. A positive correlation was found between familiarity and age and a negative correlation between perception of dangerousness, fear, and social distance with age regarding all psychoactive substances, which meant that there was an overall negative correlation between age and stigma, as the age increased the addiction stigma decreased.

Findings indicated that stigma was significantly higher ($p < 0.01$) among medical students, whereas it was significantly lower ($p < 0.01$) among psychiatrists and nurses working in Mental Health and Addiction Treatment Center and significantly ($p < 0.01$) decreased with more years of experience. Regarding substance stigma, stigma was significantly lower ($p < 0.05$) toward cannabinoids, whereas it was significantly higher toward heroin ($p < 0.01$). No future research was suggested. However, it was recommended that interventions to reduce stigma related to substance use disorders should be started from medical school. Training and education programs targeting

medical students, psychiatrists, and other members of the treatment team including nurses, psychologists, and rehabilitation specialists are imperative. The authors concluded that the stigma exhibited by these mental health professionals was more impactful negatively because clients expect to be helped and not further alienated by their professionals.

Ronzani, Higgins-Biddle, and Furtado (2009) conducted a non-controlled exploratory study with 609 primary health care providers (PHCs) from two areas in Brazil. This study investigated the stereotypes and moral attributions of PHCs in Southeast Brazil. Two hypotheses that were tested: the use of alcohol and other drugs are the most judged behaviors in relation to other health conditions and personal difficulties among PHCs in dealing with alcoholic patients are greater than with other patient groups. The authors identified an association between Brickman's moral model with the stereotyped pattern of moralization (Models of helping and coping, 1982) and their study. The participant sample consisted of females (86.5%); community health workers (CHW) (54.0%); nursing assistants 13.1%; nurses 11.8%; physicians 8.7%, 18 dental care professionals, 11 social workers, nine psychologists, eight admin techs, 10 students or other professionals with higher education and one listed as "other. The average age of the participants was 36.4 years; the average time working in primary healthcare was 4.9 years. No professionals contacted refused to participate in the study.

The participants responded to four self-administered questionnaires. The first was a sociodemographic questionnaire. The second questionnaire was a judgment scale used five stereotypical statements about alcoholism and alcoholics. The statements were assessed on a seven-point Likert scale. The third questionnaire asked two questions

about the responsibility of health problems: “How much do you think the patient is responsible for the APPEARANCE/DEVELOPMENT of this medical condition?” and “How much do you think the patient is responsible for the RESOLUTION of this medical condition?” These questions were rated on a 1-5 scale as to whether the patient is responsible for the health problem. The final questionnaire was personal difficulty evaluation. It was a single question that asked about the personal difficulty the healthcare professionals have dealing with patients who have health conditions. These were rated on a seven-point Likert scale.

The statistical analysis used was SPSS version 15. Under the moralization category, analysis of moral judgment among professional categories in relation to alcoholics demonstrated a statistically significant difference when comparing these groups (c2¼ 21.8; df¼4; p< 0.01). The group scoring the highest on the judgment scale was nursing assistants (M¼17.6), followed by community health workers (M¼17.5), nurses (M¼ 14.7), others (M¼ 14.6), and finally physicians (M¼ 13.6). These last groups show a significant difference in mean scores in comparison to the nursing assistants (Z¼3.44; p¼ 0.001) and CHW (Z¼2.53; p¼0.01). The ages of the professionals had a positive correlation with moral judgment upon alcoholics (more age, more moralization) ($p < 0.01$). There was no correlation between the judgment scale to alcohol use and difficulty in dealing with alcoholic patients. There was no difference among genders in moralization of alcoholics.

Under the patient responsibility category, the health conditions observed as having the highest incidence of the moral model were, in decreasing order: tobacco use,

marijuana/cocaine dependence, alcohol dependence, HIV/AIDS, obesity, depression, hansen's disease and schizophrenia. When comparing professionals, nurses (68.6%) and nursing assistants (65.3) were observed as demonstrating the highest level of moralization of alcoholism with a marginally significant difference between the groups (c2 ¼14.8; df ¼ 12; p¼ 0.065). As for marijuana/cocaine dependence, the highest frequency of occurrence of the moral model was among nurses (84.1%) and lowest was among physicians (64.2%), with the latter group presenting the highest percentage of professionals. The findings of the study confirm the two hypotheses tested. The behaviors of alcohol and other substance use were the most moralized by PHC professionals. Although there was little difference in the rate of moralization among the behaviors studied, it was expected the use of cocaine and marijuana would be the most moralized as these are illegal substances. Regarding difficulties in dealing with different kinds of patients results also confirmed the hypothesis that PHC professionals perceived patients dependent on alcohol, marijuana, and cocaine as most difficult to treat.

No future research studies were suggested; however, several recommendations were made. The implementation of appropriate training and education for Brazilian PHC professionals who provide health care for the Brazilian people is needed. The implementation of alcohol and drug prevention and rehabilitation service in public health must reflect the importance of the stigmatization toward different groups of patients. Understanding the sociocultural elements involved in the use of alcohol and other drugs is essential to how users are cared for or excluded by health professionals.

This section of the literature review discussed a variety way in which stigma and stigmatizing behaviors were exhibited by healthcare professionals. A systemic review

of 28 articles (Van Boekel et al., 2013) revealed that the stigma exhibited by mental health professionals and other healthcare providers was more impactful negatively because clients expect to be helped and not further alienated by their professionals. The findings revealed that poor attitudes of health professionals towards patients with substance use disorders is common and contributes to suboptimal health care for these patients. Health professionals may exhibit an avoidant approach to the delivery of care with substance use disorder patients compared to other patient groups and this may result in shorter visits, expression of less empathy, and less patient engagement and retention. In another study (Kelly & Westerhoff, 2010), the way words are used was shown to be another way in which persons with SUD may be stigmatized. This study revealed that the language used does indeed matter. When referring to individuals as "substance abuser" (versus "having a substance use disorder"), negative judgments were evoked.

One of the studies (El Rasheed et al., 2016) examined whether stigma varies according to the abused substance (alcohol, cannabinoids, heroin, and Tramadol®). Indeed, some substances used by patients evoked more stigmatizing behaviors from healthcare providers than others. This study also found that age and previous exposure towards patients with SUD was a factor. The fourth study (Ronzani et al., 2009) also found that certain substances (alcohol, marijuana, and cocaine) were more stigmatized than others. This study found that patients identified as dependent on alcohol, marijuana, and cocaine as the most difficult to treat (more than the physical health conditions). It was also noted that the less stigma toward affected individuals, the more likely they will be to seek help and to seek it earlier. In turn, this is likely to diminish

the abundant personal and social harms associated with these pervasive conditions. In all of these studies, different forms of stigma were enacted by healthcare providers. The stigma exhibited by mental health professionals and other healthcare providers was more impactful negatively because clients expect to be helped and not further alienated by their professionals. The findings revealed that poor attitudes of health professionals towards patients with substance use disorders is common and contributes to suboptimal health care for these patients. All the studies noted that the professionals in all disciplines could benefit from more and better substance-related education as well as by more contact-based education.

Nurses' Perceptions

Nursing is known to be a caring discipline, yet there is some evidence that nurses may hold negative perceptions towards persons who have substance use disorders. How nurses perceive persons with SUD can significantly impact the quality of care, the health, and the recovery of patients with SUDs. Monks, Topping, and Newell (2012) conducted a qualitative study in North West England to explore how RNs manage and deliver care to patients admitted to medical wards (with complications of drug use and to elicit the experiences and views of those receiving that care). Strauss and Corbin's grounded theory method was used to guide the inquiry. The study included a combination of a purposive and theoretical sample of RNs (N = 29), working in nine medical wards (and medical ward patients (N = 12) admitted for physical complications of problem drug use) in a large NHS acute hospital in Northwest England in 2008. Data were collected from 41 semi-structured interviews. Data were analyzed using constant comparative analysis and open, axial, and selective coding of the data.

The findings consisted of one core category, “dissonant care,” and two subcategories: “lack of knowledge to care” and “distrust and detachment.” A combination of lack of education, negative attitudes, experiencing conflict, aggression, and untrustworthiness negatively affected the nurse-patient relationship. It was suggested that future research might consist of an observational study to better illustrate how beliefs and perceptions are transferred into behaviors during care delivery. Other recommendations included better education/training and role support to reduce conflict, disruption, and violence and empower knowledgeable care for these patients.

Nilsen et al. (2013) conducted a survey study of 135 nurses from medical, surgical, and oncology areas, as well as “direct care” support staff. The purpose of this study was to investigate the perceptions of RNs caring for hospitalized medical-surgical patients with co-morbid conditions of substance abuse/dependence. The participants were convenience sample from a 200-bed teaching hospital and research facility in the Southwest United States. This study used the Drugs and Drugs Problems Perceptions Questionnaire (DDPPQ), which was completed by seventy nurses and nursing support staff who worked in medical, surgical and oncology areas. The DDPPQ is a 20-item instrument used a Likert scale to measure attitudes and therapeutic commitment in working with drug-abusing patients. The questions asked about role adequacy, role support, and role legitimacy. The Cronbach’s alpha for the instrument was 0.87 (role adequacy = 0.94), role support = 0.78, role satisfaction = 0.80, role self-esteem = 0.69, and role legitimacy = 0.89). The researchers gave the survey again to a larger sample, and the alpha was 0.95.

This study indicated that whereas the medical-surgical nurses questioned had a constructive attitude and a moderately high degree of therapeutic commitment to the drug abusing patient, the nurses. Caregivers may have a more negative perception toward abusers of certain illicit substances, considered ‘‘hard drugs,’’ or of those patients with more limited social resources. The study also showed that while the medical-surgical nurses queried, feel professionally responsible and clinically supported with SUD patients, the nurses indicated that more education on illicit substances, risk factors, outcomes and physical and psychological effects are needed to enhance therapeutic commitment; this information should be specific to the generalist nurse. The researchers indicated that education alone is not enough. Support from the organization, clinical supervision, and mentorship are also needed.

Neville and Roan (2014) conducted a descriptive, nonexperimental, qualitative study of 24 nurses in a community medical center in the Northeast United States. The sample of nurses was drawn from five inpatient units (three adult medical-surgical units, a neurological-orthopedic unit, and an oncology unit). The purpose of this study was to explore 24 nurses' perceptions of caring for hospitalized medical-surgical patients with comorbid conditions of substance abuse/dependence. Constant comparative analysis via coding of categories was used for the generation of common patterns or themes. Nurse participants (N = 24) were recruited from five inpatient units. The participants were predominantly female (96%; n = 23) and baccalaureate prepared (83%; n = 20). Four nurses held associate degrees or a diploma in nursing. As for ethnicity, the breakdown was: White nurses (n = 17), Asian (21%; n = 5), or American Indian or Alaska Native descent (8%; n = 2). Ages varied, with 10 nurses ranging from 20 and 40 years of age,

six nurses between 41 and 50 years of age, and eight nurses between 51 and 55 years of age. Work experience ranged from 11 to 30 years of experience (75%; *n* = 18), three nurses had 6 to 10 years of experience, and only three nurses with less than 5 years of nursing experience.

Four patterns were identified in response to the first question and were as follows: the ethical duty of care, negative perceptions of caring for patients with substance abuse/dependence, need for education, and sympathetic concern. What are your thoughts and feelings about working with patients with substance abuse/dependence issues? This theme represented the majority of responses regarding nurses' perceptions in working with this population. It clearly articulated nurses' negative perceptions and opinioned difficulties in providing care to patients with substance abuse/dependence. Statements reflected intolerance, anger, and the demand of patients with substance abuse/dependence necessitating greater attention and nursing care. The findings indicated that the nurses expressed negative attitudes in challenges in care with patients with substance abuse/dependence and specifically issues of safety, fear, manipulation, quandaries of care, and need for education. (p. 345). The recommendations included improving safety with increased security, encouraging collaboration with other mental health professionals, improving practice with educational opportunities, and creating a debriefing process following a violent incident.

Ben Natan, Beyil, and Neta (2009) conducted a correlational study of 135 nurses "who care for drug addicts" in three central Israel medical centers. The sample of nurses was all from the department of internal medicine (adult medical units). The study purpose was to examine nursing staff attitudes and subjective norms manifested in the

care of drug users. Using the theoretical framework of theory of reasoned action, the researchers were looking to see what degree the nurses provided the same care to drug addicts as they do to other patients in the past year and in the future. A six-point Likert-scaled questionnaire was used. A negative correlation was found between nurses' level of stereotypes concerning drug addicts and nurses' actual behavior (r = -0.32, p =.01). A negative correlation was found between nurses' declarations of difficulty in caring for patients who are addicts and their actual behavior (r = -0.28, p 0.001). Examination of actual care of patients who are drug addicts shows that respondents reported providing high (20%) to very high (41.5%) level of care to patients who are drug addicts. Approximately 6.6% reported that they provided low to very low level of care. Consistent with the model, subjective norm, attitude, and behavior were significantly correlated with intention. The strongest correlation was between intention and attitude (r = 0.61, p =.05), followed by subjective norms (r = 0.32, p=.05). No correlation was found between actual behavior and subjective norms.

The findings indicated nurses with more stereotypical views of patients who are drug addicts perceive the quality of care that they provide to patients who are drug addicts as lower than that provided to other patients. Nurses who indicated difficulties in the care of patients who are drug addicts perceived the quality of care provided in practice to such patients as lower. Examination of actual care of patients who are drug addicts shows that respondents reported providing high (20%) to very high (41.5%) level of care to patients who are drug addicts. Approximately 6.6% reported that they provided low to very low level of care. Of those who reported not having previously cared for patients who are drug addicts (19.3%), the majority reported that they have a high

(38.5%) to very high (38.5%) level of intention to provide quality care to such patients, whereas 3.8% reported that they would provide a very low level of care. No future research was discussed. However, there were several recommendations noted. The authors felt it was imperative to "change nurses' stereotypes towards patients who use drugs" (p. 573). They recommend having guest lecturers. They also suggested having 1-day courses at nursing schools. Another recommendation was to abide by the Patient's Rights Act, which emphasizes care without any discrimination. The authors suggested distributing posters. A final recommendation was to hold workshops for nurses to identify difficulties of caring for drug-addicted patients.

Gilchrist et al. (2011) conducted a multi-center, cross-sectional comparative study from Bulgaria, Greece, Italy, Poland, Scotland, Slovakia, Slovenia, and Spain. The sample consisted of a multi-disciplinary convenience sample of 866 professionals (physicians, psychiatrists, psychologists, nurses (N224), and social workers from 253 services). The study's purpose was to compare regard for working with different patient groups (including substance users) among different professional groups in different health-care settings in eight European countries. The Medical Condition Regard Scale (MCRS) is an 11-item instrument was used to gather data. Descriptive statistics were analyzed using SPSS 12.01, *t*-tests, ANOVA, and post hoc analysis. Multi-factor between-subjects analysis of variance determined the factors associated with regard for each condition by country and all countries.

Findings regarding working with alcohol (mean score alcohol: 45.35, 95% CI 44.76, 45.95) and drug users (mean score drugs: 43.67, 95% CI 42.98, 44.36) was consistently lower than for other patient groups (mean score diabetes: 50.19, 95% CI

49.71, 50.66; mean score depression: 51.34, 95% CI 50.89, 51.79) across all countries participating in the study, particularly among staff from primary care compared to general psychiatry or specialist addiction services ($p < 0.001$). The findings of the study indicated that health professionals appear to ascribe to a lower status to working with substance users than helping other patient groups (DM, depression), particularly in primary care; the effect is larger in some countries than others. Lower regard towards substance users among **nurses** may be explained by their employment in primary care and/or by their background as general nurses, limiting their practical experiences with substance-using patients. Health professionals appear to ascribe lower status to working with substance users than helping other patient groups, particularly in primary care; the effect is larger in some countries than others.

This section of the literature review discussed how nurses perceive the SUD patient. While the negative perceptions may have improved somewhat over the last few years, most nurses still prefer not to care for substance use disorder patients. Nurses feel conflicted about their perceptions of the SUD patient and their duty to provide quality care. These negative perceptions and behaviors have been attributed to lack of education about SUDs, fear for personal safety, and a lack of administrative support.

Experiential Context

This study grew out of my professional experience in working with the substance use disorder patient population for over 15 years. I have become increasingly dismayed by the negative attitudes and behaviors of some of my colleagues towards this vulnerable and often marginalized population. It was something I just did not understand. SUD patients need to be cared for with the same respect and dignity that is given to every other

patient. According to the nurses' Scope and Standards of Practice (2015) Standard 7. Ethics, the nurse "practices with compassion and respect for the inherent dignity, worth and unique attributes of all people" (p. 67). This was not what I was observing in my healthcare experiences. One particular incident occurred when a nurse called to report on patient he was sending to the addiction treatment center. This nurse said he needed to "get rid" of this patient because he had really sick patients to take care. He did not have time to care for "a drunk." Another incident occurred when I was teaching new nurses in the Critical Care Academy. One new nurse expressed that she would never be caring for "that kind of patient"—she would refuse. She did not sign up to work in critical care to take care of drug addicts, junkies and alcoholics. "Those patients" should not be sent to critical care. I was shocked. From my over 40 years in the nursing profession, I have come across patients that sometimes presented challenges in caring. However, I would never ignore them or refuse to care for them. I became increasingly intrigued to find out why some nurses felt and acted in such a stigmatizing way. I also wondered how these negative attitudes might affect the patients who experienced this stigma.

Constructivist grounded theory seemed to be the most logical choice to investigate the how and why of these negative attitudes and behaviors. Because I have extensive clinical experience in addiction nursing, as well as a broad knowledge of the literature that will be brought to the study, Charmaz's approach fit perfectly. Using constructivist grounded theory allowed the researcher to bring personal and professional experiences to the construction of the theory. Charmaz's constructivist approach allowed "shared experiences and relationships with participants and other sources of data" (Charmaz, 2014, p. 239). Charmaz (2014) noted that "what we bring to the study also

influences what we *can* see" (p. 27). It is, therefore, incumbent upon the researcher to practice reflexivity.

Practicing reflexivity means the researcher self-examines "interests, positions, and assumptions" and how these may have influenced the study (Charmaz, 2014). Reflexivity is an ongoing process because the researcher must maintain an understanding of how an individual's perspective may influence the research and the interpretation of the findings (Struebert & Carpenter, 2011). Charmaz (2014) noted that writing memos causes the researcher to pause and examine one's ideas and thoughts. Charmaz (2014) considered that memo-writing an essential part of the journey to theory construction. "Memo-writing encourages you to stop, focus, take your codes and data apart, compare them, and define links between them" (Charmaz, 2014, p. 164). Because of this researcher's comprehensive knowledge of the area under study, she practiced memoing in order to identify how her experiences may have influenced the processes. To limit any preexisting influences or biases that may exist, this author will maintain a reflexive journal to document feelings, perceptions, and reactions as to what is said or done, along with memoing. This process allowed her to document where those feelings fit into the analysis of the data.

Chapter Summary

The purpose of this qualitative constructivist grounded theory study was to develop a middle-range theory explicating the process of nurses caring for SUD patients This chapter discussed a literature review of stigma and nurses' perceptions of working with SUD patients. Also discussed was the historical background of addiction as well as the researcher's experiential involvement with SUD patients. Chapter Three will discuss the methodology of constructivist grounded theory.

CHAPTER THREE
METHODS

The purpose of this qualitative constructivist grounded theory study was to develop a middle-range theory explicating the process of nurses caring for SUD patients. The theory is grounded in the data gathered about the critical factors influencing the attitudes and behaviors of nurses caring for substance use disorder patients. A substantive theory constructed from nurses' attitudes and behaviors may provide the framework needed to minimize the effects of stigmatization in the nursing care provided to this vulnerable and marginalized population. This chapter will discuss the research design of grounded theory, the sample and setting, access and recruitment strategies, and inclusion and exclusion criteria. Data collection procedures, data analysis, and research rigor will also be discussed. Ethical considerations for human protection will also be addressed in this chapter.

Research Design

Research designs are selected to be able to answer the research question (Wood & Kerr, 2011). Research approaches generally take the form of either quantitative or qualitative methods. A qualitative approach using constructivist grounded theory was chosen for this research study. Constructivist grounded theory is the qualitative method that best serves the purpose of the study in order to gain an understanding of the meaning of the critical factors that influence the attitudes and behaviors of nurses who care for patients with substance use disorders.

Charmaz's constructivist grounded theory seeks to appreciate the variances and distinctions among the participants and to co-construct meaning with them (Charmaz, 2006). Constructivist grounded theory looks for meanings, as well as views, values,

beliefs, with the interconnection of the society of both the participants and the researcher. The researcher is an integral part of this process. Charmaz expressed that the researcher cannot detach themselves, their knowledge, and experiences from the research process (2014). The researcher is grounded in "their perspectives, privileges, positions, interactions and locations" (Charmaz, 2009, p. 11). The theory that is generated by constructivist grounded theory is a co-construction of the participant's constructions (Charmaz, 2006; Mills et al., 2006). Just as the participants bring their background and experiences to the research, the researcher also brings her experiences, history, beliefs, opinions, biases, and values, as well as the literature to the research process. All of these factors may affect and influence how the researcher views the research (Charmaz, 2014). The researcher becomes situated within the experience that is being studied and thereby becomes an active co-participant in the developing theory. This allows the researcher to develop an appreciation of the participants' perceptions, experiences and actions (Singh & Estefan, 2018). Charmaz asserted that the researcher's expertise and experience enhance the researcher's ability to co-construct meanings with participants (Tie, Birks, & Francis, 2019). In order to prevent preconceptions from entering into the research, it is imperative that the researcher engages in reflexivity. Taking a reflexive stance permits the researcher to account for his or her position about the phenomena and how they relate to the participants and characterize them in the study.

Constructivist grounded theory does not progress in a formal step-wise development from the research question, data collection, and analysis to the theoretical framework. Rather, constructivist grounded theory proceeds in a more flowing-like manner, where the researcher uses an iterative process, moving between data collection

and analysis in order to ground the findings in the data. Because of the cyclic quality of constructivist grounded theory research, it is challenging to articulate a specific design blueprint. Constructivist grounded theory utilizes an inductive process and naturalistic approach in order to unearth the richest data that is inclusive of the variety of experiences and perspectives of the participants and the researcher. Charmaz (2014) described a series of building blocks or what she describes as "flexible guidelines for collecting and analyzing qualitative data to construct theories from the data themselves" (p. 1). These "building blocks" make up the components of the flow between the data collection and analysis, and using constant comparative processes, which encourages the continuous involvement of the researcher with the data and the emerging design (Charmaz, 2014). The process begins with the data placed into categories and "coded." Initial coding proceeds word by word and then line by line. Focused coding brings forth the codes and categories that may be used to guide the theoretical direction of the study (Charmaz, 2014, p. 140). Once tentative theoretical categories are formulated, and it is found that more data is needed, theoretical sampling may be employed.

Theoretical sampling seeks to further develop and enhance the categories with more data (interviews) (Charmaz, 2014). Once these categories no longer produce new categories, it is called theoretical saturation. Memo writing occurs from the beginning. The researcher keeps memos about the interpretation of these conceptual categories, links to ideas, feelings, and questions as well as keeping the researcher involved in the analytic process (Charmaz & Bryant, 2010). These memos are used to improve the coding process and category development. Memoing is used throughout the coding and category development period and serves as record and documentation of the analytic process used.

When coding and writing memos, Charmaz (2014) recommended using gerunds to promote theoretical sensitivity (p. 245). Gerunds encourage contemplating the actions and processes in the categories. Theoretical sensitivity encourages examining the participants' world from different perspectives and allows the researcher "the ability to understand and define phenomena in abstract terms and to demonstrate abstract relationships between studied phenomena" (Charmaz, 2014, p. 161)..

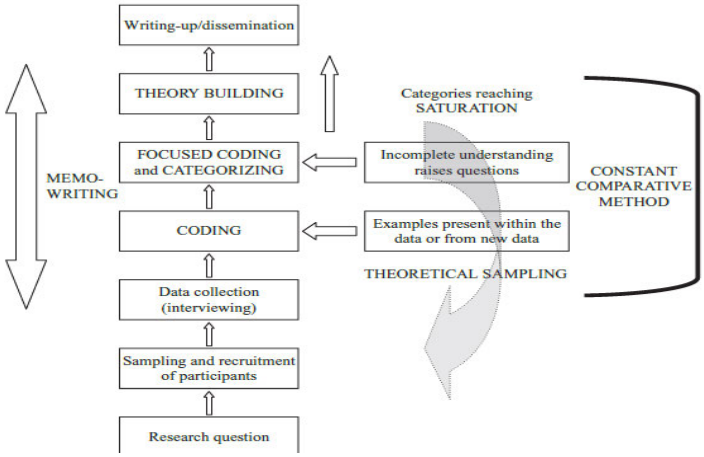

Figure 1. Visual representation of a grounded theory (Blacher, 2019, adapted from Tweed & Charmaz, 2012).

The model depicted in Figure 1 is the methodology that was used to research the critical factors influencing the attitudes and behaviors of nurses caring for substance use disorder patients. While the model appears linear, the actual application is a more cyclical and flowing model. The adapted constructivist grounded theory model shows the iterative process where interviews (data collection), coding (initial and focused), constant comparison, and memoing and were used throughout the study. These processes inform the analysis process as data results are constantly compared, moving back and forth from data, theoretical sampling (interviews), and coding, as the researcher immerses in the data, with thoughts, ideas, perceptions, and using reflexivity during the analysis.

Sample and Setting

Purposive sampling, snowball sampling, and theoretical sampling was used to recruit participants. According to Charmaz (2014), "initial sampling in grounded theory gets you started; theoretical sampling guides where you go" (p. 197). Theoretical sampling may be utilized once data collection commences to elicit more data sources. It is a way to "elaborate and refine categories…to develop the properties of your [categories] (Charmaz, 2010, p. 96). The setting for this study was derived from the two counties of Miami-Dade and Broward, in South Florida. The sample was developed from the researcher's network of professional colleagues and professional organizations. This study was conducted in two phases.

Phase I

In this first phase of the study, recruitment included purposive sampling and snowball sampling. Purposive sampling consists of a group of individuals who meet the inclusion criteria and who have a particular knowledge set that can best inform the research. These persons have firsthand knowledge or experience with the phenomenon of interest. Snowball sampling, sometimes called referral sampling, occurs when the researcher has identified participants who meet the research inclusion criteria and then asks those participants to refer others who also may meet the inclusion criteria and have firsthand knowledge or experience with the phenomenon of interest (Berg & Lune, 2012; Streubert & Carpenter, 2011). Purposive and snowball sampling was used first in selecting participants with relevant background and experiences in caring for patients with substance use disorders. Both purposive and theoretical samples were employed in this study. The recruitment of the participants proceeded in two phases. The total number of participants in both phases consisted of 20 participants.

The initial Phase I sample consisted of 16 registered nurses (RNs). This number allowed the researcher to obtain rich data. Creswell (2018) recommended that 20-30 individuals be interviewed (p. 159). However, Charmaz (2014) was more concerned with reaching saturation; "conduct as many interviews as needed to achieve it" (p. 108). Saturation was reached after 12 interviews. Four more interviews were conducted to ensure that no new data was obtained.

Phase II

A focus group was used to determine concept clarification and confirmation of the co-constructed theory. The focus group included participants known to have significant knowledge of the topic of substance use disorders and who will be able to evaluate the potential theory that was generated. The focus group consisted of four published PhD prepared RNs with expertise in addiction nursing.

Access and Recruitment of the Sample

Upon receiving approval from Barry University's Institutional Review Board (see Appendix A), access and recruitment to participants was initiated. For Phase I, purposive and snowball sampling was employed using the researcher's network of professional colleagues. Because the researcher has worked in several hospitals and belongs to several professional organizations, these professional connections were utilized to access research participants. Recruitment flyers containing information regarding voluntary participation in the study and contact information for the researcher was sent to the researcher's network of professional colleagues via email invitation. The researcher developed flyers that included the purpose of the study, participant characteristics, inclusion criteria, instructions on contacting the researcher, and estimated time required to participate in the study. The flyer also offered a small incentive for

participation and include the invitation for voluntary participation (see Appendix C). The researcher obtained IRB approval to use LinkedIn, a professional social networking site, to post recruitment flyers; however, this site was not utilized. The recruitment occurred in two phases.

Phase I consisted of 16 individual interviews. Individual interviews are conducted in order to generate rich, descriptive data regarding nurses' attitudes and behaviors towards patients with substance use disorders (Creswell, 2013). Potential participants contacted the researcher by email or phone. Once contacted, the researcher interviewed the potential participants to determine if the potential participant met the inclusion criteria. If the potential participant met the criteria, an appointment was made to meet with the researcher for an interview at a mutually agreeable time and date. All who agreed to participate in the study were offered a $20 Target gift card as a token of appreciation, regardless of whether they complete the individual or focus group interviews.

Theoretical sampling was used to guide the Phase II recruitment of four registered nurse experts in addictions and substance use disorder nursing. A total of five focus group participants were recruited, however, one participant had to cancel at the last minute. Theoretical sampling was used to direct the Phase II recruitment. The purpose of the focus group is to evaluate the "fit" of the theory generated and to confirm the theory that will be generated. The focus group participants were drawn from the researcher’s professional network of colleagues and invited to participate using the recruitment flyer via email (see Appendix D). Because focus group participants were anticipated to be selected from multi-state locations, use of the Internet technology of Skype was

employed. Because two members of the focus group could not access Skype, they joined the discussion via phone. The focus group Skype interview was also audio recorded. All participants who agreed to participate in the study were offered a $20 Target gift card as a token of appreciation, regardless of whether they completed the individual or focus group interviews.

Inclusion Criteria

Phase I

Inclusion criteria for the **individual** interviews included registered nurses who:

1. Are currently employed as an RN with at least 2 years of experience
2. Care for patients who self-identify as substance use disorder patients in any healthcare setting
3. Are fluent in English
4. Are willing to share perceptions and experiences about caring for patients with substance use disorders
5. Are willing to have the interview audiotaped.
6. Are willing to review and return the transcribed tape as part of the "member check"
7. Have access to a computer, the Internet, and phone

Phase II

Inclusion criteria for the **focus group** interview included registered nurses who are PhD prepared who:

1. Have published one or more theoretical or research articles on substance use and/or addiction in peer-reviewed, scholarly nursing journals
2. Are willing to review and reflect on the usefulness and "fit" of the generated theory to nursing education, research, practice, and policy
3. Are willing to discuss their reflections on the developed theory with other experts, published colleagues during a focus group either in person or via Skype
4. Are willing to have the focus group interview audiotaped and transcribed
5. Are willing to review and return the transcribed tape
6. Have access to a telephone and the Internet and Skype® for the focus group interview

Exclusion Criteria

Phase I

Exclusion criteria for the **individual** interviews included registered nurses who:

1. Are not currently employed as an RN
2. Have never engaged in caring for patients with SUDs
3. Are not fluent in English
4. Are unwilling to recount perceptions and experiences toward patients who have substance use disorders
5. Are unwilling to be audiotaped
6. Are unwilling to review and return the transcribed tape
7. Have no access to a computer, the Internet, and phone

Phase II

Exclusion criteria for the **focus group** interview included registered nurses who:

1. Are not PhD prepared
2. Have not published one or more theoretical or research articles on substance use and/or addiction in peer-reviewed, scholarly nursing journals
3. Are unwilling to review and reflect on the usefulness and "fit" of the emerging theory to nursing education, research, practice, and policy
4. Participated in an individual interview
5. Are unwilling to have the focus group interview audiotaped and transcribed
6. Are unwilling to discuss their perceptions and reflections of the developed theory with other experts, published colleagues during a focus group in person or via Skype

Ethical Consideration/Protection of Human Subjects

The researcher has an ethical responsibility to protect the study participants from harm and to assure their confidentiality and anonymity. In qualitative research, anonymity cannot be guaranteed, but there are several measures to maintain confidentiality. Prior to beginning any data collection, the study was approved by the Barry University Institutional Review Board (IRB) (see Appendix A). Once approved, the researcher informed the participants about the study and the actions that were taken to protect their confidentiality and/or anonymity (see Appendix B). The informed consent describes the protections to the participant and voluntary participation, risks to the participant, protection of privacy, and future use of data obtained. Privacy was

assured to protect the participants and data in the study. Participants were given the opportunity to select a pseudonym in order to protect their identity and all participants did select a pseudonym. This pseudonym was known only to the researcher. Any information obtained from the participants will not be traceable to any specific individual. The findings of the study were reported in aggregate form only. All electronic data inclusive of transcriptions, any scanned documents, demographic data sheets, electronically signed consent forms and any digital records of emails were stored on a password-protected personal computer of the researcher. Signed consent forms were stored in a locked cabinet separate from other paper records related to the study. All paper records will be stored in a locked cabinet in the researcher's home office for a period of 5 years upon completion of the study. Participants were made aware that the individual interviews would be kept confidential. However, focus group interviews preclude any guarantee of confidentiality due to the nature of the group process.

An informed consent form was required to be signed prior to any interview. There were two informed consents, one for the Phase I participants and one for the Phase II participants (see Appendix B). Informed consent for focus group participants was obtained electronically via DocuSign.com. DocuSign is a secure, web-based e-signature service. The informed consent informs the participants of the risks and benefits of the study and that their participation is wholly voluntary. The study had no known risks and no direct benefit to the participants. The participants may choose to not answer, and they may request to stop the recording at any time. The participants were informed that they may withdraw at any time with no consequences. The consents were kept in a locked cabinet in the researcher's home office separate from other data for 5 years. In order to

protect the privacy of the participants in this confidential study, the participants were asked to choose a pseudonym. This was used to identify the participants in the interviews and in the transcription. The Phase II participants were informed that due to the group interview process, confidentiality cannot be guaranteed. Once the interviews from Phase I and Phase II were transcribed, the recordings were destroyed. The demographic data and interview data were stored in a locked file in the researchers' home office separate from the informed consent for 5 years. Participation in the study is voluntary. Each participant was free to discontinue participation at any time during the study without consequences. Individual interview and focus group participants were offered a $20.00 Target gift card in appreciation for their participation in the study. All participants may keep the gift card even if they withdraw from the study without any consequence.

Data Collection Procedures

Phase I Individual Interviews

Following approval from Barry University's IRB, data collection was initiated. Nurses interested in participating in the study and meeting the inclusion criteria were interviewed by the researcher. Prior to commencing the individual interviews, the researcher welcomed and thanked the participants. The researcher explained the purpose of the study and described the study risks and benefits, procedures for the interview, and the method of audio-recording. The participants were reminded that they may choose not to participate at any point, and the interview process would be concluded without any consequences. Confidentiality was assured for the individual interviews. The $20 Target gift card token of appreciation was offered to all participants. Participants were asked if they had any questions about the process or the informed consent, and the methods to

maintain confidentially. If the participants agree to proceed, then, before the actual interview, the informed consent was signed using the participant's real name and will be kept in separate and locked location in the researchers' home office. Participants were asked to select a pseudonym and asked to complete the demographic data sheet using their pseudonym. The interviews were audiotaped, and the recording devices were placed in plain view. The recordings were transcribed by a transcriptionist who signed a third-party confidentiality agreement (see Appendix K). The demographic form, recordings, and transcriptions were labeled with the participants chosen pseudonym. The informed consent was not be labeled with a pseudonym and will be kept separate from the other data in a locked file in the researcher's home office. The interviews began once these preliminary procedures were completed (see Appendix I for the Interview Protocol.)

A semi-structured, open-ended intensive interview format was utilized to generate data regarding the participants' attitudes, behaviors, and experiences about caring for patients with substance use disorders. Phase I Individual interviews lasted a maximum of 60 minutes with an additional 10 minutes to complete the demographic sheet for a total of 70 minutes. The participants were informed that once the data was transcribed by the transcriptionist, he or she would receive the transcription by email for their review and any clarifications (member check). Once the interviews were transcribed and prior to sending them to the participants, the researcher listened to the recording while reading the transcript to check for accuracy. The researcher found that there were multiple inaccuracies in the transcripts of the first two transcripts. Another transcriptionist was them employed to transcribe the remainder of the interviews. A confidentiality form was signed by this second transcriptionist (see Appendix K). Transcripts were then emailed to each participant in the

individual interviews to confirm accuracy of the interview findings. Participants in Phase I individual interviews were asked to verify the accuracy of their interview transcripts, to make corrections, and additional comments as "member checks" to provide for study credibility (Charmaz, 2014, p. 210). Phase I participants were offered a second interview for member checking and review of the transcripts for accuracy and clarification. Only one of the participants accepted the offer of a second interview. Participants were to respond within 1 week with any clarifications, questions or concerns. If they did not respond within this timeframe, it was agreed that there were no changes to the transcript.

Phase II Focus Group Interview

The focus group participants were obtained through the researcher's professional network of colleagues and consisted of PhD prepared RNs with an expertise in substance use disorders and addictions. Nurses interested in participating in the study and who met the inclusion criteria were asked to participate in a group interview by the researcher. Because participants were selected from multi-state locations, the use of Skype and telephone was used for the interviews. Prior to commencing the focus group interviews, the researcher welcomed and thanked the participants. The researcher then explained the purpose of the study, procedures for the interview, and the method of audio-recording. They were informed that there were no risks or direct benefits. The participants were reminded that they may choose not to participate at any point, and the interview process will be concluded without any consequences. Participants were asked if they had any questions about the process or the informed consent, and the methods to maintain confidentially in a group setting.

Informed consent for the focus group participants was obtained electronically via DocuSign.com. DocuSign is a secure web-based e-signature service. A demographic form (see Appendix H) was completed by the participants and was returned electronically to the researcher. Participants were asked to select a pseudonym, but all declined and gave permission to use their names in any publications. The $20 Target gift card token of appreciation was offered to the focus group participants. Prior to the group interview, participants were provided with a manuscript to review of the emerging categories and developing theory via email to review. The actual time spent to review the emerging theory is approximated to take 60 minutes. This gave the participants time to review the emerging theory. A Skype meeting was set at a mutually agreeable time for the group and researcher. The Phase II interview was conducted using questions that are specific to the focus group and from the interview guide (see Appendix G). Follow-up questions were used, which allowed the participants to give full description and meaning to confirm the emerging theory. A semi-structured focus group interview was conducted using open-ended questions specific for the focus group. These open-ended questions allowed the group participants to describe meaning and essence and produce a rich description confirming the emerging theory. Additional questions were developed with the intent to confirm the emerging theory from the individual interviews.

The Phase II Skype interviews were also audio recorded on a smartphone recorder. The recorder was placed in view of the participants on Skype. The focus group was informed that due to the nature of the group process, confidentiality cannot be guaranteed. The researcher assured confidentiality to the extent provided by law. At the conclusion of the interview, the focus group was thanked for their participation.

Interview procedures are outlined in Appendix I. The interview with the focus group participants lasted not more than 90 minutes and an additional 10 minutes to complete the demographic data sheet (see Appendix H), for a total of 100 minutes. Reviewing the emerging theory added another 60 minutes for a grand total of 160 minutes. Immediately after the interview, the researcher made notes and write down any thoughts, feelings, or concerns that may have evolved from the interview process.

Interview Questions

In Phase I, the individual interview process is the primary method of acquiring data in grounded theory. The interview uses semi-structured interviews and begins with a broad open-ended question. This question is used to elicit spontaneous and detailed data that expresses the participants' views, understanding, knowledge, and experience (Charmaz, 2011). In order to allow this researcher to gain a deeper understanding of the meaning of the participant's attitudes and behaviors, a set of probing questions follow that will stimulate and elicit further information. The first question to open the semi-structured interview that began the semi-structured interview process was: "What are your thoughts and opinions about caring for patients with substance use disorders?" The interview guide of the questions and probe questions for Phase I are included in Appendix E.

In Phase II, the focus group reviewed and reflected on the emerging theory. The interview guide for the focus group questions begins with the open-ended question, "Please describe what you think about nurses' attitudes in general toward patients with substance use disorders." In order to allow the researcher to gain a deeper understanding of the meaning of the focus groups reflections on the theory, a set of probing questions

follow that stimulated and elicited further information. The guide for the focus group questions is included in Appendix F.

Demographic Data

A researcher developed demographic data questionnaire was developed by the researcher for the individual and the focus group participants. The questionnaire includes basic information (ages, gender, work settings, and tenure in nursing) from participants and were used to describe the characteristics of the study population. An educational background question was also asked; and specifically, about nursing education regarding substance use disorders. Another question asked whether participants had helped any friends or family members with substance use problems. This data were used in aggregate form only, using the selected pseudonyms of the participants. The responses provide information associated about how meanings are constructed for these participants and how the critical factors influence nurses' attitudes and behaviors in caring for patients with substance use disorders. The demographic data forms for Phase I are in Appendix G, and the demographic data forms for Phase II are in Appendix H.

Data Analysis

All grounded theory methods included utilizing coding, constant comparison, theoretical sampling, and memoing (Creswell, 2013). The data from this study were analyzed employing Charmaz's (2014) constructivist grounded theory approach. The data gathered were gleaned from Phase I individual interviews. These interviews were transcribed verbatim by third-party transcriptionists who signed a confidentiality agreement. Charmaz (2014) asserted that the interview transcriptions allow the details of the interview to be preserved (p. 92). The researcher read the transcripts while simultaneously listening to the audio recording to check for accuracy of the transcription.

Constructivist grounded theory coding occurs in two phases: initial and focused coding (Charmaz, 2014). Coding is the process of breaking down and classifying pieces of the data (p. 113). During the initial phase, coding was first performed using a line-by-line method. According to Charmaz (2014), line-by-line coding affords the researcher "more directions to consider and already suggests emergent links between processes in the data… (p. 124) …to see otherwise undetected patterns in everyday life…to take compelling events apart and analyze what constitutes them and how they occurred" (p. 125). This researcher read each line of the transcripts repeatedly to determine the meanings described by the participants. Charmaz suggested using gerunds when coding (p. 245). Gerunds are action words and build action directly into the codes and allows processes to be revealed that might otherwise remain unseen (Charamz, 2012, p.5). When coding line-by-line, the use of gerunds was used, and actions and processes allowed connections to be more easily created.

Focused coding is the next phase. Focused coding brings forth the codes and categories that may be used to guide the "theoretical direction" of the study (Charmaz, 2014, p. 140). Focused coding "requires decisions about which initial codes make the most analytic sense to categorize data incisively and completely" (Charmaz, 2014, p.138). The constant comparative feature requires that the researcher categorize data through a process of comparing new codes to previously created codes. Charmaz (2014) noted that for the best results, the collection of data and its analysis occur concurrently. The constant comparative analysis is a circular back and forth, iterative process between data and coding (p. 141). This constant comparison continued throughout the collection and analysis of all stages of the data. With this research method, the data collection and

its analysis are key (Crosetti, Goes, & deBrum, 2016). In constructive grounded theory, the theory is constructed from the data, and the researcher remains open to whatever concepts may evolve (Engward, 2013). In constructivist grounded theory, coding is a developing process.

Theoretical sampling is used to acquire more data by seeking more data (more interviews) to further develop the categories or themes (Charmaz, 2014). Theoretical sampling is a significant aspect of grounded theory. This allows for expansion of the categories and analysis due to any gaps which may occur and allows for saturation of the categories to occur (Charmaz, 2014). This permitted the researcher to develop the categories in more depth. The researcher thus became active in the coding process. In subsequent interviews, if the themes identified in the previous interviews were not elicited, participants were asked about existing themes to see if they observed them. By being open and comparing the concepts, the researcher found new questions to explain the behaviors (Harris, 2015). Theoretical coding allows the forming of relationships between data and the focused codes. Theoretical coding assists the researcher to bring focused coding closer to analysis by seeing how they are related (Charmaz, 2014). Table 1 illustrates initial and focused coding.

Table 1

Initial and Focused Coding

Individual Interview	Initial Coding	Focused Coding
Scoperoo: About managing time with [substance use] patients, Yeah, if I was extremely busy I would maybe cut my time with them to give to somebody else.	Too busy, need to cut down time in order to be with other patients	Avoiding

Memo: Appeared not to see the discrepancy in time management or how it might affect a patient.		
Pepper: Yeah, I want to say maybe I tried to make our conversations short, as sort as possible…I'd be in her room when I had to, but I would definitely not go into that room unless I had to. **Memo:** Task oriented, no real personal interaction. Didn't think this affected the care.	Shortened conversations/interactions. Only entered patient room when had to – tasks only	Avoiding
Fluffy: The only time I felt scared was …when lady came in drunk, very drunk, she threw a phone across the room. She ripped it out of the wall and she almost hit me. **Memo:** While the act of throwing the phone is could be considered violent. I had the same thing happen to me. Knowing why the patient was acting out, did not cause me avoid care – just had to step out of the way and wait until patient was calmed down.	Patient violence > scared nurse	Avoiding

The researcher performed "memoing" throughout the coding process. Memoing is the practice of the researcher writing thoughts, beliefs, reactions, and reflections about the emerging themes (Creswell, 2013). These memos are used to improve the coding process and category development by differentiating between major and minor categories and how they relate to each other (Charmaz, 2014). Memoing was used throughout the coding and category development period and served as record and documentation of the analytic process used. By memoing, focused codes were elevated to conceptual categories. "Memos record [the] path of theory construction" (Charmaz, 2014, p. 164).

Research Rigor

The purpose of rigor in qualitative research is to correctly and accurately characterize the experiences of the participants (Struebert & Carpenter, 2011).

According to Thomas and Magilvy (2011), trustworthiness indicates that the results of the study imbue confidence in the findings. The methods used need to be a precise representation of the population being studied. Rigor ensures the methods used are consistent and accurate and allow the means to be able to replicate a study with a different research sample. A qualitative study should not be evaluated by the same elements as a positivist study. Lincoln and Guba (1985) described the four components of qualitative research—confirmability (representativeness of the findings), dependability (reproducibility of the findings), credibility (rigor of method), and transferability (generalizability of the findings). Because qualitative research is naturalistic and uses subjective data, and quantitative research is empirical and uses objective data, the evaluation of trustworthiness and rigor needs to be assessed using the appropriate approaches (Krefting, 1991).

Credibility

Qualitative researchers address the reliability of their research using credibility. Credibility necessitates that the findings of the study need to be consistent with the reality of the participants. If the interpretation of the data (interviews) are recognizable to others who have had the same experience and those individuals can identify with that experience, then this is considered credible (Krefting, 1991). Several techniques may be used to ensure credibility. The interviews were transcribed word-for-word, and the recordings were listened to while reviewing the transcription for accuracy. Member checks were requested of the participants. Member checks include having the participants review the transcripts and interpretations to ensure it is consistent with what the member intended. Member checks are done to assure that the participants and the

researchers' perceptions are aligned (Krefting, 1991; Streubert & Carpenter, 2011; Thomas & Magilvy, 2011).

Lincoln and Guba (1985) regarded member checks as "the most crucial technique for establishing credibility" (p. 314). The participants may reveal things that they might not otherwise reveal to a "stranger" (Krefting. 1991; Lincoln & Guba, 1985; Thomas & Magilvy, 2011). Triangulation of the data is another approach used to confirm credibility. Information or data should be evaluated against other data. In this study, triangulation was performed by use of the focus group of expert participants to confirm the emergent substantive theory by participating as part of the theoretical sampling process. Triangulation enhances credibility by verifying that the various viewpoints have been assessed (Lincoln & Guba, 1985; Thomas & Magilvy, 2011).

Dependability

Dependability in qualitative research refers to when the results have been shown to be credible. Shenton (2004) noted that credibility and dependability are closely related. He goes on to note that dependability may be achieved, through what is called "overlapping methods." This is achieved by using comparison groups (individual and focus group interviews) (p. 71). All interviews were audiotaped, and detailed memos of this process were kept. A detailed audit trail that describes all the steps of the study were written so that other researchers may duplicate the research processes. The specific details include: the purpose of the study; how and why the participants were selected; how the data was collected, analyzed and interpreted; and the strategies used to establish credibility and dependability (Thomas & Magilvy. 2011).

Confirmability

Shenton (2003) stated that confirmability is the concern for objectivity. A detailed audit trail that details the methodological steps taken allows the reader to understand how the theory emerged from the data should be included in the research report. This may take the form of text or diagram (p. 72). For confirmability, rich detail and description, which indicate the data and analysis are organized appropriately, are necessary (Corbin & Strauss, 2015). Confirmability may be employed in several ways. First, this researcher kept an audit trail of all paperwork, along with detailed notes and memos from both the individual and focus group interviews; as well as all field notes are written to enhance the remembrance of details and descriptions (Lincoln & Guba, 1985). Confirmability assures that the data characterizes what the participants have provided.

The researcher asked the participants for clarifications of words, metaphors, slang phrases, and definitions. The researcher asked broad questions that allowed the participant to respond without having the researcher lead the participant in any particular direction. Next, triangulation is another technique used as part of confirmability. The data must emanate from the participants and should not contain "the researcher's biases, motivations, or perspectives" (Shenton, 2004; Thomas & Magilvy, 2011). Next, the use of reflexive analysis of the researcher was employed. Reflexivity is how this researcher assessed her perspective, history, and experiential background may have influenced the research process. Keeping a journal or use of memoing is how this researcher was made aware of how her thoughts, feelings, and ideas may bias the credibility of the research (Krefting, 1991; Shenton, 2004; Thomas & Magilvy, 2011).

Transferability

The very nature of qualitative research does not lend itself to the generalizability of a quantitative study (Shenton, 2004). In qualitative research, transferability refers to the likelihood that the data may be applied (or transferred) to other participants/groups/settings. Streubert and Carpenter (2011) stated that the findings of the study should have merit with/to others. This is also called "fittingness." The findings may be determined to "fit" or are transferable to others. To determine the fittingness, there must be thick descriptions about the participants, the context of the study, and the setting, so that another researcher can determine if the findings could be transferred under similar conditions in similar contexts (Lincoln & Guba, 1985; Thomas & Magilvy, 1991; Shenton, 2004).

Chapter Summary

The purpose of this qualitative constructivist grounded theory study is to develop a middle-range theory explicating the process of nurses caring for substance use disorder (SUD patients. This chapter described the research design chosen, the sampling procedures of purposive, and theoretical sampling and recruitment of participants. The inclusion and exclusion criteria were described. Data collection and analysis methods were explained. Ethical considerations were detailed. Qualitative research rigor and trustworthiness were explained. Chapter Four will follow with a discussion of the results of this study.

CHAPTER FOUR

FINDINGS OF THE INQUIRY

The purpose of this qualitative constructivist grounded theory study was to develop a middle-range theory explicating the process of nurses caring for substance use disorders (SUDs) patients and to develop a middle-range theory explicating the process of nurses caring for SUD patients. In this chapter, the researcher will present the results of the data collected from a total of 16 nurse participants and four nurse experts in the focus group. A description of the individual and focus group participants and their demographic data will be described as well as aggregate selections from the interviews of the participants, and the results that were co-constructed from the data will be described. This study produced a theoretical framework that describes the factors influencing nurses who care for patients with substance use disorders. A substantive theory could be used as a framework for guiding nursing practice, nursing education, and nursing research.

This study was conducted following Charmaz's constructive grounded theory approach (2014). Charmaz (2014) has stated that grounded theory proposes "a set of general principles, guidelines, strategies…rather than formulaic prescriptions" (p. 3). Constructive grounded theory utilizes constant comparative analysis, initial and focused coding, and memoing, along with the researcher's experiences, interactions, and perspectives to co-construct theories. Because this researcher has extensive knowledge in the area of substance use and addictions, Charmaz's (2014) approach of integrating the researcher's experiences, interactions, and perspectives to co-construct theories best supports this researcher's epistemology. Applying Charmaz's approach (2014), this researcher analyzed face-to-face, semi-structured individual interviews and focus group

interviews. This allowed for the collection of rich data to be co-constructed, leading to the basic social process (BSP). The BSP is supported by three conceptual categories (*avoiding, stigmatizing, and struggling with role*) and supportive subcategories (*disrupting behaviors, language, safeguarding, judging)* and one core category, *lacking education* and the subcategories of *feeling incompetent* and *lacking confidence.* All provide examples of rich descriptions that illustrate the categories.

Prior to any data collection, Barry University IRB approval (see Appendix A) was obtained. Participants were recruited using purposive and snowball sampling. Data were collected in two phases. Phase I consisted of 16 individual interviews, and Phase II consisted of a focus group interview with four participants. Those participants who met the inclusion criteria were invited to participate in a semi structured face-to-face interview. Both Phase I and Phase II participants completed consent forms (see Appendix B) and demographic questionnaires (see Appendix G & H). All interviews were audio taped by the researcher and transcribed by a third-party transcriptionist and reviewed by the researcher for accuracy. Because the initial transcriber was not as accurate as necessary, a second transcriber was engaged for the rest of the interviews. Both signed the third-party confidentiality form (see Appendix H).

All participants selected pseudonyms to protect their identities. All participants in Phase I were RNs with over 10 years of nursing experience in a variety of practice settings and who self-identified as having cared for patients with substance use disorders. All 16 Phase I interviews were face-to-face, semi-structured interviews that were audiotaped and transcribed verbatim. All participants were given the opportunity to review the transcript of their interview through member checking. The researcher utilized memos and journaling throughout the entire research process. Memoing by the researcher was

employed in order to maintain sensitivity during the data collection process and to sharpen the focus of coding (Charmaz, 2014, p. 164). Memos were created soon after each interview to allow the researcher to document thoughts and reactions and during the analysis process to document reflections and reflexivity.

The coding and analysis process followed Charmaz's guidelines (2014) and consisted of constant comparative analysis using line-by-line coding and gerunds within the same interview and then between all subsequent interviews. Focused coding was utilized to build upon the initial coding in order to synthesize and to broaden the initial codes (Charmaz, p. 138). The process of constantly comparing all the interviews (data) with each other provided an awareness as to what questions needed to be deleted, modified, or formed as suggested by the analyzed data and the emergent conceptual categories. Data that shared specific characteristics and qualities were grouped together, giving rise to the three conceptual categories and supportive subcategories: *avoiding (disrupting behaviors), stigmatizing (language), struggling with role (safeguarding, judging),* and the core category of *lacking education (feeling incompetent, lacking confidence);* all of these revealed the basic social process of *achieving understanding: pathway to care.* Once the categories reached saturation (no more new data or perceptions were collected), Phase II took place.

Phase II consisted of a focus group interview with four participants using a semi-structured format. The participants were offered the opportunity to select a pseudonym; however, due to the nature of conducting the focus group interview via Skype, confidentiality could not be guaranteed. All four of the focus group participants refused the use of a pseudonym and agreed to have their names used in publications. Phase II

participants are PhD-prepared RNs who are experts in the field of substance use, addictions, and nursing and have published in scholarly peer-reviewed journals. The purpose of the focus group interview was conducted to confirm the conceptual categories and the basic social process that emerged from the individual interviews. The data analysis process allowed for the co-construction of the categories and subcategories by the participants and the researcher. The categories that emerged from the data were *avoiding.* In the avoiding category, the subcategory *disruptive behaviors* evolved. The second category that emerged was *stigmatizing.* In this category, the subcategory of *language* developed. The next category was *struggling with role.* In this category, *safeguarding* and *judging* emerged as subcategories. The core category *of lacking education* had two subcategories that were constructed. These categories and the supportive subcategories describe the basic social process *achieving understanding: pathway to care*. The following section includes excerpts from the Phase I interviews that illustrate the participants' remarks. The next section also describes the characteristics of the sample demographics of the individual participants.

Sample Description

Two groups were interviewed for this study. Phase I consisted of individual face-to-face semi-structured interviews. This group (n = 16) consisted of purposively and snowball sampled Registered Nurses (RNs) who self-identified as having cared for substance use disorder patients. The participants included 14 females and two males. The demographic survey data informed the researcher of personal characteristics which helped define the similarities and differences in participants' attitudes, behaviors and experiences of caring for substance use disorder patients and to gain a better

understanding of the participants' experiences, perspectives, and their contextual background.

These participant interviews provided the rich data from which the major conceptual categories were co-constructed. Phase I participants embodied various specialty areas, ages, number of years in practice, and positions. Saturation in Phase I was reached after 12 interviews. Another four interviews were undertaken to confirm that no new information was obtained, and saturation was realized. Once saturation of the categories was achieved, theoretical sampling established the Phase II participants (*n* = *4).* Phase II participants comprised the focus group interview. Phase II participated in a semi-structured Skype interview or by telephone if not able to access Skype. These participants were PhD-prepared RNs who are experts in the field of substance use, addiction, and nursing and who have published in scholarly peer-reviewed journals. The purpose of the focus group interview was conducted for confirmability of the conceptual categories and the basic social process that emerged from the individual interviews in Phase I. Both Phase I and Phase II participants (*n* = 20) completed a demographic questionnaire.

Demographics Characteristics of the Sample

A researcher-developed demographic survey form consisting of 11 attributes (see Appendix G) was completed by all Phase I participants. The particulars of the study and the informed consent were explained to each of the participants prior to beginning the interviews. All participants were from within Miami-Dade and Broward counties. Table 2 lists the overall demographic information collected from the participants in Phase I as it relates to this study. There were 16 participants (*N* = 16) in Phase I. Of the participants,

14 were female (87.5%), and two (12.5%) were male. The ages of the participants ranged from 34-69 years with a mean age of 55 years. Ethnic backgrounds of the participants consisted of African American = 1 (6.25%), Caucasian = 6 (37.5%), Hispanic or Latino = 6 (37.5%), one identified as Other (6.25%), one identified as White Hispanic (6.25%), and one identified as African (6.25%). The highest level of nursing education included three diplomas (18.75%), two Associate degrees (12.5%), two bachelor's degrees (12.5%), six master's degrees (37.5%), and three doctoral degrees – (two DNPs and one PhD) (18.75%). The clinical areas the participants reported working in was varied and several participants cited working in several areas. The areas consisted of: cardiac, diabetic care, women's health, post-operative, orthopedic, med-surg, critical care, emergency department, mental health, gastroenterology, and ambulatory infusion. The participants were asked how often they care for substance use patients: daily = 5 (31.25%), weekly = 2 (2.5%), monthly = 4 (25%), every 6 months = 2 (12.5%), other (rarely) = 3 (18.77) When asked if they or someone in their life ever experienced a substance use disorder, 11 answered yes (68.75%), and five answered no (31.25%). The participants were asked if they helped any family members or friends whose health problems were caused by substance use problems: 12 answered yes (75%) and four answered no (25%). For the question of having received any education for substance use disorders in nursing curricula, 10 answered yes (62.5%), and six answered no (37.5%). As for taking any continuing education on substance use disorders, 11 responded yes (68.75%), and five responded no (31.25%).

Table 2

Demographic Characteristics Phase I (N = 16)

Characteristics	**N**	**%**
Age (Mean)	55	
Gender		
F	14	87.5
M	2	12.5
Ethnic Background		
Caucasian	6	37.5
African American	1	6.25
Hispanic or Latino	6	37.5
White Hispanic	1	6.25
African	1	6.25
Other	1	6.25
Years RN Experience		
11-15	3	18.75
16-20	1	6.25
21-25	1	6.25
26-30	4	25.0
31-35	4	25.0
36>	3	18.7
Highest Degree Earned		
Diploma	1	18.75
ASN	2	12.5
BSN	2	12.5
MSN	6	37.5
Doctorate (DNP)	3	18.75
Types of Patients Cared For		
Cardiac	2	12.5
Diabetes	4	25.0
Women's Health	1	6.25
Post-Op	2	12.5
Med-Surg	4	25.0
Critical Care	1	6.25
Emergency Dept.	2	12.5
Mental Health	3	18.75
Gastroenterology	3	18.75
Ambulatory Infusion	1	6.25

(Table 2 continues)

Characteristics	N	%
How Often Care for SUD Patient		
Daily	5	31.25
Weekly	2	12.5
Monthly	4	25.0
Every 6 months	2	12.5
Other (rarely)	3	18.75
You/Someone you know Experience SUD		
Yes	11	75.0
No	5	31.25
Helped Family/Friends		
Yes	12	75.0
No	4	25.0
Substance Use Education in Nursing Program		
Yes	10	62.5
No	6	37.5
T**ook SUD CEUs**		
Yes	11	68.75
No	5	31.25

Phase I: Individual Interview Participants

This section imparts the Phase I participants' characteristics with data gathered from the demographic survey data and the interviews. Each participant chose a pseudonym to ensure confidentiality. Knowing the demographic details aided the researcher in learning more about each of the research participants. The demographic information acquired added to the credibility of this study.

Fluffy is a 44-year-old white Hispanic female who has a PhD and currently teaches undergraduate nursing students. Her area of clinical expertise is the emergency department. She has 20 years of nursing experience. She has stated that she has helped

family members whose health problems were caused by substance use problems. **Fluffy** reported never having had any substance use education in her basic nursing program, nor has she taken any continuing education on substance use. **Fluffy** describes her background experience with substance use patients this way:

> My experience with them is in the ER would be really the ones that come in with alcohol. We would just hang the yellow bag…. the banana bag, the rally bag, and then I really wouldn't give them anything no matter what. Maybe some Phenergan for the nausea. And then that's it. We discharge them out - like they'd be gone.

Tinkerbell is a 53-year-old Hispanic female with a master's degree in Nursing and currently teaches undergraduate nursing students. Her area of clinical expertise is in women's health. She has 26-30 years of nursing experience. She has stated that she has helped family members whose health problems were caused by substance use problems**.** **Tinkerbell** reported having had some substance use education in her basic nursing program and has she taken continuing education on substance use. **Tinkerbell** described her background experience with substance use patients this way:

> I've had both personal and professional experience… my personal experience was my child who got arrested for marijuana… and I was also doing all my clinical my stuff in mental health... at the Jackson Behavioral Center which has a drug wing.

Henry is a 58-year-old Hispanic male who has a DNP and currently teaches undergraduate nursing students. His clinical area of expertise is in the medical-surgical area and psychiatric nursing. He has 31-35 years of nursing experience. His area of clinical expertise is in medical-surgical nursing, specifically cardiac. He has stated that

he has helped family members whose health problems were caused by substance use problems**.** **Henry** has reported having had some substance use education in his basic nursing program. He has not taken any continuing education on substance use. **Henry** describes his background experience with substance use patients this way: "During my years at the County Hospital where I worked … in medical/surgical nursing. Patients were addicted to crack cocaine, heroin and alcohol. Sometimes, all at the same time, sometimes different types of addictions."

Lindsay is a 69-year-old Caucasian female with an associate degree in nursing. She currently works in a behavioral health unit. She has 11-15 years of nursing experience. She has stated that she has helped family members whose health problems were caused by substance use problems. She has reported having had no substance use education in his basic nursing program. However, **Lindsay** has obtained a drug and alcohol counseling certification. She stated that she has taken nursing continuing education on substance use. **Lindsay** described her background experience with substance use patients this way:

> I started out caring for substance abuse disorder patients, actually as a mental health tech. Then I went to nursing school and went back and worked in the detox unit. All together about 15 years I think I was with substance abuse patients. It is a field that I enjoy, and I understand they are sick.

Marie is a 63-year-old Caucasian female who has a DNP and currently works as the nurse manager of a mental health unit. She is also adjunct faculty at a local university. She has over 40 years of nursing experience. **Marie** has stated that she has helped family members whose health problems were caused by substance use problems**.**

She has reported having had no substance use education in his basic nursing program. She stated that she has taken some nursing continuing education on substance use. **Marie** described her background experience with substance use patients this way:

> I've worked in in-patient psych and day programs, partial hospitalization programs probably for 35 years. And over time the number of folks that have an addiction, we've seen a great increase and we've seen really nasty drugs in South Florida that have ruined lives.

Redman is a 59-year-old Caucasian female with a bachelor's degree in nursing. She currently works in a Behavioral Health Unit. **Redman** has 31-35 years of nursing experience. She has stated that she has helped family members whose health problems were caused by substance use problems. She has reported having had no substance use education in his basic nursing program. She stated that she has taken some nursing continuing education on substance use. **Redman** describes her background experience with substance use patients this way: "I went into substance abuse because it was something very close to me and my family. I started work at …an addiction treatment program many, many years ago, and it was a very good addiction program."

Miss Lucky is a 53-year-old African female who has a DNP. She currently works in an ambulatory infusion area. Her clinical area of expertise is in medical-surgical nursing. She has 21-25 years of nursing experience. She has stated that she has helped family members whose health problems were caused by substance use problems**.** She has reported having had no substance use education in his basic nursing program. She stated that she has not taken nursing continuing education on substance use. **Miss Lucky** described her experience with substance use patients this way: "I haven't really

had like a formal training but… we have a Psych Department where I work and with those patients comes medical issues and they're going to be distributed all over the hospital before they end up going to psych."

Riley is a 65-year-old Caucasian female with a diploma in nursing. She currently works in Gastroenterology. She has over 40 years of nursing experience. She has stated that she has helped family members whose health problems were caused by substance use problems. She has reported having had no substance use education in her basic nursing program. She stated that she has not taken nursing continuing education on substance use. **Riley** described her background experience with substance use patients this way:

> Actually, the very first time [I experienced substance use] was as a student, you know, in nursing school. And back then we really didn't know much about it. I didn't really know how to handle it but I know back then it's not treated the way it was now. I mean, they weren't in there for substance abuse, they were in there for something else but this came out, that the patient had an addiction to opioids.

Ladybug is a 55-year-old Caucasian (with Native American roots) female with a master's in nursing. She currently works as a nurse manager in a gastroenterology unit. L**adybug** has 26-30 years of nursing experience. She has stated that she has helped family members whose health problems were caused by substance use problems**.** She has reported having had no substance use education in her basic nursing program. She stated that she has not taken nursing continuing education on substance use. **Ladybug** described her background experience with substance use patients this way: "My first experience would be with a family member, rather than a patient. My youngest brother… started at

a very young age like sniffing glues and it carried on into his adulthood that he was an alcoholic. I lost him last September."

Pepper is a 37-year-old Hispanic female with a master's in nursing. She currently works as nursing faculty in the simulation area. Her clinical area of expertise is in the medical-surgical area. She has 11-15 years of nursing experience. **Pepper** has stated that she has helped not family members whose health problems were caused by substance use problems. She has reported having had some substance use education in her basic nursing program. She stated that she has not taken nursing continuing education on substance use.

Pepper described her background experience with substance use patients this way:

> I don't really deal too much with substance abuse but every now and again you get a patient with that. The most memorable patient that I can think of at the moment is one that would actually follow me around the unit after the 4-hour dose was due and she would come and warn me at the 5-minute mark to tell me [her] medication is due.

Zombie is a 51-year-old Hispanic female with a master's in nursing. She is currently a clinical educator in a hospital. Her clinical area of expertise is in the medical-surgical and critical care areas. She has 31-35 years of nursing experience. She has stated that she has helped not family members whose health problems were caused by substance use problems**.** She has reported having had some substance use education in her basic nursing program. She stated that she has taken nursing continuing education on substance use. **Zombie** describes her background experience with substance use patients this way:

> When you have patients that they have substance abuse, you probably don't know immediately that they have that problem. It's not until they are with you… for a day or two or longer. And then the patient starts presenting with some withdrawal signs and symptoms and then you try to, you know, treat them. You start seeing changes in behavior. You start seeing … hallucinations, changes in mental status.

Kikosam is a 61-year-old Hispanic male with a Master's in Nursing. He currently works as faculty for undergraduate nursing students. His area of clinical expertise is in psychiatric nursing. He has 11-15 years of nursing experience. **Kikosam** has stated that he has helped family members whose health problems were caused by substance use problems**.** He has reported having had some substance use education in his basic nursing program. He stated that he has taken nursing continuing education on substance use. **Kikosam** described his background experience with substance use patients this way:

> I have many years of experience working with patients that suffer from addiction. And I guess initially I was really concerned about working in that kind of setting because of my…. cultural belief in reference to what addicts are were. But then after a year dealing with them I became more sensitive to that population. I am Dominican, from Dominican Republic.

Scoperoo is a 68-year-old Caucasian female with an associate degree in nursing. She currently works in gastroenterology and also has worked in the medical surgical area. **Scoperoo** has 26-30 years of nursing experience. She has stated that she has helped not family members whose health problems were caused by substance use problems. She has reported having had some substance use education in her basic nursing program. She stated that she has taken nursing continuing education on

substance use. **Scoperoo** described her background with substance use patients this way, "Most of my experience with drug abusers or alcoholics was in nursing school and briefly on the immunology floor. Most of those were a lot of street prostitutes that were also drug addicts."

Catness is a 65-year-old Caucasian female with a diploma in nursing. She currently works in gastroenterology, post-op area. She has over 36 years of nursing experience. She has stated that she has helped family members whose health problems were caused by substance use problems. **Catness** has reported having had some substance use education in her basic nursing program. She stated that she has taken nursing continuing education on substance use. **Catness** described her background with substance use patients this way:

> My first job was at a large hospital and I worked in a psych unit. We had… a lot of different types of diagnoses of which were a lot of people that had substance abuse problems. And there were a lot of alcoholics. There were a lot of different types of drugs problems that came in from professional people to people on the street, even housewives.

Rose Smith is a 58-year-old African American female with a master's degree in nursing. She currently works in an ambulatory setting for an insurance company. Her clinical area of expertise in in diabetes and women's health. She has 26 years of nursing experience. **Rose Smith** has stated that she has not helped family members whose health problems were caused by substance use problems**.** She has reported having no substance use education in her basic nursing program. She stated that she has taken nursing continuing education on substance use. **Rose Smith** described her background

experience with substance use patients this way: “Back when I first started in nursing I… [worked in] – a hospital that had an alcoholic unit so I would work there sometimes. But they basically dealt with alcohol-drugs, but mostly alcohol.”

Lola is a 34-year-old Hispanic female with a bachelor’s degree in nursing. She currently works in an ambulatory setting for an insurance company. Her clinical area of expertise is in the pediatric emergency department. She has 31-35 years of nursing experience. **Lola** has stated that she has helped family members whose health problems were caused by substance use problems. She has reported having some substance use education in her basic nursing program. She stated that she has not taken nursing continuing education on substance use. **Lola** described her background experience with substance use patients this way:

> I worked in a pediatric children’s hospital, so I did see… several children… – teenagers, really, that had come in overdosed or, you know, they had been drinking and then on top of that maybe had taken something. And so, they came in…usually unconscious and some of them… we would have to intubate, some of them we would have to…pump their stomachs and things like that. I’ve not had any substance use education, just the mandatory Florida License CEU.

Results of the Inquiry

Three conceptual categories and the core category and all the subcategories were co-constructed from the data of the individual interviews in Phase I, which are used to describe the process of interest in this study. Based on the analysis of the data, the basic social process (BSP) was identified to be *Achieving Understanding: Pathway to*

Care. The BSP is informed by three conceptual categories (*avoiding, stigmatizing, and struggling with role* and the core category of *lacking education*) and the subcategories (*disrupting behavior, language, safeguarding, judging, feeling incompetent,* ß *lacking confidence).* The core category of *lacking education* is linked to the three other conceptual categories in that it informs and influences all the other categories. A total of 16 participants participated in the Phase I interviews. Theoretical saturation was reached after 12 participants were interviewed. In order to ensure no new categories emerged and to fully insure that saturation of the categories occurred, four more interviews were conducted. This confirmed that saturation had been achieved. A discussion of these categories, subcategories, and the basic social process will be reviewed in detail, and quotes from the participants' will be presented. Minimal corrections have been made to the quotes in order to enhance readability, including spelling and punctuation, the addition of filler words will be denoted by the mark [ ], and the omission of side issues will be denoted by ellipsis …

Conceptual Categories

Avoiding

The category of *avoiding* denotes nursing care where the nurse is distancing him or herself from or evading the care of a patient with a substance use disorder. Being too busy or perceiving that the substance use patient takes up too much of the nurses' time were remarks that some nurses used as justification for not engaging with the substance patients in their care. A subcategory that emerged from the concept of *avoiding* was *disrupting behavior*. Some of the negative behaviors exhibited by patients include hostility, being antagonistic, and being aggressive. This will be further explained later in this section.

Fluffy stated:

> Cardiac arrest patients are the easiest patient. They're out of my bed in 15 minutes because they're going to Cath and …you come in and, and you may not be having the big one. I could stabilize you in 30 minutes. And then I'm just observing now I'm titrating my nitro I'm doing it, I'm doing that. You're going up to the unit. I preferred that patient then that other patient [with] substance.

Scoperoo commented: "About managing time with patients, Yeah, if I was extremely busy I would maybe cut my time with them to give to somebody else."

Pepper remarked: "Yeah, I want to say maybe I tried to make our conversations short, as sort as possible… I'd be in her room when I had to, but I would definitely not go into that room unless I had to."

Lindsay noted: [On her behavioral health unit]:

> Substance use disorder is not really addressed. My unit does not really address recovering from drugs and alcohol. They don't take that as an issue really. They're looking for a psych diagnosis. They don't do a whole lot of talking about it.

Miss Lucky remarked:

> As a Nurse Manager [on a med-surg unit] I had to get involved since we couldn't manage him [the patient] …we had to call the Psych Depart. and get them involved. We don't have the ability to manage those things, so we had to call the special team in the Psych Depart. to come and take care of it.

Kikosam stated:

> [Describing a nurse, he works with] As a nurse I'm going to take care of you because you have a medical problem and I'm going to give you medication and that's it. They [the nurse] really have a personal problem with addiction. I'm not saying they have an addiction, but they don't see addiction as a medical problem.

Marie commented (on nurses in her hospital): "They would much prefer the patient go to ICU and have an Ativan drip than to deal with them on the medical floor. That's kinda crazy."

Disrupting Behaviors

A subcategory that influenced avoiding care is patient behaviors. Many of the nurses reported that patients' negative behaviors make caring for this population quite difficult and led them to avoiding these patients. Patients who were manipulative or exhibited what was perceived as violent behaviors caused the nurses to avoid those patients.

Fluffy also stated:

> The yelling and the screaming, the belligerent, especially when you get patients in the trauma they were just in pain because they broke something, I think that what's different though in these patients you have that component you also have the mental component behind the scenes of their addiction, of their substance abuse problems. They manipulate you, they tell you that something is wrong and nothing really is wrong. But then again, you never know…"

Miss Lucky stated:

> A patient, a young man, came in and he had a huge substance abuse problem. This patient was so paranoid, so into using his drugs…he [was crushing his medication or whatever [substance] on a can of Coke. He would go onto the bathroom and lock himself in there …we would see that he was crushing something and sniffing it …it's a struggle for the staff …because those patients end up in the hospital because they lie and cheat and do whatever they had to do to get what they want.

Lindsay commented: "Substance abusers are very manipulative, and they want to get what they want to get. I'm not saying it in a negative way. It's just part of the disease."

Zombie noted:

> I had a patient who was… I want to say was a homeless patient and I think he was a drug abuser and he was complaining of pain all the time. He had an amputation and kept saying that his stump hurt. We could tell that probably was not that type of pain. He kept saying pain, pain, pain, so we had pain medication that we would give him. I remember it was Oxycontin. You have to give the instructions, "please don't chew [the pills]. He's looking at me and says "no, no, no, I'm not chewing the medication". The next think... the patient is breathing like 6 per minute…and I'm freaking out and I'm calling for help. We had to push Narcan. He was mad, the patient was very mad at me after that. He woke up angry and he didn't want me to be his nurse anymore.

Scoperoo commented:

> I learned quickly how manipulating they could be to get something they wanted or to get sympathy and things like that… I am more aware of their manipulative

> abilities and I don't buy into a lot of their stories, but then as a med-surg or GI nurse, I don't have to. That's not what I'm here for.

Catness remarked:

> There was a lot of violence. A lot of nurses would get beat up. Patients would get beat up, other patients. They would, some of them, would get really agitated and start throwing things, you know, it was mostly the alcoholics. It was really, really scary times, but we had our ways of dealing with that too.

Stigmatizing

Goffman (1963) described stigma as occurring when a persons' identity is considered different or not normal by society. These people are perceived to have an attribute that society defines as "discrediting" and are therefore marginalized. Phelan and Link (2006) added to Goffman's definition by connecting labeling and stereotyping. Labelling and stereotyping leads to discrimination, exclusion and diminished social status. The category of *stigmatizing* illustrates that some nurses use stigmatizing language when referring to their patients with substance use disorders. The subcategory of *language* informed the category of *stigmatizing.* Using stigmatizing language is also indicative of influencing the nurses' attitudes and behaviors towards substance use patients.

Fluffy stated: "I didn't really have any interaction with *those types* of patients."

Lindsay remarked: "I don't know. I'm guilty of saying referring to the patient's drug-seeking, and it's true, they are. To me I don't feel that it changes the way they are treated."

Tinkerbell: commented on nurses she worked with:

> They see them more as abusers of substance ... I mean, I do hear the comments, he's just a drug addict. He's here for fix. … I've had it out with some of our nurses … Those ER nurses, they want to say, oh, he's just a drug addict. You [are] to take care of his pain. If he says he has pain, you have to treat it.

Marie stated:

> Somebody said, "frequent flyer" and I said, "You know, we prefer to think of them as "friendly faces." So, on the next visit they came to me and they said "okay, the friendly faces." But you know, it's just little things like that that matter. Or "med seeking" it's another … phrase that makes me nuts. I don't really allow it on my floor.

Redman remarked:

> It's a horrible stigma about addiction. I mean, people think that they're just, those people are just stupid, they don't care about anybody, that they do it because they want to. I mean, nobody wants to live that lifestyle. It's a horrendous lifestyle. Many of them end up being homeless. They lose their jobs. They lose their family, their loved ones. I mean, who would want to live that lifestyle. It is a disease. It is something that they cannot help unless they get help from us, you know?

Redman also shared when asked about using non-stigmatizing language:

> It may help with people's perceptions. Me, personally, I'm a tell-it-like-it-is kind of person, you know? It's substance abuse. You're abusing it. And actually, the people that do it know that they're abusing it, okay? They – but I mean the perception that… as long as the people who are experiencing the

> disorder understand the new lingo you. You don't want to confuse people. You want people to know exactly what's going on and what's going on with them. As long as it's something… classified as something that they'll understand, everybody understands, it's still basically that you are using and abusing. I mean, it may but here we go again with me being black and white. This is what you're doing. So, whatever they call it, it still needs to be treated.

Miss Lucky commented:

> This is an international issue. Everywhere you go you have the same stigma as "God, the mother didn't do a good job. The family didn't do a good job." Blame it on the family. It's the same thing here and it's a sad situation because you see a mother or parent, mostly the mothers that are sacrificing everything and the children went and got into the wrong crowd and they end up on the street running and looking for drugs. It becomes the mother's problem. So, it's a tough thing.

Henry shared:

> I was given a report and the nurse who had a very bad night, I was coming in, said to me that she (the patient) was a crack whore. What do you want? She's a crack whore. I was so morally disappointed in her. I just couldn't believe that she would express herself about somebody she had just taken care of the past 12 hours.

Struggling With Role

This category conveys the dichotomy of feelings that the nurses expressed about dealing with substance use disorder patients. The nurses felt an obligation to give good care and yet they also felt challenged in their interactions with patients. Some of the

nurses indicated that they were non-judgmental towards substance patients, despite using stigmatizing language or wanting to move these patients to different areas. Other nurses demonstrated empathy. This category was informed by two subcategories: *safeguarding* and *judging.*

Fluffy stated:

> I saw my role more as, as kind of like the stepping stone, like I'm here to stabilize them, get them out of their critical medical condition, and then in my mind I had to be part of that kind of spoon that would feed it to something else.
>
> with them on the medical floor.

Catness stated (Dealing with patients): "I just did my job. That's it. You know, in that situation, it was just such a short-term that there wasn't any time for therapy. I took care of the patients as best I could."

Riley shared:

> [As a student] They weren't in there for substance abuse, they were in there for something else, but this came out, that the patient had an addiction to opioids. The teacher was telling us to just deal with the reason he [the patient] was brought in. So, I sort of disliked the patient…because you figure they're weak…

Lindsay remarked:

> It's like… they [nurses] act like they don't understand it is a disease. They act like, oh, they're just, you know, they just want drugs, or they stick them at the end of the line it the ER and they won't do anything to take care of them.

Henry commented (regarding ER nurses treating patients with SUD):

> There's always a debate on that. And also because they really looked at them as

> tremendous trauma potential for them – if two or three were going to DTs. And then you had an MI coming in and then their baby came and disaster. They would rather have these folks (SUD patients) that were more in their way to be a little bit more manageable because in their mind they would feel that DTs you handle them rather than when they're really ready to crash without realizing that the DTs can crash on you like this too also.

Kikosam noted:

> The lady that got pregnant by her father, she was a substance abuser, opiate, heroin addict. And I remember one day she came to me and I wasn't her nurse but I guess we have more rapport with her than her own nurse. And then she said she wanted to talk to her nurse about she was pregnant and that she wanted to terminate the pregnancy. And that particular patient's nurse, she was Catholic Irish, like almost a nun. And when I told her be careful what you're discussing because she wanted to have an abortion. So, she went to her nurse and she came back to me crying because of what that nurse told her. So very insensitive. I mean, how would you feel if you were the one being HIV-positive and being pregnant, what would you do? It's easy to judge people.

Marie noted:

> In my hospital, which is a small community hospital, I felt like the nurses were not understanding of the pathophysiology of addiction and they needed to show a little more compassion in my mind. So I got tired of seeing patients reprimanded. "You're back again, you spent all your money, you…" you know, so forth and so on. So, uh, so yeah, I have a lot of experience in dealing with

folks mostly that have a dual-diagnosis.

Safeguarding

A subcategory that influenced *struggling with role* is *safeguarding*. Despite the challenges of dealing with disruptive patient behaviors and how much the nurses avoided patient care, the nurses were very aware of safety issues and keeping the patients safe. *Safeguarding* the patients against the dangers of withdrawal, leaving the unit too early or self-harm kept the nurses vigilant. This subcategory is illustrative of how the nurses were *struggling with role.*

Fluffy remarked:

> Safety from the perspective of they were not going to harm themselves [patients] when they left me, yes, but not safety from the, from the perspective of are they going to use when they leave me.…Oh my God, what am I going to do? You know? Because you care but you just feel ill-equipped to deal with them and the easiest way is just to keep them safe and get rid of them.

Lola shared: **"**We had to make sure of their [patients] safety – so the one-to-one".

Zombie remarked:

> I teach patient safety and I tell the nurses when we are talking about medication reconciliation what they do with their meds…if they're taking controlled substances or anything for pain, to make sure that they keep it in a safe place. So others do not have free access to that medication because the little kids can...help themselves to the medication.

Catness shared: "We would just make sure that the physicians knew for their safety that they smelled of alcohol and what kind of doses of medications they were on."

Marie shared:

> Who knows what really occurs with their health needs with most I met who have an addiction problem, there's mental health needs. They need support, they need, good medical care, they need supportive environment, they need a family that listens. A lot of people don't have that.

Ladybug commented: "I think the hardest part is getting these people to stay on the medication. That's a big problem because, you know, they'll start to feel good, so they'll go off of it."

Judging

A subcategory that influenced *struggling with role* is *judging.* In this subcategory, *judging* describes the opinions of the nurses towards patients with substance use disorders. The dichotomy is that some of the language and behaviors of the nurses do not coalesce with their words.

Miss Lucky shared:

> The patient comes, and the nurse comes to do the IV and they see it…oh! My God that patient is a drug addict!" And it becomes a discussion. Whereas somebody would come from having open heart and "oh, you know, that patient had a bypass surgery. Oh, my God, looks good." So, you can see there are two different scenarios, they're completely different for us it's the same kind of environment. It's only struggling with one part of the body. How do we change our minds to see it as it should be? It's hard.

Redman remarked:

> People who do not understand addiction greatly, who don't work with

> addicted patients, they, some of them – unfortunately too many of them – still have stigma attached to addiction and that issue, but I think if we had more education and people were exposed to it and understood it a little more that maybe people would come to a greater understanding. And therefore take care of the patients better.

Pepper shared: "Religiously, I've always been taught to treat others as you want to be treated… and that's really the motto that I live by. I don't think I have any biases against it (substance use)."

Lola (the pediatric ED nurse) commented:

> After becoming a parent, I don't really like to judge other parents…your child just gets involved with …friends and different things and you kinda lose control. I try not to judge them [parents] too much. Another reason why I try not to be so judgmental because sometimes you just don't know what these children are going through. It's frustrating and a difficult situation, you have to take into account the background and the history that they come from.

Henry stated: "I have always been a very sensitive to the pain of others. So that worked for me really well. That kind of environment. Non-judgmental. To the point that I don't judge anything."

Catness remarked:

> My first job as a nurse was in psych so that's when I had to deal with all of this. And in having the background to human behavior, you really look at people differently and see how they suffer and all the circumstances why they do things. And people do substance abuse for many different reasons. You know,

> it could be for physical pain, it could be for mental anguish, it could be for just to get high and then they get hooked on something. Experimentation. They get hooked on something. There's different reasons why they start abusing. A lot of its self-medication for some type of anguish either physical or mental. And you see all the suffering that goes on and I think that that made me just look at just life differently in people in general.

Lacking Education

Lacking education about substance use is the core category. All the other categories had a lack of education as an integral aspect. The participants were essentially caring for their substance use patients with on-the-job training. The subcategory of *lacking confidence* and *feeling incompetent* was described by all the participants as being central to how they cared for and interacted with patients. They attributed this lack of confidence and feeling incompetent to a lack of education of substance use and caring for patients with substance use disorders.

Rose Smith stated:

> Back then … there's not a lot of understanding and education on people with substance abuse. I basically learned on my own. There were just some things you pick up with experience, with CEUs and with educating yourself and reading more about it as you meet people that suffer from substance abuse.

Fluffy remarked:

> Nothing! I had preparation. And the preparation that we got was when we know when we started to see trends in the types of patients that would come in, we had um, a clinical educator that kind of would educate us, not so much on the disease

process, but she would educate us on… how to get rid of them quickly

Lindsay shared:

When I went to nursing school, there was a very small little piece of an addiction treatment. Substance abuse. Very small. And the whole the way they taught it was wrong. They were talking moderation and it was very brief. It was very lame. When I took the certified addiction in professional courses that shed a lot of light and got me to understand a lot more about it.

Marie commented:

I don't recall any education on substances, quite frankly. Um, even in my master's program, I really don't recall any education on substance abuse. The nurses that I talk to did not feel confident caring for this population. They didn't feel competent, they didn't feel, I hate to say it, but they didn't feel compassion.

Kikosam remarked:

The nursing care, the caring part of the course is important because I want to try to change their attitude, the new nurses' attitude, about patients that have problems with substance abuse. So, that humane component that has nothing to do with the protocol, the medication protocol, it has to be there if I want the new nurses to learn how to treat those people with dignity and respect like any other human being**.**

Pepper noted:

In school I wanna say I did have a certain – not an entire class or anything like that but maybe segments of classes that focus on substance abuse or whatnot. But in practice, not really an emphasis on how to take care of that patient or the

> psychology behind it. I don't think so. And not now in my education job. Definitely not. If you had that situation with a student, I mean I've never had any training in that at all.

Catness commented: [I took courses] "That was in psych. You know, we took courses on addiction and you know, signs and symptoms and how to deal with it. There was a lot of courses through the years….and even recently I took for CEUs".

Henry shared:

> Well, in school, yeah. We cared for the patient with substance abuse and all that, during my psychiatric rotation. And in medical/surgical too. Withdrawals, DTs, the psychosocial emotional care. The education [was] very good. Whenever I hear these nurses or anyone else say, " I really don't know enough about them, I say "you don't have to know so much about it. You can look it up yourself. The literature. That's what I did everywhere I went."

Redman remarked:

> I had little to no education in my schooling. When I was fresh out of school I was working a medical surgical unit. I had a patient who had a carotid endarterectomy. This patient started having—he was almost ready to go home—started having some issues with…"stories". "there are ants crawling, there are ants all over my bed" and I'm like "oh my God!". And I'm the new nurse, crawling under the bed, crawling behind the bed, and I can't find any ants. And I come back and he's got another story of this mouse that he's seeing and blah-blah-blah. I really did not put in, put two and two together at that point. I didn't really know. I called his cardiologist. His cardiologist goes "ooooh." I guess he knew he was a drinker. Back in those days, we didn't [know to ask] a lot about social habits …

Zombie noted on not having any education:

> When the patient starts presenting with some withdrawal signs and symptoms and then you try to, you know, treat them. You don't know what it is. You start seeing changes in behavior. You start seeing sometimes hallucinations, changes in mental status. Things like that. And then all of a sudden you're like, okay, what is wrong with the patient. But then you don't link at that point it could be related to that.

Scoperoo commented on her education:

> [My education] was in psych, yes. Within the psych course, yeah. Part of my psych I had two things of psych, one was at South Florida State... They taught us, you know, to wear street clothes, to wear sneakers in case you have to run, and do not let them get between you and the door. All those things. My second bout of psych was in a hosp – well, it was an inpatient setting but it was specifically for kids. Not small kids but teenagers and young adults with substance abuse problems. However, in those days, their version of substance abuse have been something as simple as smoking a couple of joints of marijuana and their parents would throw them in the program. And as a nursing student, of course, most of what I did was just sit and talk with them.

Ladybug shared:

> [Education in school] Nothing that I can recall. I think the only training I did receive was just recently but that was just because it was required for nursing. The CEUs. But no, I've not [had any courses] just the mandatory Florida License CEU.

Lacking Confidence and Feeling Incompetent

Two subcategories that influenced the *lacking education* category are *feeling incompetent* and *lacking confidence.* The nurses agreed that the lack of education was a reason for lacking confidence and lacking competence caring for this patient population. The participants indicated that because of this absence of basic substance use education they felt incompetent, insecure, and without the confidence to care for the patients with substance use disorders in their care.

Fluffy stated**:**

> I felt comfortable dealing with the component and even with the psych component of a psych disease, but I didn't feel competent to deal with that specific problem that this patient was in [substance use]. For me to be therapeutic. Because you care but you just feel Ill-equipped to deal with them and the easiest way is just to keep them safe and get rid of them.

Lucky shared:

> We don't have the ability to manage those things [addiction], so we had to call the special team in the psych dept. There's a problem and the staff couldn't handle it and they were frustrated but we don't even have a choice…because you cannot refuse taking care of a patient.

Marie also remarked:

> I find the nurses on the floor are very frightened of the medication. They're frightened of giving all the medication they should be giving. They keep thinking somebody's going to go into cardiac arrhythmia. They would much prefer the patient go to ICU and have an Ativan drip than to deal with them on

the medical floor.

Zombie noted:

> I remember not being able to realize, not even till later on, perhaps having a conversation with a doctor and then the doctor saying, “oh, yes, the patient, you know, has some history of alcohol abuse” or things like that. And you’re like “daa”, you know, that’s why then, you know, doctors I don’t think really they’re well informed, either. So they just – what they do, they give you a little more Ativan or a little bit of this or a little bit of that to make it, you know, a little bit better but they don’t actually pursue the handling or treating or managing that specific, you know, issue with the patient.

Kikosam commented on his:

> They are in the psych clinical. So occasionally they get across with somebody that have it. And I found that they really feel uncomfortable talking to them, to those patients. That was not going to [happen] if they didn’t have the lecture. I introduce [substance use] in the classroom because that’s what really made them see the patient, the reason why.

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Figure 2. Initial conceptual model: Achieving understanding: Pathway to care (Blacher, 2019).

The above figure illustrates the initial conceptual model. Each hexagon represents a category with the associated subcategory which was revealed by the Phase I participants. The categories do not stand alone; each one is interconnected with the others. The core category, *lacking education*, is omnipresent in all the other categories.

Focus Group Characteristics

The purpose of the focus group was to confirm the conceptual categories, subcategories, core category and basic social process. The theoretical sampling group was comprised of four nursing experts who have practiced as nurses for 36+ years each. All four participants indicated that they held the highest level of education - a PhD. Each participant has published on substance use disorders and addiction and/or received grants for research as well as presented at national and international meetings and conferences.

Prior to the interview beginning, participants were provided with an explanation of the research and objective of the focus group interview. Each participant signed an informed consent using DocuSign. Additionally, each participant in the focus group completed a demographic questionnaire. Two of the focus group participants met via Skype® and two members of the focus group participants met via telephone as they could not connect to Skype. The meetings were audio recorded by the researcher and subsequently transcribed by the third-party transcriptionist who signed a confidentiality agreement (see Appendix H). The group was informed that due to the nature of the meeting, confidentiality of participants could not be assured. Focus group participants were offered the option of using a pseudonym in the group and in the dissertation and in any publications related to this study. All four of the focus group participants declined using a pseudonym. The participants were informed they were free to leave the meeting at any time without any consequences. A description of the characteristics of the theoretical sample focus group participants is described below. Table 3 follows, which includes the demographic characteristics of the Phase II participants.

There were four (N = 4) female focus group participants. The number of years each focus group participant has been a registered nurse is over 36 years (100%). All four indicated that they that held a PhD, the highest level of education, (100%). All four indicated that they were involved with nursing education (100%). One participant indicated also being a researcher (25%), one indicated having a specialty of public/community health (25%), and one indicated being nurse practitioner (25%). One participant reported being semi-retired but still working as a preceptor and guest lecturer and having a private practice in an outpatient setting. Three nurses reported being

Caucasian (75%). One participant reported being Asian (25%). Three nurses reported having been involved with substance use disorder patients, however at varying amounts of time (weekly [25%], every 2 months [25%], more than 6 months [25%], and one reported no longer having an active practice [25%]). All four participants indicated that they had helped family and/or friends with substance use disorders (100%). All four noted that they had not had any substance use education in their basic nursing programs (100%).

Table 3

Demographic Characteristics Phase II Participants (N = 4)

Characteristics	**N**	**%**
Age		
59	1	25.0
60	1	25.0
73	2	50.0
Gender		
F	4	100
Ethnic Background		
Caucasian	3	75.0
Asian	1	25.0
Highest Degree Earned		
PhD	4	100
Years RN Experience		
36+	4	100
Practice Setting		
Educator: Academia	4	100
Researcher	1	25.0
ARNP	1	25.0
Retired	1	25.0
Time with SUD Patients		
Weekly	1	25.0
Every 2 months	1	25.0

Other than every 6 months	1	25.0
No longer in practice	1	25.0
Helped Family/Friends		
Yes	4	100
Substance Use Education In Nursing Program		
No	4	100

Phase II Focus Group Interview Participants

Peggy Compton, RN, PhD, FAAN is a 59-year-old Caucasian female who is an associate professor of nursing and the van Ameringen Chair in psychiatric and mental health nursing at the University of Pennsylvania. She has over 36 years of nursing experience. She stated that she has helped family/friends whose health problems were caused by substance use problems. She has reported not having had substance use education in her basic nursing program. **Dr. Compton** is a full-time faculty member and a nurse researcher. Her research focus is based around pain and opioids in chronic pain patients. **Dr. Compton** has helped to establish methods to identify substance use disorders and addiction in chronic pain patients. She has had multiple funded research projects and published in numerous books/chapters as well as published multiple papers on substance use and addictions, some of which include the *AANA Journal, Drug and Alcohol Dependence, Pain Medicine, Drug and Alcohol Dependence, Clinical Journal of Oncology Nursing, Journal of Gerontological Nursing, J. Nurse Practitioner*, and the *Journal Pediatric Oncology Nursing*.

Dr. Diane E. Snow, **PhD, RN, PMHNP, CARN-AP, FAAN** is a 73-year-old Caucasian female who is Clinical Professor (retired) but still serves as preceptor and guest lecturer at the University of Texas at Arlington. **Dr. Snow** has over 36 years of

nursing experience. She stated that she has helped family/friends whose health problems were caused by substance use problems. She has reported not having had substance use education in her basic nursing program. **Dr. Snow** has served as the Director of the Psychiatric Mental Health Nurse Practitioner Program. Her research focus is binge drinking and family history and genomics, outcomes of psychiatric mental health NP practice, co-occurring disorders - substance abuse, anxiety, and bipolar disorder. **Dr. Snow** has published in numerous books/chapters as well as published multiple papers on substance use and addictions, some of which include *Supplement to Current Psychiatry, Journal of Affective Disorders, Journal of Addictions Nursing, and Archives of Psychiatric Nursing*, and others.

Nancy Campbell, PhD, FNP-C, CARN-AP, FAANP, FIAAN, FAAN is 73-year-old Caucasian female who is an Associate Professor of Nursing at the University of Buffalo, NY. **Dr. Campbell** has over 36 years of nursing experience. She stated that she has helped family/friends whose health problems were caused by substance use problems. She has reported not having had substance use education in her basic nursing program. Her research focus is High Risk Adolescent Behavior, Advanced Practice Issues & Education, and IPE/IPCP education. **Dr. Campbell** has received many awards and has published in numerous publications on substance use and addictions, some of which include *Journal of Addictions Nursing, Perspectives in Psychiatric Care, Journal for Nurse Practitioners, and the International Journal of Nursing Education Scholarship.*

Dr. Elizabeth Fildes, EdD, RN, CNE, CARN-AP, PHNA-BC, FIAAN is a 60-year-old Asian female who is a Professor in the Graduate Programs at Chamberlain College of Nursing of Chamberlain University. She has over 36 years of nursing

experience. She states that she has helped family/friends whose health problems were caused by substance use problems. She has reported not having had substance use education in her basic nursing program. **Dr. Fildes'** research focus is on the use of distance counseling technology to increase treatment access for individuals with nicotine addiction and co-occurring disorders in frontier, rural and underserved communities. Her translational research activities focus on nicotine addiction treatment and substance abuse prevention. Since 1998, she has presented on the effectiveness of distance counseling technology in local, regional, national and international conferences. She has published numerous articles on tobacco cessation and has also published in the Core Curriculum of Addiction Nursing. **Dr. Fildes** is the founder and senior director of the Nevada Tobacco Users Helpline (NTUH). She has authored four books and contributed to publications focused on tobacco and nicotine addictions, including "Your Journey to a Nicotine Free Life, A Transformation."

Confirmation of the Conceptual Categories, Subcategories and Basic Social Process

The purpose of the focus group was to confirm the conceptual categories, subcategories and the basic social process (BSP) that were co-constructed from the individual interviews. The four participants of the focus group are experts in the field of substance use and addictions. They provided valuable insight and perspectives from their many years as experienced nurses and extensive expertise as PhD-prepared nurses as well as from their publications regarding substance use and addictions. The focus group was provided with a copy of the model that was developed in Phase I, which depicted the three conceptual categories and subcategories and the core category one week prior to the focus group meeting. The focus group provided confirmation of the three conceptual

categories, subcategories, and the core category that emerged from within the data of the individual participants. The BSP *Achieving Understanding: Pathway to Care* the emerging substantive theory was also reviewed. The focus group commented on each of the three conceptual categories, subcategories, core category and the BSP. The group felt that the categories were all related, intertwined, and connected. The experts' feedback on the main categories is described next.

Avoiding

The focus group participants confirmed the category of *avoiding* and the subcategory of disrupting behaviors. The general discussion was in agreement. There was much dialogue by the group addressing the reason for avoidant behavior. The group was in agreement that the avoidant behavior by nurses was informed by the *disruptive behaviors* reported by the individual interview participants. The focus group felt that the avoidant behavior was mostly due to a result of lack of knowledge.

Dr. Compton stated: "Perhaps they avoided them because they were just different, they weren't people they were comfortable with…ethnically, or socioeconomically, or educationally?"

Dr. Snow commented: "Well, it [avoidant behavior] surprises me - occurring on a psych unit. People just don't see it as their problem."

Dr. Campbell noted:

> Patient manipulative behavior is not appreciated by nurses. If you want to irritate a nurse, manipulating is the way to do. Avoiding is part of the struggle that the nurse experiences because of the impact that the patient has on nursing care. Avoiding is a form of coping strategy to deal with the

manipulating behaviors.

Dr. Fildes stated: “Avoidant behaviors do not surprise me. Nurses don’t know how to react to patient manipulation. They are not taught how to react to this.”

Stigmatizing

The focus group participants confirmed the category of *stigmatizing* and the use of stigmatizing *language*. They all accepted that the use of stigmatizing language was very much a problem. The examples shared from the individual interviews served as a basis for much conversation as to why nurses are still using stigmatizing language and ways to help resolve it.

Dr. Compton stated:

> I wonder what their own experience with addiction was. There’s a kind of lore that a lot of people who go in to nursing were caretakers in an alcoholic family or were caretakers … and they bring some of those biases … Maybe anger at a family member or guilt or disappointment. They don’t have the tools to really handle it, you know, they don’t know that. It’s easier not to talk about it.

Dr. **Snow** commented:

> Even if they don’t know what to say, they could say things other things…If the nurses had a resource they could ask, may be refer to someone. They could do some motivational interviewing or something like, “okay, we do have someone you could talk to”. It’s a time to bring in the addictions nurse or the social worker…Say, “Would you be willing to talk to that person?” If there was a way to educate... what you can say... “I hope you can reach out to

> get the help you need" or "what have you tried so far"? They need some sort of information on intervention that they …can do very quickly. Even if the nurses are not going to deal with "the problem", they're establishing a relationship with someone in that moment. They could say something to the effect, "I lived with this in my family and I hope you get help to save your life." It's just something if they knew how important that would be because you never know when you are the one that says something that sparks the interest or the connection. The whole motivational interviewing thing, or part of it anyway, is that you connect it to why they are, you know, some of their problems, and then you educate about how alcohol affects your GI tract, you know, or something to connect it, "could it be possible that this is contributing to your problem" and again using language that is…person-first language.

Dr. Campbell noted:

> Stigma is present. I saw this in my students who are in general nursing. Language is so important. We need to encourage nurses to use patient centered language. More publicity is needed about the difficulty about the consequences of addiction.

Dr. **Fildes** shared: "This is an organizational issue. I brought this [stigma] to the director of my program and was told it was not a priority. How can we as educators change behaviors when we face organizational obstacles?"

Struggling with Role

The focus group participants confirmed the category of *struggling with role.* This category received much discourse as it was thought to be germane to the other categories. *Struggling with role* included nurses being *judgmental* and at times not being *judgmental*, *safeguarding* their patients and protecting themselves. Regarding comments made by Phase I interviews about working with colleagues who are in alternative to discipline (ATP) programs**, Dr. Compton** stated:

> They believe they treat everybody equal and want to do good for people and yet when it comes to actual behavior and language, they're stigmatizing and blaming. I find [this] even with psych nurses. They're happy to talk about depression or schizophrenia but addiction is still even kind of marginalized in that group.

In dealing with the struggle of the nurses' role in caring for SUD patients**, Dr. Snow** said:

> There are points in our lives when you do have an awareness of how things have affected you and therefore how you affect other people. You know, we can't make that happen for people but we can help them. We can help them in school. You know psych used to be, used to teach a lot about how you feel about what people say and what your needs are and all that. I think there's some of that still but self-awareness is something we can still promote in various [programs], in all of our undergraduate education as well as graduate.

Dr. Campbell shared, “When nurses struggle with their role, they are really exhibiting a deficiency of self-efficacy.”

Dr. Fildes commented: “New nurses, especially, struggle with these components, with all these concepts. As educators we need to find ways to provide tools that will assist them.”

Lacking Education

The core category of *lacking education* engendered much discussion. All the focus group participants agreed that education was significant in that there is a severe deficit in addictions education. Although the focus groups participants were cognizant of the Phase I participants comments, they preferred to discuss the need for education and ways to solve the issue.

Dr. Compton shared:

> If you’re better educated, you can get over maybe some of those family issues but if you don’t have the education, some of those family issues may predominate, you know. I was wondering, coming from a pain perspective, are there certain nursing interventions that they were more or less comfortable with? You know going to take a blood pressure, maybe not a big deal, but managing their pain meds, that may be a more difficult negotiation for them. Did they differentiate between the tasks? Did th participants mention pain management at all ?Perhaps it was identified something that was a bigger hurdle for them? It’s a dilemma. I went to the state board of nursing to find out if there were questions on addiction items on NCLEX. I tried to put it under controlled conditions just to see how

many items there were or if there were any at all. They told me it would be a threat to public health to be able to view the exam. I said the threat to public health part is nurses not knowing how to take care of these people.. If there are any questions on board exams about addiction, it is more like alcohol related to liver disease as opposed to alcoholism as a disease that we can intervene with.

Dr. Snow remarked:

The theory of integrating care- the medical, psych, addiction should all be diagnosed and treated together. That needs to be incorporated in to curriculum**. Dr. Campbell** had a grant for FNPs to infuse addictions into the master's program (I was a consultant on that). A similar initiative could be encouraged for undergraduates as well, to infuse addiction content across the curriculum. Its communication skills that is what you're learning. Use a bit of persuasion versus coercion to … at least to make the change.

Dr. Campbell shared:

We need to teach across the curriculum and integrated addictions throughout the health care continuum. Students are not getting the information they need. With the onset of the opioid crisis is the time to start teaching across the spectrum for all addictions. We need to teach causes, preventions, diagnosis and treatment. Primary care is where I see the most need especially behavioral issues. The education process is not consistent. education needs to include attitudes, knowledge, skills and behaviors.

education alone won't compensate.

Dr. Fildes commented, "Education must target the affective domain. Faculty needs to develop a tool kit and educational modules."

Regarding the initial schematic model (see figure 2), the focus group participants made the following remarks.

Dr. Compton stated, "I thought it was interesting. I mean, I thought it was a nice little model. It is interesting that you place lack of education at the center. Everything seems to pivot off that category."

Dr. Fildes commented, "This is a good model – it's good for all types of patients in any area. It is very universal. It could be used very universally. I'm thinking it could even be used for working with undocumented individuals."

Dr. Campbell shared:

> The model is good. I don't know how you could do it on the diagram, but I see all the categories inter-connected. Struggling with role could be related to all the other categories as does education (lacking education). This impacts the lack of confidence and competence. I see all the categories as a pathway to care.

Figure 3. Major categories, subcategories and basic social process: Achieving understanding: Pathway to care (Blacher, 2019).

The model's structure was changed to incorporate the focus group's feedback on how the model evolved to show ow the three conceptual categories, subcategories and the core category was interconnected. The final model more accurately reflects the focus groups very important perspectives. Figure 3 illustrates the basic social process *achieving understanding: pathway to care.* This was derived for the three conceptual categories that are represented by: *avoiding*, *stigmatizing*, *struggling with role*, and the core category of *lacking education*, as well as the subcategories of *disrupting behaviors, language, safeguarding, judging, feeling incompetent and lacking confidence*. All of these supported the basic social process of *achieving understanding: pathway to caring*. Constant comparative analysis and co-construction of the data make it reasonable to unpack the data the participants shared regarding the critical factors that influenced the attitudes and behaviors of caring for substance use disorder patients.

The Basic Social Process: Achieving Understanding: Pathway to Care

The basic social process of *achieving understanding: pathway to care* evolved from blending of the data collection, the constant comparative analysis process and the co-construction of the three conceptual categories, subcategories, and the core category. Interwoven throughout the participant data is the sense that the participants wanted to do good; to practice good nursing care but did not seem to know how to do that. The feelings of incompetence and lack of confidence was largely due to not having the education, knowledge, and skills to care for the substance use disorder population. Avoiding patients is not a typical nursing attribute. Upon deeper questioning, it was disclosed that the nurses were reacting to patient behaviors. These behaviors challenged the nurses, and it was easier for them to use avoidant behaviors than to encounter the patient. The use of stigmatizing language was another category that became prevalent. Were the nurses using this language out of "habit"; doing/saying what is usual in society, or due to lack of knowledge on the effect of stigmatizing language? Were they struggling with the role of being a "good nurse". This is the default for most nurses. Weaving throughout all the categories was the core category lacking education about addiction and caring for substance use patients. This lack of education causes nurses to feel that they do not have the confidence and competence to care for this often-challenging group of patients. When nurses have an understanding of the disease process of substance use disorders and addiction, the care of patients with substance use disorders would be easier to achieve.

Restatement of the Research Questions

By using the coding approach described by Charmaz (2014), the basic social process of *achieving understanding: pathway to care* was co-constructed with the voices of the Phase I participants and the focus group participants in order to answer the research questions that were used to guide this study:

1. What are the critical factors that influence the attitudes and behaviors of nurses caring for SUD patients?
2. How do nurses describe the experiences that influence their attitudes and behaviors while caring for SUD patients?
3. How do nurses describe their decision-making processes in choosing interventions when caring for the SUD patient?

Connection to Theory

The theory of *achieving understanding: pathway to care* is supported by three conceptual categories: avoiding, stigmatizing, and struggling with role and the subcategories: *disrupting behaviors, language, safeguarding, and judgmental*: the core category of *lacking education* and subcategories of *feeling incompeten*t and *lacking confidence*. These categories interact in a contiguous manner, interlaced throughout each category interdependently and with each category. These categories are the processes that comprise how the nurses care for patients with substance use disorders. The three conceptual categories and subcategories and the core category and its subcategories explain the theoretical basic social process of *achieving understanding: pathway to care.* The *avoiding* category grew out of the nurses expressing that they would shorten the time they spend with patients. This was informed by the nurses' perception of the patients'

behaviors (i.e., manipulating, drug seeking, being aggressive, demanding, unreasonable, and uncooperative). Monks et al. (2012) reported, "lack of understanding of drug use was offered as a reason for limiting the assessment process" (p. 942). MacDonald (2003) noted that when a nurse identifies these negative behaviors because the patient does not act as a patient is expected to, the nurse may feel that they are losing control of the situation or the unit's routine and avoid the patient (pp. 306-307).

The *stigmatizing* category was derived from the words that the nurses used to describe the patients as well as their attitudes towards their patients with substance use issues. Stigmatizing is a social process that evolves from an attribute that is felt to differ from what society determines as the "norm." Goffman (1963) stated that the individual may be reduced in our minds form a whole and usual person to a tainted, discounted one. Nurses may spread these labels and stigmatizing behaviors and words to other nurses during the handoff or report process, shaping the attitudes of other health care providers (Higgins Riet, & Peek, 2007). *Struggling with role* is a category where the participants described how they expressed their contradictory feelings toward the substance use patient. According to the American Nurses Association (2015b) nurses have a duty to care for all patients with the same compassion, respect, and dignity, regardless of the patients' diagnosis. Some participants stated they were obligated to give "good care;" others indicated they "just did their job"—they performed their tasks and left. The nurses also felt responsible for keeping their patients safe from harming themselves.

The core category that interconnects with the other three is *lacking education.* This category was informed by the subcategory that further explicates the participants' felt *incompetent and lacking confidence* when caring for substance-related issues of the

patients. The nurses felt that their lack of substance use education fueled their feelings of feeling incompetent and lacking confidence to care for these patients. All the participants admitted not receiving any formal education on substance use issues while in their respective nursing programs. It is only recently that the participants received any substance use education by way of the mandatory Florida licensure requirement of Impairment in the Workplace. This seems to be a vicious cycle: lacking education about substance use and avoiding patients due to behaviors that are not understood, using stigmatizing language and attitudes not realizing that this causes patients to feel badly and to act in ways that are perceived as abnormal or unbecoming a good patient.

Figure 3 illustrates the basic theoretical social process *achieving understanding: pathway to care.* The pathway to care represents that education and knowledge is needed to achieve an understanding of substance use disorders and addiction by nurses. The categories and subcategories do not stand alone; each one is connected to the others and the one core category, the lack education and knowledge that is pervasive in all the other categories. With education, the nurses would have a better understanding of the withdrawal process and might not resort to avoidant care. With education, nurses would understand that using stigmatizing language and behaviors is harmful to patients with substance use disorders. The nurses voiced some caring behaviors such as safeguarding patient's safety. They want to be good nurses and ethical nurses, but they struggle with these feelings. Education and knowledge would lead to greater feelings of confidence and competence when caring for the substance disorder patient. This is the process of achieving understanding, which will lead to the pathway to care.

Chapter Summary

In this chapter, the results from the data collection obtained from the participants during Phase I and Phase II and the analysis of this inquiry were discussed. Phase I involved the individual interviews from 16 participants. Phase II involved the focus group interviews made up of four nurse experts in substance use disorders and nursing, who confirmed the conceptual categories, sub-categories, core category and the basic social process that were co-constructed during the individual interviews. The conceptual categories that were co-constructed from the data included: *avoiding, stigmatizing,* and *struggling with role and the core category of lacking education; as well as the subcategories of disrupting behaviors, language, safeguarding, judgmental.* All of these categories lead to the basic social process of *achieving understanding: pathway to care.*

CHAPTER FIVE

DISCUSSION AND CONCLUSION OF THE INQUIRY

The purpose of this qualitative, constructivist, grounded theory study was to develop a middle-range theory explicating the process of nurses caring for substance use disorders (SUDs) patients. Using the grounded theory approach delineated by Charmaz (2014), the basic social process of *achieving understanding: pathway to care* was co-constructed from the data generated by the participants in Phase I and II of the study. Chapter Five will discuss the meanings and interpretation of the study findings, significance and implications of the study as well as the strengths and limitations. Recommendations for future research will be discussed.

Exploration of the Meaning of the Study

This constructivist grounded theory study was informed by the underpinnings of symbolic interactionism and pragmatism. The philosophical underpinnings of symbolic interactionism and pragmatism provided the lens through which the subject was examined. The intention of this study was to gain a thorough understanding of how nurses attributed meaning to their care of patients with substance use disorders. Using the guidelines suggested by Charmaz (2014), the data were collected and analyzed and the concepts were co-constructed. The participants shared their experiences, thoughts, values, and beliefs encompassing the positions they hold in the care of patients with substance use disorders. Employing the constructivist grounded theory paradigm, the researcher considered the data and analysis as created from a mutual perspective (Charmaz, 2014, p. 239). The interaction of the participants and the researcher led to the generation of categories, sub-categories, a core category, and subsequent theoretical

concepts that confirmed the basic social process of *achieving understanding: pathway to care.* Constructivist grounded theory addresses how "people's actions affect their local and larger social worlds" (Charmaz, 2006, p. 132).

This study was guided by the philosophical underpinnings of symbolic interactionism and pragmatism. Pragmatism is a perspective, developed by the America philosophers/sociologists Charles Sanders Pierce, John Dewey, and William James. (Crotty, 1998). In 1878, a philosophical perspective (later to become known as pragmatism) was put forth by C.S. Pierce, a sociologist (McCready, 2010). It was not until 20 years later that William James began discussing and expanding on Pierce's original thoughts and actually termed it pragmatism (Maddux & Donnett, 2015; McCready, 2010). Pierce referred to his work as practicalism (Maddux & Donnett, 2015). Although James wholly credited Pierce with the originating doctrine of pragmatism, Pierce did not care for James' "empirics-focused principles" and renamed his ideology as "pragmaticism" (McCready, p. 193, 2010). James is thought to be the co-founder of pragmatism and is thought to be the leading influence of pragmatism (McCready, 2010). The perspective of pragmatism posits that practicality or worthwhileness of the phenomenon is superior to inductive knowing. It is a perspective that is based on action and the interaction of people. The truth is discovered through inductive methods via interactive interpretation (Munhall, 2012). The researcher attempts to understand the phenomena of interest through the experiences of the participants in order to explain the social processes being experienced (Creswell, 2013; Munhall, 2012; Patton, 2012). The pragmatist's thinking is that if the knowledge that is produced offers practical experience and is valuable, it is worthwhile pursuing (Corbin &

Strauss. 2008; Munhall, 2012). Pragmatists believe that practicality is of the utmost importance and that theories are based on practical application and actions. This is how individuals come to understand their world. The meanings materialize from useful actions to resolve problems (Charmaz, 2014). Pragmatism maintains that findings may be reviewed and adjusted to create improvements using inductive means and reflection to garner ore of the human experience (Munhall, 2012). It is fluid in nature and may have many interpretations (Charmaz. 2014). There is a strong emphasis on the outcomes of the inquiry. William James writes "pragmatism is the attitude of looking away from first things, principles, 'categories' supposed necessities; looking away towards last things, fruits, consequences, facts" (Crotty, 1998, p. 73). Pragmatists may use a variety of methods to collect data using whatever works to achieve the goals. The problem, not the methodology, is important. Pragmatism informs symbolic interactionism (Charmaz, 2010). Pragmatism posits that usefulness or worthwhileness of the phenomenon is superior to inductive knowing. Pragmatists believe that practicality is of the utmost importance and that theories are based on practical application and actions. It is a perspective that is based on action and the interaction of people. The truth is discovered through inductive methods via interactive interpretation (Munhall, 2012). In pragmatism, the researcher endeavors to understand the phenomenon of interest through the experiences of the participants in order to explain the social processes being experienced (Creswell, 2013; Munhall, 2012; Patton, 2012,). The problem, not the methodology, is important. Pragmatism informs symbolic interactionism (Charmaz, 2010).

Symbolic interactionism is a theoretical perspective that seeks to explore what occurs within a person's world. It was an idea first developed the sociologist, George H.

Mead, and later made known by Herbert Blumer (1969) during the early 20th century. According to Blumer (1969), reality is socially constructed. Blumer based symbolic interactionism on three premises: (a) human beings act toward things on the basis of the meanings that the things have for them; (b) meaning of things is derived from or arises out of, the social interaction that an individual has with one's fellow; (c) meanings are handled in and modified through, an interpretive process used by the person in dealing with the things he encounters (Blumer, 1969, p. 2; Munhall, 2012, p. 228).

The nurse participants in this study shared how their experiences with caring for patients with substance use disorders was influenced by their thoughts, actions, and reactions. The nurse participants' decision-making practices were also affected when choosing interventions to use when caring for their patients with substance use disorders. According to Johansson and Wiklund-Gustin (2016), nurses caring for patients with substance use disorders may feel frustrated, exasperated, and dissatisfied when caring for this patient population. In some cases, the patients' behaviors may test the nurses caring attitudes. This may cause the nurses to be judgmental and to act in a controlling manner. Some of the nurses shared that caring for this patient population brought out personal issues with family or friends. Applying the simultaneous processes utilizing constant comparison of data collection, data analysis, memo-writing and reflection, the four categories emerged: *avoiding, stigmatizing, struggling with role,* and *lacking education.* The categories came together as the participants co-constructed meanings to their experiences with caring for patients with substance use disorders. *Avoiding* is a category that derived from the participants stating that they did not want to care for patients with substance use or minimized the amount of time that they spent caring for these patients.

When explored further, the nurses indicated that the patients displayed *disrupting behaviors* such as manipulating, drug seeking, being aggressive, being demanding, being unreasonable, and being uncooperative. This produced the subcategory of *disrupting behaviors*. T hese caused the nurses to avoid caring for the patients. *Stigmatizing* developed as a category from the described attitudes and behaviors, such as labeling. The subcategory of *language* resulted from the words nurses used when discussing their patients. Nurses utilize stigmatizing behaviors and words during the handoff or report process. This may influence the language and attitudes of other health care providers. *Struggling with role* is a category that sprang the participants' expressions of their contradictory feelings toward the substance use patient. Participants stated they felt obligated to give "good care;" others indicated they "just did their job" and performed their tasks and left with minimal interaction. *Safeguarding* is a subcategory that developed from the nurses' descriptions of a strong need to keep their patients safe from harm. The subcategory of *judging* stemmed from nurses having/describing judgmental or nonjudgmental attitudes. The core category of *lacking education* was created because lacking education about substance use disorders or addiction is intertwined and interlinked to all the other categories and subcategories. None of the nurses had any substance education in their basic nursing programs. They expressed that this lack of education caused them to feel incompetent and had a lack of confidence when caring for substance use patients. The subcategories of feeling incompetent and lacking confidence explains the necessity for these subcategories. All categories provided the framework for the basic social process of *achieving understanding: pathway to care.* The exploration of

the social phenomenon of the critical factors revealed *achieving understanding: pathway to care*.

Interpretive Analysis of the Findings

Chapter One provided an introduction to this study. The problem statement, purpose, and the philosophical underpinnings were described. In Chapter Two, the background, purpose, and literature review were provided, which contributed to a summary of the historical context of the experience of individuals caring for patients with substance use disorders. Within the literature review, substance use, stigma, and nurses' perceptions was well represented in the scientific literature. These studies supported the need to address nurses' experiences in caring for patients with substance use disorders. The purpose of this study was to explore the critical factors that influence the attitudes and behaviors of nursing caring for patients who have substance use disorders. A substantive theory constructed from nurses' attitudes and behaviors may provide the framework needed to minimize the effects of stigmatization in the nursing care provided to the vulnerable and marginalized population.

The results in this study emerged after completing the interviews. The data from the individual interviews was analyzed using constant comparative analysis according to the guidelines of Charmaz's constructive grounded theory. The data analysis yielded the conceptual categories that emerged in this study: *avoiding, stigmatizing,* and *struggling with role and their subcategories*, along with the core category of *lacking education* and its subcategories. The final analysis of the data generated the theoretical framework of *achieving understanding: pathway to care* as the social process for nurses caring for patients with substance use disorders. This framework describes the dynamic and interconnected process nurses go through from

understanding to a pathway to caring. The experts from the focus group were able to confirm the constructed conceptual categories. The model was reviewed and discussed with the focus group. It was suggested by the focus group to modify the model's structure to show a more flowing and interconnectedness of the categories, sub-categories, core category, and the basic social process. Each of the categories and subcategories will be discussed, interpreted, and supported with literature. The findings of the study with the supporting literature and the voices of the participants follow.

Avoiding

Avoiding emerged as one of the categories from the data where participants described how they responded to caring for a patient with a substance use disorder. In this study, *avoiding* is experienced as a withdrawal of actual physical presence or psychological interaction between the nurse and the patient. This distancing impacts the special relationship that is the crux of a caring nurse-patient relationship. Nurses are integral in providing not only supportive care, but health education on a variety of issues as well, leading to better health outcomes for patients (Ford, 2011).

In a qualitative hermeneutic phenomenological approach using observations and interviews from 12 nurses in a home nursing unit, Michaelsen (2012) explored nurses' relationships with patients regarded as being difficult. During the nurses' visits to 96 patients over an 18-month period, which included participant observations, three strategies were recognized: persuasion, avoidance (emotional distance), and compromise. The negative emotions and subsequent frustrations felt by the nurses' stemmed from patients who were perceived by the nurses as challenging, demanding, aggressive, or non-compliant. This limits the ability of good communication between the patient and the nurse. When nurses used the avoidance strategy, it resulted in important social and

health problems not being recognized in some patients (p. 90). This limits the ability of good communication between the patient and the nurse. Avoidance may lead to the overlooking of critical symptoms being overlooked. The patients then may feel frustrated, annoyed, and isolated. By withdrawing either psychologically or physically, the nurses were employing a survival strategy in order to manage their negative emotions concerning the patients.

In this study, *avoiding* is seen as a protective mechanism for the nurses to manage their conflicted feelings. The nurses in the current study illustrate this with the following remarks**:**

Fluffy commented:

> [Referring to substance use patients in the emergency room]: Initially, I would try to get rid of it. Honestly. The way that I worked, I would trade them off and either get another trauma and a vaginal patient. I didn't want to deal with it. I really didn't. It's just…to me it was double the work of a trauma because there was too much honesty, too much interaction, too much topic.

Lindsay stated: "I saw nurses going into patients' rooms and "here's your meds, let's do your blood pressure" and then they would be gone."

Pepper remarked:

> I would still do everything that she needed—just go in and do whatever tasks needed to be done. And then leave. No small talk. Just, "oh, good morning. Here you go. Are you okay?" Do my assessment. Do this. Do that. And then just go in as needed. I think it does put up a barrier because you're kind of like shortening the amount of time you want to spend with them, for sure. But as far as developing

like a relationship with them, I think it does affect that.

Sometimes, nurses utilized avoiding behaviors when dealing with work overload. **Scoperoo** shared, "That's not what I'm there for. I'm dealing with their medical problems and in the case of GI, I was only seeing them for a short time."

Pepper shared:

> This one patient would follow me around the unit when the 4-hour dose was due and she would come and warn me at the 5-minute mark to tell me "my medication is due in 5 minutes, I need my Dilaudid so get it ready". And then she would go back to her room and she would come back on the dot, "do you have it? Give it to me". She would want me to give it to her in the middle of the hallway and I would have to tell her, "no, we can't do it here, we have to go back to your room". So, it was a little bit of a stalking issue with her…

These findings were supported by a study by Khalil (2009). The activities of nurses avoiding care due to patients' disruptive behaviors is reported in a qualitative descriptive survey study of 373 nurses asking about how nurses categorized and treated as difficult and good patients in eight public hospitals in South Africa: three general hospitals, two psychiatric hospitals, two maternity hospitals, and one pediatric hospital. The analysis consisted of counting the frequency that a specific word or phrase were used to describe the behaviors of patients. The good patients were compensated with "tender loving care" by the nurses, and difficult patients were ignored or had interventions delayed. The prime behavior of a good patient is "friendly and calm." The second most acceptable behavior of a good patient is of accepting help without complaining. The third best patient behavior was identified as being very polite. The characteristics of bad patients

consisted of being uncooperative and refusing interventions, rudeness, and aggressiveness. These patients received only care that was necessary. The results of the study found that most nurses provided the appropriate care for patients regardless of patient behaviors.

This study supported the descriptions participants shared about caring for patients with substance use disorders

Pepper provides an example:

> I would still do everything that she needed - just go in and do whatever tasks needed to be done. And then leave. No small talk. Just, "oh, good morning. Here you go. Are you okay?" Do my assessment. Do this. Do that. And then just go in as needed. I think it does put up a barrier because you're kind of like shortening the amount of time you want to spend with them, for sure. But as far as developing like a relationship with them, I think it does affect them.

In the current study, *avoiding* is supported by several examples of avoiding activities that relate to substance use patients. By using avoiding behavior, some nurses may ignore or overlook problems that the patient might be having. Sometimes there was an emphasis placed on the physical so as not to have to deal with the emotional or social needs.

In support of the category *avoiding*, the subcategory of *disruptive behavior* illustrates why nurses avoid care. Nurses report that aggressive, agitated, angry, manipulative patients and those with violent tendencies are why some nurses avoid care (Ford, 2011). Many nurses have reported that patients' negative behaviors make caring for this population quite difficult. Nurses' negative attitudes derive from the challenges of

working with a population that instills fear and has issues of personal safety and mistrust (Neville & Roan, 2014).

Brunnero and Lamont (2010) conducted a quasi-experimental study using an action research approach to assist nurses in developing an e-learning education program to engage nurses in an experiential learning experience about difficult nurse patient relationships and strategies for management. The first part established the magnitude of the problem. The second phase established a learning methodology to resolve the problem. A sample of 23 nurses completed the Difficult Patient Stress Scale. The Difficult Patient Stress Scale uses six clinical scenarios to evaluate the frustration of the nurses towards the cases presented. The third phase disseminated the tool. In the first phase, it was found that the staff was ill-equipped in the skills necessary to manage the difficult patient. The nurses identified patients who exhibited demandingness, aggression, manipulation, and non-adherence to advice. The nurses believed that the patient was the party who needed to change but had an inability to adjust to hospital routine. An inequitable relationship emerged. It was found that utilizing an e-learning scenario based experiential education format would influence the most nurses. The same 23 sample of nurses was administered the Difficult Patient Stress Scale after viewing the e-learning activity. The result indicated a positive improvement in the stress levels, skills and knowledge levels after the e-learning experience. By increasing nurses' knowledge and skills and lowering stress levels while working with so-called difficult patients, improved patient outcomes will occur. The behaviors identified as demandingness, aggression, manipulation, and non-adherence to advice may be considered disruptive and contribute nurses partaking in avoidant behavior.

The participants shared their experiences of caring for patients with what they perceive as negative behaviors. These behaviors make caring for this population quite difficult and led the nurses to avoiding these patients. Patients who were manipulative or exhibited what was perceived as violent behaviors caused the nurses to avoid those patients. **Fluffy** commented: "The yelling and the screaming, the belligerent … They manipulate you, they tell you that something is wrong and nothing really is wrong. But then again, you never know… **Lindsay** remarked: "Substance abusers are very manipulative, and they want to get what they want to get. I'm not saying it in a very negative way. It's just part of the disease."

Catness remarked:

> There was a lot of violence. A lot of nurses would get beat up. Patients would get beat up, other patients. They would, some of them, would get really agitated and start throwing things, you know, it was mostly the alcoholics. It was really, really scary times, but we had our ways of dealing with that too.

Stigmatizing

Stigmatizing emerged as a category from the data. The participants' use of stigmatizing language and descriptions of their behaviors appeared throughout their interviews. Goffman (1963) first described stigma in the literature in the early 1960s and defined stigma as a "deeply discrediting attribute" (p. 3). Stigma is a social process that affects everyone it touches. Stigma, whether words, attitudes, or behaviors, identifies differences, imparting negative attributes or labels distinguishing between "us" from "them," creating a sense of "otherness" that causes discrimination, inequities, and loss of status. Pescolido and Martin (2015) explained that labels create stereotypes that cause

the negative consequence of social inequality. Language, or the words used to describe people, and/or their behaviors may be perceived as stigmatizing. These stigmatizing words may have damaging effects on the people they are referring to. In the case of persons with the substance use disorders, research has shown that stigma may prevent the person with substance use issues access to medical care, employment, housing or seeking substance treatment (Kelly & Westerhoff, 2010; Mundy, 2012; Can & Tanriverdi, 2015). Some of the nurses in this current study reported how stigmatizing words affected them or their family. Some of the nurses in the study use stigmatizing language in the interviews. (Italics will be added to their comments to indicate stigmatizing language and attitudes used by the nurses).

Ashford, Brown, and Curtis (2018) investigated explicit and implicit bias towards individuals with a substance use disorder. The study was a large (N = 1288) quantitative study that recruited from the general public utilizing a Go/No Association Task (GNAT) and vignette-based social distance scale. The terms "substance abuser" and "opioid addict" have shown to elicit greater negative explicit bias. Participants were placed into seven groups for each word pair selection of the study (e.g., substance abuser and the person with a substance use disorder, addict and person with a substance use disorder, etc.) (p. 132). Three vignettes were used for each group of seven participants for a total of 21 vignettes across the entire study. Each participant was randomly assigned to one of the three vignettes within their group: a control vignette, a stigmatizing word vignette, and a non-stigmatizing word vignette. The results of this study revealed that "substance abuser" and "opioid addict" are compellingly associated with the negative and significantly different from the alternative positive terms "person with a substance use

disorder" and "person with an opioid use disorder" (and other terms, addict and person with a substance use disorder, etc.), respectively. Stigmatizing words are believed to negatively influence the quality of healthcare provided by healthcare professionals. **Fluffy** epitomized the concept of 'otherness:"

> A clinical educator that kind of would educate us, not so much on the disease, but how do I *get rid of them* - their insurance is only going to pay for a day …And they say [staff educator] like, well that's *not our problem*. *They* can figure that out later.

Pepper referring to a patient with pain commented**:**

> I could tell that it was not pain, when she would look for me, *she wasn't in any visible pain* like behavioral-wise, you know, *no grimacing, nothing like that*. It was a substance *abuse* issue. And she was also known as a *frequent flyer* that would come to the hospital a lot for that.

Goddu et al. (2018) conducted a study of 413 medical students and residents. Using randomized vignettes of two medical record notes which utilized stigmatizing versus neutral language to describe the same hypothetical patient with sickle cell disease (SCD) and pain management. The note with the stigmatizing language was associated with greater negative attitudes towards the patient and less vigorous pain management. It was found that the stigmatizing language used in the medical record notes negatively influenced the medical students and residents towards the hypothetical patients. This study indicates that language has a formidable influence on attitudes and behaviors. Not only do verbal words matter but so does the written word from medical records. The language used in medical records may be detrimental in perpetrating stigma or, if used appropriately, may promote patient-centered care decrease disparities in stigmatized

populations. The voice of **Rose Smith,** when describing the experience she had with her children with SCD, illustrates how persons with SCD are stigmatized. **Rose Smith** commented:

The hospitalist said, I don't wanna give her… (the kid is screaming and yelling, she's in so much pain). Ion't want to give her anymore because I don't want her to get *addicted* to this.

Rose Smith added, "Oh, she's gonna be a drug addict so that's why we don't want most of these sicklers they become drug addicts, you know," [The nurses' comments].

Fluffy also commented on sickle cell patients:

> I worked neuro step down. At that time—that is where they put the sickle cell patients and … a lot of them, they we're very *dependent*, I guess you could say on "*medication"* That was where I first heard the term *seeker*. I never heard that term before.

Phillips and Shaw (2013) conducted a two (active difficulty vs. remission) by three (substance use, smoking, obesity) factorial design study. This study expanded upon previous research on perceptions of individuals by comparing people who are described as using substances with people who are described as smoking and people who are described as obese. It was hypothesized that people who were actively using substances were the most highly stigmatized group, receiving a high level of reported intention to be socially distant from the individual. The researchers also investigated the idea that people who currently have a condition are more stigmatized than those in remission from the condition. The definition of stigma used by Phillips and Shaw for public stigma as defined by Corrigan and Shapiro (2010). They noted that public stigma occurs when

"large segments of the general public agree with the negative stereotypes" about a group of individuals" (p. 900).

In this study, nurses described attitudes and behaviors that may be interpreted as stigmatizing or discriminating. They uninhibitedly used words that are considered stigmatizing. Language or the words used to describe people and/or their behaviors may be perceived as stigmatizing

In support of the category *stigmatizing,* the subcategory *language* illustrates how nurses frequently refer to their patients with substance use. Often, they do not realize how these words may negatively impact the patients. **Tinkerbell** commented: They see them more as abusers of substance ... I mean, I do hear the comments … he's just a drug addict. He's here for fix. **Lindsay** remarked: I'm guilty of saying/ referring to the patients' drug seeking, and it's true, they are … **Scoperoo** used stigmatizing words, "*street junkie*." We had a few HIV *drug abuser 'street junkie'* in the sense of very almost illiterate. Some were just *street prostitutes,* that kind of thing."

Struggling with Role

Struggling with role is a category that emerged from the data provided by the participants' discussions about caring for patients with substance use disorders. Nurses have a professional and ethical responsibility to abide by the principles of *The Scope and Standards of Practice* as defined by the American Nurses Association (2015). Standard 7. Ethics asserts that the nurse "practices with compassion and respect for the inherent dignity, worth and unique attributes of all people" (p. 67). The nurses interviewed in this study appeared to struggle with this concept, as evidenced by avoiding care and using stigmatizing language or exhibiting stigmatizing behaviors. Yet, some of the nurses did understand their role and did give the patients very good care.

Redman commented:

> The role of the nurse is to be the patient advocate. As a nurse we are the ones that should be sitting there and talking to them and educating them and counseling them and encouraging them and loving them. That's my job.

Some of the participants expressed some role uncertainty. Despite the participants using stigmatizing language, the nurses did convey that they felt their care was adequate or more than adequate and that they were "doing their job." Giving good care is more than just "doing one's job;" it includes caring. It seemed that the nurses wanted to give good care for their substance use patients but felt they did not know how. The nurses seemed to want to be caring but expressed that there were obstacles that may have inhibited them.

Ladybug stated:

> I hate to say it, but I think I still have a very negative outlook on all of this. They teach that it's a disease and I still have a hang-up on that. It's so different when somebody's drinking. They're physically doing this to themselves. I think it's more of a behavior than a disease.

In a qualitative study using a phenomenological approach, Anderson, Willman, Sjostrom-Strand & Borglin (2015) explored nurses' understandings of caring. From the 24 nurse interviews, four different ways of caring were revealed: "caring as person-centredness, caring as safeguarding the patient's best interests, caring as nursing interventions and caring as contextually intertwined" (p. 1). Caring as person-centredness was defined in the study as being able to "see the person behind the patient." Concurring with this, **Henry** remarked**:**

> Many of our patients … unfortunately … made bad decisions, but were great people. That's how I looked at it. The only thing that was different from me and them was that I made better decisions than they did. They were great people.

Kikosam also agreed:

> I became more sensitive … dealing with different human situations, you know, made me understand as a nurse that I'm not dealing just with a patient taking the medication…but somebody who has a variety of human problems. That may have been the reason the person is using as opposed just to see the patient "oh, he's just a substance abuser."

Miss Lucky shared**:**

> The patient comes and the nurse comes to do the IV and they see it…" oh! My God that patient is a drug addict!" And it becomes a discussion. Whereas somebody would come from having open heart and "oh, you know, that patient had a bypass surgery. Oh, my God, looks good." So, you can see there are two different scenarios, they're completely different for us it's the same kind of environment. It's only struggling with one part of the body. How do we change our minds to see it as it should be? It's hard.

In support of the category *struggling with role*, the subcategory of *safeguarding* illustrates nurses are concerned about the safety of their patients

Keeping patients safe was of significant concern to the nurses. Despite the challenges of dealing with patient behaviors, the nurses were aware of safety issues—for the patients as well as for themselves. Safeguarding patients was of paramount concern. Safeguarding the patients against the dangers of withdrawal, leaving the unit too early, or self-harm

kept the nurses vigilant. This was voiced by **Lola:** "We had to make sure of their [patients] safety—so the one-to-one." Caring as nursing interventions was described by the nurses in the study as, "care activities that lead to either relief or improvement of symptoms and enhanced wellbeing. Assessing and observing vital signs and physiological readings, while at the same time striving to understand the patient's symptoms and body language" (p. 5). This was best expressed best by **Zombie** when she shared:

> When you have patients that have substance abuse, you probably don't know immediately that they have that problem. It's not until they are with you ... for a day or two days. And then the patient starts presenting with some withdrawal signs and symptoms and then you know you try to treat them. You don't know what it is. You start seeing changes in behavior, sometimes hallucinations, and changes in mental status. You don't link at that point it could be related to that [substance use], especially with those patients that are... on the ventilator.

Caring as contextually intertwined was explained as how caring is intertwined with what is occurring on the unit. Having a heavy workload or insufficient staffing, paired with limited face-to-face patient time, were classified as being intricate features of contextual caring. **Scoperoo** added**:**

> I did have one young man who was a street kid and he had some drug abuse problems and I really felt sorry for him. I spent a lot of time with him when I had time in between, or if had dinner, sometimes I would go sit in his room and talk with him. Sometimes I would sit and do my charting. I didn't have anything I could to help him, really, so I just watched his lab work a little more closely…

Johansson and Wiklund-Gustin (2015) conducted a qualitative study that was part of a value based clinical application methodology. The study's purpose was to describe nurses' caring encounters with patients suffering from substance use disorders while in an inpatient psychiatric unit. Data consisted of four reflective group dialogues with six nurses over 3 months. The main theme of multi-faceted vigilance identified how nurses attempt to provide good care while at the same time are attentive to patient's behaviors and how they, the nurses react to the behaviors. The focus of the study was on the various everyday challenges the nurses experienced while working with substance use disorder patients. The challenges arise because many nurses think the persons with substance use disorders are dangerous and are unpredictable. Maintaining caring roles all the time may be very difficult and take a toll on the nurse and the nurse-patient relationship. Yet, patients with substance use disorders, who may already have feelings of social inadequacy, believe that having a good relationship with their nurse is quite important to their healing. However, the lack of knowledge and understanding regarding patients with substances use disorders causes the nurses to feel discouraged and unconfident (pp. 303-304). Nurses in this study did communicate that they were attempting to offer good, caring nursing care.

This category conveys the dichotomy of feelings that the nurses expressed about dealing with substance use disorder patients. The nurses felt an obligation to give good care and yet they also felt challenged in their interactions with patients.

Lindsay remarked:

> The person that is suffering from the disease… I recognize it as a disease and I acknowledge the struggle, and I think they are the same as anything else. Same as

> any other person. They come from multiple walks of life. Some of them are nice. Some of them are not nice, just like regular people, except they are sick. They have the disease. I think they need help. I think they need compassion and care and to be taken care of; to be shown that there is a way out.

Marie also shared:

> They need support, they need, good medical care, they need supportive environment, they need a family that listens. A lot of people don't have that. I don't think compassion takes time. I think it's just the way that you interact. I mean, you can take a blood pressure and be compassionate or not. I mean, you're still going to take the blood pressure. So, I think it's the way that we enter the room, the eye contact we have, the focus on the computer that we have a little too much and not looking at the patient and sitting. I don't buy that there's no time for his. I just don't buy it.

Catness added:

> I just felt a lot of sympathy and compassion because…they really, really suffered. When you see them in that state having to come in and having to be detoxed, it was really very sad and they really suffered a lot.

In a qualitative descriptive study, Reed and Fitzgerald (2005) examined nurses' attitudes and how they affect the care given, the problems that relate to providing care, and the influence of education, support and experience. The themes developed were not our role, fear, comfort from education and support, and mental health care as integral to nursing. The categories described in this study support the views described by nurses in this current study regarding the struggle with their role as nurses caring for patients with

substance use disorders. The category of not our role revealed that there was a dislike of caring for people with mental health and these nurses would not do so, if given a choice. This category is supported by comments from participants in this study.

In support of the category *struggling with role,* the subcategory of *judging* is illustrated by the remarks of the participants. Judging describes the opinions of the nurses towards patients with substance use disorders. The dichotomy is that some of the language and behaviors of the nurses do not necessarily coalesce with their words. **Lindsay** stated:

> It's like… they [nurses] act like they don't understand it is a disease. They act like, oh, they're just, you know, they just want drugs, or they stick them at the end of the line it the ER and they won't do anything to take care of them.

Riley shared:

> **[**As a student] they weren't in there for substance abuse, they were in there for something else, but this came out, that the patient had an addiction to opioids. The teacher was telling us to just deal with the reason he [the patient] was brought in. So, I sort of disliked the patient…because you figure they're weak…

Fear was another category described by the nurses in the study. The nurses feared for their own safety as well as for other patients. They felt threatened and vulnerable for their physical and emotional well-being. In this current study when asked about feeling safe, the participants indicated that this was due to their personal life experience and that mental health was an integral part of nursing care. Commenting on personal life experiences, **Marie** commented, "I grew up in a household with an alcoholic father, so I think it was very significant. I saw the, you know, I worried about the family and the

children." **Riley** stated, **"**My first husband was an alcoholic, so I didn't realize that until after we were married, and his drinking increased. That was the beginning of my education because I went to ALANON." **Henry** shared**:**

> I had a brother who had a severe problem with alcoholism. I had alcoholism in my family. To me, I guess I could have turned out to become an alcoholic, but it was the opposite. I didn't want any part of drugs or alcohol. It horrified me.

Redman also revealed personal experience**:**

> I have a brother who is…actually two brothers who have substance abuse problems. They're both alcoholics. One is homeless on the streets. The other one has had all kinds of issues that involve divorce, using when he's married…infidelity, the whole nine yards, which I'm sure that the substances have not helped him with so I went into substance abuse because it was something very close to me and my family.

In the study cited, personal experience had a powerful effect on the attitudes and ultimately on the care given. The nurses from my study also indicated that their personal life experiences had a dramatic effect on the nursing care delivered to their substance disorder patients.

Lacking Education

Lacking education emerged as the core category that is interwoven throughout all the categories. All participants voiced not having substance use education in their nursing programs and almost none had employer provided programs or support. Caring for this patient population presents many challenges to the nurses due to a lack of understanding of the needs of patients with substance use disorders (Brunnero & Lamont,

2010; Khalil, 2009; Michaelsen, 2012). Lack of knowledge of substance use also breeds stigmatizing attitudes and behaviors which negatively impacts on the health of patients (Ashford, Brown & Curtis, 2018; Can & Tanriverdi, 2015; Goddu et al., 2018; Kelly & Westerhoff, 2010; Mundy, 2012; Pescolido & Martin, 2015). Due to the lack of having had any education on alcohol and drugs in their nursing curriculum, the nurses verbalized that they felt insecure and incompetent to care for this patient population. As shown by the voices of the nurses in this current study, the lack of education in the nursing curriculum about addiction is a major contributor to nurses not having the basic foundation necessary to care for persons with the disease of addiction. Facilities of all levels of care are being inundated with people who have a substance use disorder and practicing nurses need to know who to provide the best care to the population of patients with a substance use disorder. The participants described their lack of substance use educational experiences.

Fluffy stated**:**

> Maybe I would have been fantastic at it. [If] somebody would have trained me, but I wouldn't know. So, there's definitely a lack of education and clinical education. Not so much the books because you can read a book. We've seen it and interacted with the patient and talk to them and really sat there and had a conversation, you know, it doesn't seem real.

Lindsay shared**:**

> When I went to nursing school, there was a very small little piece of an Addiction treatment. Substance abuse. Very small. And the whole the way they taught it was wrong. They were talking moderation and it was very brief.

> It was very lame. When I took the certified addiction professional courses, that shed a lot of light and got me to understand a lot more about it.

Rassool and Rawaf (2008) conducted a quasi-experimental, pre-and posttest study of 110 undergraduate nursing students who have completed the second year of their educational program in the mental health. The main purpose of the study was to evaluate the effect of an educational program on alcohol and drug on knowledge attainment and attitude and confidence with intervention skills of the undergraduate nursing students. The curriculum consisted of having the students recognize their own attitudes towards substance misuse, drug use, and the stereotypes; describe the method of use and the effects of commonly misused psychoactive substances; identify three screening methods for use in alcohol and drugs; carry out a basic drug and alcohol assessment, outline the prevention strategies and treatment options available for substance misusers; and discuss the role of the nurse in the assessment and treatment of substance misuse. The findings of this study revealed that the educational program had an impact in enhancing the knowledge, attitude change, and intervention confidence skills of undergraduate nursing students. The mean scores in the posttest attitude questionnaire indicated a more positive attitude towards substance misusers. Another positive outcome was that the students felt optimistic that drug and alcohol dependence were treatable illnesses. Having positive attitudes towards persons with alcohol and drug misuse enhances the nurse-patient relationship, which leads to providing appropriate care. One of most significant aspects of the educational program is not only about knowledge acquisition, changes in attitudes and skills development but that the students are able to transfer what they learned in clinical practice to the delivery of quality care to those with substance misuse problems.

With the current national opioid epidemic, student attitudes regarding illicit drugs is important to recognize. A study conducted with student nurses by Harling and Turner (2102) was undertaken to provide insight into the factors which influence the attitudes of student nurses towards illicit drugs. This constructivist grounded theory imparted the groundwork for creation of an educational program to challenge the apparent negative attitudes of nurses towards persons who use illicit drugs. The initial stage of data collection involved the use of informal conversational interviews (N = 12), students were then recruited to participate in semi-structured interviews (N = 9), and finally, four focus groups were later conducted in order to expand on the data generated in the semi-structured interviews. Several categories emerged from the data that influenced the students' attitudes to illicit drugs. One was contemporary social order. These attitudes are influenced by the wider society in which they live. Another theme was culture. This category is about data pertaining to the students' experiences gained within local communities and through social networks. Nurse education was considered as a separate category of data. Adult medicine students (n = 29) reported that they had not received any taught hours linked to substance misuse, while mental health students (n = 22) reported a mean of five hours of education linked to substance misuse. Significantly, the students who completed the questionnaire indicated the importance of substance misuse as a topic area of nurse education. Students said that they would like more factual information on illicit drugs to be included in the nursing curricula, citing issues such as the physical effects of drugs and treatment interventions as areas for further learning. Knowledge deficits with regard to drugs could result in the students developing a reluctance to engage with substance using patients.

The nurses in the current study expressed not having received any substance use education in their nursing programs, nor did they receive any education or support from their workplace. All the other categories in this current study had the lack of education as an integral aspect. The participants were essentially caring for their substance use patients with on-the-job training.

In another study concerning nursing students and patients with opioid use, Lewis and Jarvis (2019) conducted a qualitative content analysis. The purpose of this study was to examine 11 senior nursing students' experiences with patients who have an opioid use disorder in the clinical setting. From the semi-structured interviews, six themes emerged: navigating ethical dilemmas, gaining comfort with time and experience, avoiding the "elephant in the room," learning from real-world scenarios, witnessing discriminatory care, and recognizing bias and stigma. Findings of this study were consistent with other research showing that health professionals experience difficulty and discomfort caring for patients with SUD, which may lead to avoidant behavior and missed opportunities for interventions. However, none of these studies addressed these aspects in student nurses. Despite the fact that the a few students at first felt uncomfortable, they expressed becoming more comfortable with more experience. The students were eager to learn about harm reduction strategies and are capable of harm reduction topics. Students in the clinical areas are quite capable of offering education about overdose prevention and management and the common comorbidities such as hepatitis C and HIV.

One of the findings in the study was the expressions of stigma and bias the students received from some of the staff nurses in the clinical setting. Several staff nurses who worked with the students conveyed their biases and stigmatizing words and

behaviors in caring for the patients with substance use disorders. Nurses who work with students (or new nurses) are role models and need to be mindful of how their words and actions influence and affect students. The students indicated that they had a sincere a desire to provide empathetic care, a readiness to learn, and displayed a willingness to identify and overcome their own biases. This is an important study in that it addresses educating student nurses on substance use disorder, specifically opioid use disorders. This is an area that nursing does not typically address. It also addresses teaching and learning about substances use disorders in patients while students are in the clinical area, seeing and experiencing real patients with the disease of addiction. Two of the participants made interesting comments regarding clinical education at the different facilities where they work. **Tinkerbell** commented, "Talking about how clinical nursing educators deal with substance use patients—It takes up too much time to deal with a patient's behaviors." **Kikosam** remarked**:**

> [While teaching in a psych clinical] occasionally, they get across with somebody that as it [substance use patient] … I found that they [students] really feel uncomfortable talking to them, to those patients.

Providing substance use content in an undergraduate nursing program can make significant changes to attitudes towards persons with substance use disorders. Puskar, Gothan, Terhost, and Hagle (2013) developed a curriculum (in conjunction with the Institute for Research, Education, and Training in Addiction (IRETA) to prepare baccalaureate student nurses to provide Screening, Brief Intervention, and Referral to Treatment (SBIRT). This is an evidence-based, public health approach to screening to assess patients for risky substance use and referral to treatment for those who may have a

substance use disorder that needs treatment. The program includes 13 hours of education (10 modules) during the junior year in the Psych Mental Health course. The curriculum includes 6 hours of didactic and experiential instruction via an in-class seminar, 3 hours of practice and supervised feedback during clinical rotations, and 2 hours of practice with culturally diverse scenarios in the simulation laboratory. The purpose of the study was to explore the changes that take place in the outlooks of 319 undergraduate nursing students in dealing with patients' alcohol and drug use. To measure student attitudes the Alcohol and Alcohol Problems Perception Questionnaire (AAPPQ) and the Drug and Drug Problems Perception Questionnaire (DDPPQ) were administered immediately prior to the in-class seminar and 30 days after the seminar. Both of these evidence-based tools assess the same properties: role adequacy, role legitimacy, role support, motivation, work satisfaction, and task-specific self-esteem (Watson, Maclaren, Shaw, & Nolan, 2003; Watson, Maclaren, and Kerr, 2007). When asked about her undergraduate substance use education, **Fluffy** remarked:

> I think if they would have had perhaps like a workshop or some sort of seminar where we could have just addressed that and then maybe had some clinical scenarios or acting out where you know how to deal with them and talk to them. If in school… like having an extra class would have…worked, you know, [It] would have really been [of benefit... I think the benefit of it would have really been to see it in action to maybe look at little skits or clips of actual patients or perhaps actors acting it out. How they, that interaction between the nurse and the patient. I think that that's what I was missing…. You go in and you look and you read, and you see the studies… But it's hard to connect it into the clinical

> component if you have never seen it. And then you don't know if what you're seeing is really what you're reading. So, it's kinda hard.

The lack of substance use education in the undergraduate nursing curriculum has left practicing nurses feeling that they are without the preparation, knowledge, and skills to care for this patient population. The nurses also feel that they lack the confidence and competence needed to give the proper care for this sometimes-challenging group of patients. **Marie** is a nurse manager on a behavioral health unit. She commented**, "**The nurses I talk to do not feel confidant caring for this population. They didn't feel competent, they didn't feel, I hate to say it, but they don't feel compassion."

Rose Smith shared**:**

> There's not a lot of understanding and education on people with substance abuse. I basically learned on my own. There were just some things you pick up with experience, with CEUs and with educating yourself and reading more about it as you meet people that suffer from substance abuse.

In fact, several of the participants noted that they were informed about substance use from the required RN license requirement in Florida. Taking a two-credit continuing education on Impairment in the Workplace is a necessity in order to renew a license. According to the Florida Board of Nursing, renewal continuing education must include "... two (2) hours in recognizing impairment in the workplace..." (Florida Board of Nursing, 2019). **Ladybug** remarked, "It gives you a little more insight to things. And it gives you information to how to handle, who to report to. It's a step. It's not always gonna be easy but it's a step." **Pepper** added, "I've taken the license course. I've never

had any other training. **Zombie noted**, “I’ve taken the course to renew my license – I’ve had several instances that co-workers were in the IPN…”

In an effort to improve the competency and confidence of practicing nurses caring for substance use disorder patients, Russell, Ojeda, and Ames (2017) conducted a quasi-experimental pre-class-post-class study of 57 acute care nurses. The purpose of the study was to determine the influence of a 2-hour interactive educational intervention on the perceived competency of nurses who care for patients with behavioral and substance abuse disorders. One competency indicator in particular showed a significant improvement. The pre-class competency statement, which had the lowest rating, was “Make the approach with a positive, nonjudgmental attitude” (3.5%), with 26 (45.6%) of the nurses disagreeing with the statement. The post-class rating of this statement was markedly improved with 56 (of 57) or 98.3% of the nurses reporting that they agree or strongly agree. In this study, statistically significant increase was found in perceived competency related to self-confidence, attitudes, communication, and knowledge of resource availability among participating nurses. After the 2-hour educational class, the nurses showed a positive increase in self-reported competency as a result of the educational intervention.

The subcategory of *lacking confidence* and *feeling incompetent* was described by all the participants as being central to how they cared for and interacted with patients. The participants indicated that because of this absence of basic substance use education they felt incompetent, insecure, and without the confidence to care for the patients with substance use disorders in their care. In the current study the nurses all shared that the

lack of education caused them to feel incompetent and lacking in confidence when caring for the substance use population.

In another study of practicing nurses who care for substance use disorder patients, Perry and Azulay Chertok (2018) conducted a quasi-experimental one group pre-test and post-test study of 31 hospital-based nurses. The purpose of this study was to evaluate a continuing education intervention on nurses' knowledge and perceived competency regarding the care of hospitalized patients with substance use disorder. The study found a statistically significant improvement in the response to the statement regarding perceived competency in "knowing the questions to ask if the nurse suspects drug or alcohol use." The change was 3% in the pre-class rating and increase to 4.32% in the post class rating. After the educational class, the nurses demonstrated an overall statistically significant improvement in hospital nurses' knowledge and perceived competency with regard for caring for patients with substance use disorder following the evidence-based continuing education intervention.

Significance of the Study

The results of this study may have meaningful implications for disciplines outside of nursing such as psychology, social psychology, psychiatry, and social work since there is a dearth of theories on nurse's attitudes and behaviors towards patients with substance use disorders by these disciplines. This study may influence the overall scientific community in relation to the advancing of grounded theory method. Grounded theory is a method of discovery that embraces the views of the participants and may include the inquiry of a social process that will lead to the generation of a substantive theory. Grounded theory methodology is ideal for research areas that have limited or no well-

developed theories. It is hoped that this study will offer a new theory, which has been constructed from the participant data, concepts, and categories to explain nurse's attitudes and behaviors toward patients with substance use disorders.

Significance of the Study to Nursing

This study is significant in that nurses are often unaware of how their attitudes and behaviors influence the nursing care of patients with substance use disorders. The creation of a middle range theory regarding nurses' attitudes and behaviors toward caring for persons with substance use disorders will provide a foundation to improve nursing practice, education, research, health and public policy. Smith and Parker (2015) noted that nursing theories guide advancement and direction for nursing. Nurses have an ethical obligation to incorporate theoretical knowledge into whatever their nursing role may be. The knowledge acquired by investigating this study problem may lead to interventions being developed that identify and alter negative attitudes, behaviors, and perceptions that are held by nurses and other healthcare providers towards patients with substance use disorders (SUDs). A better understanding of stigmatizing attitudes and behaviors by nurses toward patients with substance use disorders could lead to positively changing the negative effects of stigma towards SUD patients and advance positive healthcare outcomes.

Implications for Nursing Education

Nurses across all health care settings will find themselves caring for patients with substance use disorders. It is imperative that nursing education, particularly undergraduate education, prepare nurses to care for this patient population. The current nursing curriculum is appallingly deficient in addressing the necessary educational

knowledge regarding substance use disorders. Information clearly identified from the data in this study indicated that nurses are not getting the knowledge that would be indispensable to the care of their patients with substance use disorders. Ideally, this information should be made available in the nursing curriculum. Essential to this curriculum is knowledge regarding stigma information; attitudes, behaviors and language, and its impact on the care of patients (Bartlett et al., 2013; Van Boekel et al., 2013; Kelly & Westerhoff, 2010). In order to have an understanding of the causes of substance use disorders and the behaviors caused by them, it is imperative for nurses to also have a basic appreciation of the neurobiology of substance use (Finnell, Nowazi & Carey, 2013; Koob & Volkow, 2016). Undergraduate education has shown to be an appropriate time to teach Screening, Brief Intervention and Referral to Treatment (SBIRT) (Burns et al., 2012; Finnell et al., 2018). Faculty, especially clinical faculty needs to provide the opportunities for students to explore the care of patients with substance use disorders across the continuum of care. With the knowledge from *achieving understanding: pathway to care,* educators and nursing leaders could influence the curriculum—both didactic courses and clinical courses. Substance use education needs to be part of the outcome measures for all graduates. In order to prepare nurses for the future of in increasingly complex health care milieu, educators need to advocate for inclusion of substance use education into the undergraduate nursing curriculum.

Implications for Nursing Practice

There are currently nearly four million nurses in the United States today and they are present in every healthcare setting (ANA, n.d.). Nurses are not only qualified but are ideally positioned to care for patients with substance use disorders within their scope of

practice (ANA, 2015). The Institute of Medicine (2011) summons nurses to practice to the full extent of their education. The nurse participants in this study reported caring for a variety of patients in a variety of specialties, and yet, many of the nurses stated they did not know how, or they avoided caring for patients with substance use disorders. They also expressed feeling incompetent and having little or no confidence in caring for substance use disorders patients. None of the participants had any education on substance use disorders in their nursing program. The lack of education, knowledge, and skills was the core category in this study. Lack of education impacted the other categories of stigmatizing behaviors and language as well as struggling with their roles. It is essential for nurses to have the knowledge and skills needed to provide evidence-based care for persons with substance use disorders. Nursing is guided by a social contract with society. Nurses have an ethical obligation to provide care for the ill, disadvantaged, underprivileged, underserved, and vulnerable in society (ANA, 2017). Once nurses are in the practice setting, organizations could provide orientation programs and competency programs which inform the employees about the facilities philosophy of patient care and stigma language. The findings from this study could very well serve as a guide for nurses, nurse educators, and nurse leaders to make significant changes that will impact the care of patients and improve the health care setting.

Implications for Nursing Research

The findings of this study add to the body of knowledge of nursing. This study may be significant to nursing research because it explored the topic from the perspective of nurses who shared their personal experiences and illuminated the critical factors which influence and guide their practice. As a result of this study, categories that emerged can

be used to develop new research from the concepts and categories that support the core category *achieving understanding: pathway to care* and theoretical model. This framework needs to be tested and further explored with a more diverse study population to significantly confirm its categories. The data regarding this study could have broader implications with other populations and additional studies may be performed which will enhance generalizability of the results. Additional research is needed to develop a variety of best practice teaching strategies that would promote competence and confidence for both students.

Implications for Health and Public Policy

Substance use disorders have become a public health crisis ((NSDUH, 2016; UNODC, 2017). Substance use disorders are a national health care priority. Nurses are poised to influence policy around substance use disorders on a local and national level. The IOM (2011) has a call for action for nurses to become more involved with policy development. This study is significant to improving health and public policy because it is focused on substance use issues. With better education about substance use disorders and stigma, nurses of all levels can advocate for better healthcare for this marginalized population. Nurses can get involved in health promotion and prevention. They can start by getting involved in their workplaces by promoting and supporting policies to provide stigma free care. Establishing uniform protocols and guidelines at their institutions is another way to become involved. Along with general education for students, colleges of nursing need to emphasize inclusion of social justice in curriculums. Understanding the intersection of health disparities and social justice issues are needed in order to move the needle forward on public health

policies for substance use disorders. The framework of *achieving understanding: pathway to care* can provide a foundation for nurses to have an increased involvement with public health issues and health disparities as well as advocacy for this group of patients.

Strengths and Limitations of the Study

This study has both strengths and limitations. One strength of this study is that the voices of the nurses who had experiences in caring for patients with substance use disorders provided the rich descriptions allowing for the co-construction of the conceptual categories, sub-categories, and a core category that lead to the social process of achieving understanding: pathway to care to be developed. The purposive selection of 16 individual interviews supplied the thick, descriptive data. Maintaining trustworthiness of the study is a strength of this study. Every effort to ensure the rigor of the study was exercised. The researcher used continuous constant comparative analysis method and extensive memoing and reflexive journaling throughout the process, which ensured conformability. By following the accepted guidelines for data collection and analysis, dependability of the study was achieved. The conceptual categories were saturated after 12 interviews and verified by an additional four more totaling 16 Phase I interviews. Transferability was realized by use of the demographic data, personal characteristics. and the sample descriptions of the Phase I participants. Another strength is the use of triangulation between the individual participants and the focus group experts. The basic social process of achieving understanding: pathway to care, was confirmed by a focus group of four experts. A strength of the focus group experts was their geographic diversity within the United States (Pennsylvania, Texas, Nevada, and New York). This theoretical sample of experts reviewed the conceptual categorical, sub-categories, a core category, and basic social

process. They provided feedback and confirmed the initial conceptual model. Another strength is that the conceptual model and basic social process may be applied to other populations. The researcher also sought advice from the dissertation chair and committee members to provide guidance on grounded theory procedure.

Several limitations exist for this study. There is a lack of geographical variability for the Phase I participants, as they are all located in two counties of South Florida. Another limitation is the age of Phase I participants. The mean age is 55 years. Perhaps a younger group of nurses would have different experiences with caring for substance use disorder patients. A limiting factor might be the participants' ability to remember incidents as they actually occurred, as well as to be completely candid when they do respond. A final limitation is that the researcher is a novice and is inexperienced in the constructive grounded theory approach. Constructive grounded theory is a complex process for a novice researcher.

Recommendations for Future Study

There are several recommendations for future research in this area. Future research studies should consider a more diverse group of participants. The diversity might be more inclusive of gender, age, geographic location, and practice settings. Replication studies highlighting the core category and conceptual categories could be conducted. Longitudinal studies on the effects of educational programs in nursing curriculums and continuing education programs focusing on outcome studies of the attitudes and behaviors of nurses caring for substance use patients after having the education and knowledge are also needed. Other research could include the addition on stigma and ethics and identifying and evaluating the effects nurses' and patients' relationships with

substance use disorders. Quantitative studies might be conducted to evaluate the significance of the relationship among the factors affecting nurses caring for substance use patients.

Summary and Conclusions

This research study used the constructivist, grounded theory methodology of Charmaz (2014) to explore the critical factors that influence nurses' attitudes and behaviors caring for patients with substance use disorders. The purpose of the inquiry was to co-construct a substantive theory. A purposive, snowball sample of 16 individual participants who met the inclusion criteria was used in Phase I of the study. This sample self-identified as caring for patients with substance use disorders and generated the data needed to co-construct the theory of *achieving understanding: pathway to care*. The theory consists of three conceptual categories (*avoiding, stigmatizing*, and *struggling with role*, and the core category of *lacking education*, and supported by the subcategories of *disruptive behaviors, language, safeguarding judging,* and *feeling incompetent and lacking confidence.* A focus group interview of four nurse experts in substance use, addictions, and nursing confirmed the conceptual categories and the theoretical framework. The focus group also confirmed that the model might be used with other populations. The findings from this study has implications for nursing education, practice, research, health and public policy. The strengths and limitations of the study were also addressed. This study recommends several possibilities for future research in caring for patients with substance use disorders and nursing. This study affords a way to understand the meanings of nurses' experiences in caring for patients with substance use disorders. It is hoped that continuing research will contribute to the body of nursing

knowledge, adding to the understanding of improved caring for patients with substance use disorders.

Chapter Summary

In this chapter, the results from the data collection and analysis of the data were discussed. Phase I included 16 individual interviews involving RNs who have cared for patients with substance use disorders. Phase II consisted of a focus group interview with four participants who served as part of the theoretical sample to confirm the major categories and the basic social process that emerged from Phase I. Phase II results were also discussed and explained. The categories are *avoiding, stigmatizing,* and *struggling with role,* and the core category of *lacking education.* These categories are supported by the subcategories of *disruptive behaviors, language, safeguarding judging,* and *feeling incompetent and lacking confidence*. The basic social process that emerged from these categories and which is the conceptual model of *achieving understanding: pathway to care.*

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APPENDIX A

IRB APPROVAL LETTER

Barry University
Division of Academic Affairs

Institutional Review Board
11300 NE 2nd Avenue
Miami, FL 33161
P: 305.899.3020 or 1.800.756.6000, ext. 3020
F: 305.899.3026
www.barry.edu

Research with Human Subjects
Protocol Review

Date:	February 27, 2018
Protocol Number:	1192914-1
Title:	The Critical Factors Influencing the Attitudes and Behaviors of Nurses Caring for Patients with Substance Use Disorders
Name:	Ms. Suzan Blacher CNHS
Faculty Sponsor:	Dr. Jessie Colin

Dear Ms. Blacher:

On behalf of the Barry University Institutional Review Board (IRB), I have verified that the specific changes requested by the convened IRB on February 21, 2018 have been made.

It is the IRB's judgment that the rights and welfare of the individuals who may be asked to participate in this study will be respected; that the proposed research, including the process of obtaining informed consent, will be conducted in a manner consistent with requirements and that the potential benefits to participants and to others warrant the risks participants may choose to incur. You may therefore proceed with data collection.

As principal investigator of this protocol, it is your responsibility to make sure that this study is conducted as approved by the IRB. Any modifications to the protocol or consent form, initiated by you or by the sponsor, will require prior approval, which you may request by completing a protocol modification form.

It is a condition of this approval that you report promptly to the IRB any serious, unanticipated adverse events experienced by participants in the course of this research, whether or not they are directly related to the study protocol. These adverse events include, but may not be limited to, any experience that is fatal or immediately life-threatening, is permanently disabling, requires (or prolongs) inpatient hospitalization, or is a congenital anomaly cancer or overdose.

The approval granted expires on March 18, 2019. Should you wish to maintain this protocol in an active status beyond that date, you will need to provide the IRB with an IRB Application for Continuing Review (Progress Report) summarizing study results to date. The IRB will request a progress report from you approximately three months before the anniversary date of your current approval.

If you have questions about these procedures, or need any additional assistance from the IRB, please call the IRB point of contact, Mrs. Jasmine Trana at (305)899-3020 or send an e-mail to **dfeldman@barry.edu.** Finally, please review your professional liability insurance to make sure your coverage includes the activities in this study.

Sincerely,

David M. Feldman, PhD
Chair, Institutional Review Board
Barry University
Department of Psychology
11300 NE 2nd Avenue
Miami Shores, FL 33161

****

Note: The investigator will be solely responsible and strictly accountable for any deviation from or failure to follow the research protocol as approved and will hold Barry University harmless from all claims against it arising from said deviation or failure.

APPENDIX B

BARRY UNIVERSITY INFORMED CONSENT FORMS

This section contains individual and focus group consent forms.

APPENDIX B
INFORMED CONSENT – INDIVIDUAL
Barry University
Informed Consent Forms
Individual Interview

Your participation in a research project is requested. The title of the study is: **A Grounded Theory Study of the Critical Factors Influencing the Attitudes and Behaviors of Nurses' Toward Patients with Substance Use Disorders**. The research is being conducted by Suzan Blacher, a doctoral student in the College of Nursing and Health Sciences at Barry University, and is seeking information that will be useful in acquiring knowledge about the attitudes and behaviors of nurses toward patients with substance use disorder. The purpose of this research is to explore the knowledge, attitudes, and behaviors of nurses toward patients with substance use disorders. To achieve this aim, a face-to-face interview using open-ended questions related to the topic will be conducted. It will last approximately 60 minutes, plus an additional 10 minutes to complete a demographic questionnaire. The researcher will transcribe the digital recording (using a professional transcriber) of this first interview and send it to you via email or mail for you to review it for accuracy and then we will have a follow-up interview in-person, or via telephone, or email to go over the transcription. The purpose of this second interview is for clarification and verification of information collected during the first interview. This second meeting is expected to last approximately 30 minutes; the total time is approximately 100 minutes. We anticipate the number of participants to be a maximum of 25 individuals.

If you decide to participate in this research, you must meet the following criteria: Registered Nurses who:

1. are currently working with patients who have substance use disorders in any healthcare setting
2. are ready and willing to recount perceptions and experiences toward patients who have substance use disorders
3. are at least 2 years post-graduation
4. must read, write, and speak English
5. are willing to have the interview audiotaped and transcribed
6. are willing to review and return the transcribed tape as part of the "member check"
7. must have access to a computer, the internet, and phone.
8. If using Skype, you must know how to use the video conferencing method Skype® with access to a computer, email, or fax and telephone.

A $20 Visa gift card will be sent to you via mail by the researcher on the day of the interview as a token of appreciation for participating in the study. Thank you for agreeing to be part of the study. You may keep this gift even if you withdraw from the study.

Your consent to be a research participant is strictly voluntary and should you decline to participate, or should you choose to drop out at any time during the study, there will be no adverse effects. You may also choose not to answer any or all questions.

There is no known risk as a result of your participation in this study. Although there are no direct benefits to you, your participation in the study may help our understanding

of your knowledge, attitudes, and behaviors of nurses toward patients with substance use disorders

As a research participant, the information you provide will be held in confidence to the extent permitted by law. As this project may involve the use of Skype: to prevent others from eavesdropping on communications and to prevent impersonation or loss of personal information, Skype issues everyone a "digital certificate," which is an electronic credential that can be used to establish the identity of a Skype user, wherever that user may be located. Further, Skype uses well-known standards-based encryption algorithms to protect Skype users' communications from falling into the hands of hackers and criminals. In so doing, Skype helps ensure user's privacy as well as the integrity of the data being sent from one user to another. If you have further concerns regarding Skype® privacy, please consult the Skype privacy policy. Confidentiality cannot be guaranteed in the Skype interview communication. After the interview, the researcher will delete the conversation history. Once this is done, the conversation cannot be recovered. To ensure confidentiality, the researcher will establish a separate Skype® account for this research project only. After each communication, the researcher will delete the conversation history. Once this is done, the conversation cannot be recovered. The conversation will be transcribed by the researcher. Following verification of transcription, the digital recording will be destroyed.

As stated previously, to the fullest extent of the law, the information you provide as a research participant will be kept confidential; consent forms will be separated from data and locked in an alternate file in the researcher's office, no names or other identifiers will be collected on any of forms used, except for this consent. Any published results of the research will not use your name, or any characteristics that can reveal your identity. Data will be kept in a locked file in the researcher's office and on a personal, password-protected computer that is accessible only by the researcher. Audiotapes will be destroyed after transcription. Your signed consent form will be kept separate from the data. All data will be kept for 5 years after the study as required by law and then indefinitely.

If you have any questions or concerns regarding the study or your participation in the study, you may contact me, Suzan Blacher, MSN, RN, CARN at [redacted] or my supervisor, Jessie M. Colin, at [redacted], or Barry Institutional Review Board point of contact, Barbara Cook, at [redacted]

If you are satisfied with the information provided and are willing to participate in this research, please signify your consent by signing this consent form.

Voluntary Consent

I acknowledge that I have been informed of the nature and purposes of this experiment by Suzan Blacher and that I have read and understand the information presented above, and that I have received a copy of this form for my records. I give my voluntary consent to participate in this experiment.

_____ _____

Signature of Participant *Date*

_____ _____ _____ _____

Researcher *Date* *Witness* *Date*

APPENDIX B
INFORMED CONSENT – FOCUS GROUP
BARRY UNIVERSITY
INFORMED CONSENT FORMS
(For use with Skype)

Your participation in a research project is requested. The title of the study is: **A Grounded Theory Study of the Critical Factors Influencing the Attitudes and Behaviors of Nurses' Toward Patients with Substance Use Disorders**. The research is being conducted by Suzan Blacher, a student in the College of Nursing and Health Sciences at Barry University, who is seeking information that will be useful in acquiring knowledge about the attitudes and behaviors of nurses toward patients with substance use disorder. The purpose of this research is to explore the knowledge, attitudes, and behaviors of nurses toward patients with substance use disorders. The aim of the research is to generate a substantive theory about the knowledge, attitudes, and behavior of nurses caring for substance use disorder patients. A $20 Visa gift card will be given at the beginning of the interview as a token of appreciation for participating in the study. You may keep this gift even if you withdraw from the study. To achieve the aim of the study, the following procedures will be used: a digitally recorded group interview of approximately seven people, at a mutually agreed time and location by all participants and researcher will be conducted. The focus group interview will be conducted face-to-face or via Skype®, using open-ended questions related to the topic of knowledge, perceptions, attitudes, and behaviors of nurses toward substance use disorder patients. In addition, focus group participants will review categories and emerging theory that generated from prior individual interviews. This interview will last approximately 90 minutes, with 10 minutes (total 100 minutes) allocated to complete a demographic questionnaire. The number of participants is anticipated to be a maximum of seven expert PhD prepared nurses who have published one or more theoretical or research articles on substance use and/or addiction in peer-reviewed in scholarly nursing journals and who are willing to review and reflect on the usefulness and "fit" of the emerging theory to nursing education, research, practice, and policy. Be willing to discuss their perceptions and reflections of the developed theory with other experts, published colleagues during a focus group in person or via Skype®. Be willing to have the focus group interview audiotaped and transcribed. If unable or unwilling to interview with the researcher in person, have access to a telephone or the Internet (Skype) resources for the focus group interview.

If you decide to participate in this research, you must meet the following criteria:

1. PhD-prepared RN who has published one or more theoretical or research articles on substance use and/or addiction in peer-reviewed, scholarly nursing journals
2. PhD-prepared RN willing to review and reflect on the usefulness and "fit" of the generated theory to nursing education, research, practice, and policy

3. PhD-prepared RN willing to discuss his or her perceptions and reflections of the developed theory with other experts, published colleagues during a focus group via Skype, telephone, or in person
4. PhD-prepared RN willing to have the focus group interview audiotaped and transcribed.
5. Agree to participate in an interview face to face or via Skype group interview, lasting approximately 90 minutes at a place and time that is convenient for the group.
6. Be willing to discuss your knowledge, perceptions, and attitudes toward patients with substance use disorders.
7. Be willing to have the interview audiotape recorded and transcribed
8. You must know how to use the video conferencing method and have access to a computer, email, and telephone.

Your consent to be a research participant is strictly voluntary, and should you decline to participate, or should you choose to drop out or not answer certain questions at any time during the study, there will be no adverse effects on you.

There is no known risk to you as a participant in this research. Although there are no direct benefits to you, your participation in the study may help us acquire knowledge, perceptions, and attitudes of nurses toward substance use disorder patients.

As a research participant, the information you provide will be held in confidence to the extent permitted by law. As this project involves the use of Skype, to prevent others from eavesdropping on communications and to prevent impersonation or loss of personal information, Skype issues everyone a "digital certificate" which is an electronic credential that can be used to establish the identity of a Skype® user, wherever that user may be located. Further, Skype uses well-known standards-based encryption algorithms to protect Skype users' communications from falling into the hands of hackers and criminals. In so doing, Skype helps ensure user's privacy as well as the integrity of the data being sent from one user to another. If you have further concerns regarding Skype privacy, please consult the Skype privacy policy. The researcher will establish a separate Skype account for this research project only. The Skype focus group participants have the option of being visible to the researcher and other participants, but all participants will be audible to one another, therefore, confidentiality cannot be guaranteed. The conversation will be digitally recorded, and at the conclusion of the interview, the researcher will delete the conversation history. The recordings will be later transcribed by the researcher, using a professional transcriber, and the digital recordings will be destroyed after transcription is verified. Once this is done, the conversation cannot be recovered.

Although the researcher guarantees to keep all information obtained from the group confidential, due to the nature of groups, confidentiality by group members cannot be guaranteed. All focus group members are asked to respect the privacy of other group members. Any published results of the research will be in aggregate form, and pseudonyms will be used. Transcripts of recordings will be kept in a locked file in the researcher's office and on personal, password-protected computer that is accessible only by the researcher. Your signed consent form will be kept separate from the other data. All data will be kept indefinitely.

If you have any questions or concerns regarding the study or your participation in the study, you may contact me, Suzan Blacher, at [redacted]

[redacted] my supervisor, Dr. Colin, at [redacted] or the Institutional Review Board point of contact, Barbara Cook, at [redacted]. If you are satisfied with the information provided and are willing to participate in this research, please signify your consent by signing this consent form.

Voluntary Consent

I acknowledge that I have been informed of the nature and purposes of this experiment by _____ and that I have read and understand the information presented above, and that I have received a copy of this form for my records. I give my voluntary consent to participate in this experiment.

_____ _____

Signature of Participant *Date*

_____ _____ ____

Researcher *Date* *Witness* *Date*

(Witness signature is required only if research involves pregnant women, children, other vulnerable populations, or if more than minimal risk is present.)

APPENDIX C

BARRY UNIVERSITY

RECRUITMENT FLYERS

This section contains individual and focus group flyers.

APPENDIX C
Recruitment Flyer
Phase I

NURSES NEEDED FOR RESEARCH STUDY

Registered Nurses Needed to Explore Nurses' Experiences in Caring for Substance Use Disorder Patients

Phase I (Maximum of 25 Volunteers Needed)

Registered Nurses (RNs):

- **Currently employed as an RN with at least 2 years of experience.**
- **Care for patients who self-identify as substance use disorder patients in any healthcare setting.**
- **Fluent in English.**
- **Willing to share perceptions and experiences about caring for patients with substance use disorders.**
- **Willing to have the interview audiotaped.**
- **Willing to review and return the transcribed tape as part of the "member check".**
- **Have access to a computer, the internet, and phone.**
- **Total time commitment is 100 minutes.**

You will receive a $20 Target gift card in appreciation of your participation in the study.

If you would like to participate in the study, please contact:

Primary Investigator: Suzan Blacher, MSN, RN, CARN [redacted]

Faculty Supervisor: Dr. Jessie Colin: [redacted]

Barry University IRB: Jasmine Trana: [redacted]

APPENDIX C
Recruitment Flyer
Phase I

NURSES NEEDED FOR RESEARCH STUDY

Registered Nurses Needed to Explore Nurses' Experiences in Caring for Substance Use Disorder Patients

Phase II (Maximum of 9 Volunteers Needed)

Registered Nurses (RNs) who are PhD prepared:

- Have published one or more theoretical or research articles on substance use and/or addiction in peer-reviewed, scholarly nursing journals.
- Willing to review and reflect on the usefulness and "fit" of the generated theory to nursing education, research, practice, and policy.
- Willing to discuss reflections on the developed theory with other experts, published colleagues during a focus group either via Skype.
- Willing to have the focus group interview audiotaped.
- Have access to a telephone, Internet and Skype® for the focus group interview.
- Total time commitment is 160 minutes.

You will receive a $20 Target gift card in appreciation of your participation in the study.

If you would like to participate in the study, please contact:

Primary Investigator: Suzan Blacher, MSN, RN, CARN [redacted]

Faculty Supervisor: Dr. Jessie Colin: [redacted]

Barry University IRB: Jasmine Trana: [redacted]

APPENDIX D

BARRY UNIVERSITY

INTERVIEW GUIDE FOR INDIVIDUAL INTERVIEW

Opening question

What are your experience and views of delivering care to patients with substance use disorders?

Additional Questions for Interviews

Transitional questions

1. Tell me a story about a time when you cared for a person with SUD.
2. Describe how you felt you when caring for a person with SUD.
3. How prepared educationally did you feel in providing care for this patient?
4. What recommendations would you suggest for the care of persons with SUD at your health care facility?

Probe Questions

1. Describe how it feels being assigned to care for a person with SUD.
2. What aspects of caring for a person with SUD made you feel confident?
3. Describe the roles and responsibilities of a nurse when caring for a person with SUD.
4. What guides your care of persons with SUD?

Additional probe questions added to the interview guide:

1. What is it like to care for a person experiencing SUD?
2. How would you describe a patient experiencing problematic drug or alcohol use?
3. Are you personally affected by the assignment of caring for a person with SUD? Do you feel distressed when caring for these individuals?
4. Did you feel that the rapport that you had with your patient facilitated your confidence?
5. Describe the "good" or "safe" care of a person with SUD.
6. Tell me the role that interpersonal relationship plays in your care of the individual experiencing SUD.

Concluding question

Do you have any comment or information that you want to add that was not covered during our conversation?

(Blacher, 2016, adapted from Novak, J. M. (2013)

APPENDIX E

BARRY UNIVERSITY

INTERVIEW GUIDE FOR FOCUS GROUP INTERVIEW

Initial Open-Ended Questions

1. Please describe what you think about nurses' attitudes in general toward patients with substance use disorders.
2. What is your experience with substance use disorder patients?
3. Can you tell me about an instance where you saw or perceived a patient who was not getting the best nursing care?
4. What are your thoughts on the personal traits or values that might help (or hinder) a nurse's involvement in caring for a patient with substance use disorder?

Intermediate Questions:

1. What are your thoughts regarding the categories that emerged during the individual interviews?
2. How would you describe nursing's professional role in caring for addiction patients?

Ending Questions:

1. Do you think the categories represent your views of attitudes and behaviors of nurses toward patients with substance use disorders?
2. Is there anything else you would like to add?

APPENDIX F

BARRY UNIVERSITY DEMOGRAPHIC QUESTIONNAIRES

This section contains individual and focus group demographic questionnaires.

APPENDIX F

BARRY UNIVERSITY

DEMOGRAPHIC QUESTIONNAIRE FOR INDIVIDUAL INTERVIEW

Participant Demographics Form

Do not write your name on this paper, Use your pseudonym.

Please answer the following questions by filling in the blank or circling the best answer.

- Age ____
- Gender____

What do you consider to be your ethnic background?

- African American
- Caucasian
- Hispanic or Latino
- Asian
- Other

What is your highest degree earned?

- Associate in Nursing (ASN)
- Bachelor's in nursing (BSN)
- Master's in Nursing or related field (MSN)
- Doctoral or terminal degree

Years of Experience as an RN?

- 1-5
- 6-10
- 11-15
- 16-20
- 21-25
- 26-30
- 31-35
- 36 or more

What type of patients do you *generally* care for (Circle all that apply)?

- Cardiac
- Diabetic
- Women's Health
- Oncology
- Post-operative
- Orthopedic
- Med-Surg

- Critical Care Area
- Other _____

How often do you care for substance use disorder patients?

- Daily
- Weekly
- Monthly
- Every 2 months
- Every 4 months
- Every 6 Months
- Other

Have you or someone you know in your personal life ever experienced a substance use disorder?

- Yes
- No

Have you received any education in substance use disorders in your nursing program?

- Yes
- No

Have you taken any continuing education on substance use disorders?

- Yes
- No

APPENDIX F
BARRY UNIVERSITY
DEMOGRAPHIC QUESTIONNAIRE FOR FOCUS GROUP

Do not write your name on this paper. Use the pseudonym.

Please answer the following questions by filling in the blank or circling the best answer.

- Age ____
- Gender____

What do you consider to be your ethnic background?

- African American
- Caucasian
- Hispanic or Latino
- Asian
- Other

Years of Experience as an RN?

- 1-5
- 6-10
- 11-15
- 16-20
- 21-25
- 26-30
- 31-35
- 36 or more

In what setting do you practice nursing? (Check all that apply)

- Educator
- Nurse practitioner
- Management/Administrator
- Researcher
- Acute care/hospital
- Chronic care/rehabilitation
- Clinic/outpatient
- Long-term care
- School nursing
- Public/Community health
- Academia
- Retired
- Other_____

How many years have you been involved with substance use disorder patients?

- Daily
- Weekly
- Monthly
- Every 2 months
- Every 4 months
- Every 6 Months
- Other

Have you or someone you know in your personal life ever experienced substance use disorder?

- Yes
- No

Have you received any education in substance use disorders in your nursing program?

- Yes
- No

APPENDIX G

BARRY UNIVERSITY

INTERVIEW PROTOCOL

1. Introduce researcher to the participant(s). Welcome and express appreciation for their participation in the study.

2. Explain the purpose of the study, the types of questions to be asked, the expected time frame for the interview, the ability to stop the interview and/or withdraw from the study at any point in time, the process of audio taping and transcribing the interview, and the methods being used to maintain confidentiality and anonymity. Remind participants in the focus group interview that the confidentiality of information may not be possible due to the nature of the focus group process.

3. Ask participant if he or she has any questions and give informed consent form to be signed by the participant.

4. Ask he participant to select a pseudonym to be used as an identifier.

5. Give the participant(s) the $20.00 VISA gift card prior to beginning the interview.

6. Conduct the interview using the guide for the individual or focus group interview questions.

7. Thank the participant(s) at the end of the interview.

8. For the individual interview, inform the participant that the researcher will be sending the verbatim transcription via email within three days. Schedule a time for member checking either over the phone or in person within one week.

9. Take several minutes to self-reflect, take field notes, and journal thoughts and feelings.

10. Transcribe the interview within TBD

11. Send transcribed interview to participant for the member check, and schedule confirmatory interview within one week.

APPENDIX H

BARRY UNIVERSITY

THIRD PARTY CONFIDENTIALITY FORM

Appendix H

Barry University Third Party Confidentiality Form

Confidentiality Agreement

As a member of the research team investigating_ I Cara Melo understand that I will have access to confidential information about study participants. By signing this statement, I am indicating my understanding of my obligation to maintain confidentiality and agree to the following:

- I understand that names and any other identifying information about study participants are completely confidential.
- I agree not to divulge, publish, or otherwise make known to unauthorized persons or to the public any information obtained in the course of this research project that could identify the persons who participated in the study.
- I understand that all information about study participants obtained or accessed by me in the course of my work is confidential. I agree not to divulge or otherwise make known to unauthorized persons any of this information unless specifically authorized to do so by office protocol or by a supervisor acting in response to the applicable protocol or court order, or otherwise, as required by law.
- I understand that I am not to read information and records concerning study participants, or any other confidential documents, nor ask questions of study participants for my own personal information but only to the extent and for the purpose of performing my assigned duties on this research project.
- I understand that a breach of confidentiality may be grounds for disciplinary action, and may include termination of employment.
- I agree to notify my supervisor immediately should I become aware of an actual breach of confidentiality or situation which could potentially result in a breach, whether this be on my part or on the part of another person.

[illegible]

Signature Cara Melo

Date Printed Name

Date Printed Name

Appendix H
Barry University
Third Party Confidentiality Form

Confidentiality Agreement
THE CRITICAL FACTORS INFLUENCING THE

As a member of the research team investigating ATTITUDES & BEHAVIORS OF NURSES I understand that I will have access to confidential information about study participants. By CARING FOR signing this statement, I am indicating my understanding of my obligation to maintain PATIENTS WITH confidentiality and agree to the following: SUBSTANCE USE DISORDERS.

- I understand that names and any other identifying information about study participants are completely confidential.
- I agree not to divulge, publish, or otherwise make known to unauthorized persons or to the public any information obtained in the course of this research project that could identify the persons who participated in the study.
- I understand that all information about study participants obtained or accessed by me in the course of my work is confidential. I agree not to divulge or otherwise make known to unauthorized persons any of this information unless specifically authorized to do so by office protocol or by a supervisor acting in response to the applicable protocol or court order, or otherwise, as required by law.
- I understand that I am not to read information and records concerning study participants, or any other confidential documents, nor ask questions of study participants for my own personal information but only to the extent and for the purpose of performing my assigned duties on this research project.
- I understand that a breach of confidentiality may be grounds for disciplinary action, and may include termination of employment.
- I agree to notify my supervisor immediately should I become aware of an actual breach of confidentiality or situation which could potentially result in a breach, whether this be on my part or on the part of another person.

Signature	5/4/18 Date	MARILYN CABRERA Printed Name
Signature	Date	Printed Name

Certificate of Completion

The National Institutes of Health (NIH) Office of Extramural Research certifies that **Suzan Blacher** successfully completed the NIH Web-based training course "Protecting Human Research Participants".

Date of completion: 01/24/2018.

Certification Number: 2615580.

VITA
Suzan Blacher, MSN, RN, CARN

March 9, 1953	Born – Brooklyn, NY
1977	Diploma, Massachusetts General Hospital School Nursing, Boston, MA
1977-1981	Staff RN, Assistant & Head Nurse, Investigator Mount Sinai Medical Center, Miami Beach, FL
1981-1983	Quality Assurance Coord. Holden District Hospital Holden, MA
1992-2000	Home Health Field Nurse, Baptist Health South Florida Miami, FL
2000-2003	GI RN South Miami Hosp Miami, FL
2003-2004	Home Care Liaison, Baptist Health South Florida Miami, FL
2005	BSN Barry University Miami, Shores, FL
2004-2010	RN Clinical Educator South Miami Hospital Miami, FL
2010-2012	Clinical Educator, University of Miami Hosp Miami, FL
2011	MSN, Drexel University Philadelphia, PA
2012- Present	Assist Clinical Professor Drexel University, Phil. PA

PUBLICATIONS

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Blacher, S., Bivens, B., Hernandez-Pupo, N., Perez, M., Wallace, R., & Lovell-Martin, B. (2015). The alarming impact of socioeconomic factors on population health indicators. Sigma Theta Tau Lambda Chi Chapter Research Conference, Miami, Fl. Podium Presentation

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Blacher, S., Smentkowski, R. (2014) The value of certification. International Nurses Society on Addictions Conference, Washington, DC, October 2014. Podium Presentation

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