UNDERSTANDING CHEMICAL DEPENDENCY

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This is the second article in a series addressing impaired practice issues in nursing.

Chemical dependency can be defined as use of drugs and/or alcohol to a degree that causes interference in personal welfare and/or the safe delivery of nursing care. Chemical dependency is endemic in our society; estimates exist that at least 20% of our population is at risk or suffers from it. The incidence of chemical dependency in nurses is even greater; one in seven is at risk.

The problem of impaired practice in nurses affected by chemical dependency raises considerable legal and ethical issues. Impaired practice has costs and consequences affecting quality of care, turnover and retention, morals, and risk management issues. Quality of care is impacted and the risk of preventable errors escalates when judgment, observational ability, and concentration are impaired. Both economic and human costs are highest when the problem goes unrecognized until a crisis occurs that necessitates intervention.

Financial costs to the institution include sick time, absenteeism, decreased productivity, and cost of recruiting, hiring, training, and orienting new staff. Non-economic costs include public loss of confidence in the institution and nursing profession, and staff morale decreased by feelings of anger, betrayal, guilt, and shame. Costs to the chemically dependent nurse include loss of license to practice, income, potential loss of health benefits, cost of treatment, possible legal costs, and health risks associated with the disease of addiction.

ETIOLOGY OF CHEMICAL DEPENDENCY

Nurses at risk for chemical dependency tend to have certain traits in common. They tend to have a strong need to care for others, and to measure self worth by how much they are able to tend to others' needs.

Seventy percent have a family history of alcohol problems. They graduate in the upper third of their class, are ambitious, are achievement oriented, and have outstanding job performance. Their first drug use is usually in nursing school, or after years of legitimate self-medication for physical or psychological pain.

There are a number of attitudes that increase the risk for chemical dependency. These include the beliefs that:

- Addiction is a moral flaw rather than a disease.
- That knowledge of drugs and their effects will prevent addiction from occurring.
- That drug or alcohol use can enhance healing.
- That self-medication is appropriate to relieve physical and/or psychological pain.

Other risk factors include role strain, burnout, insomnia, decreased self-esteem, self-pity and feelings of powerlessness.

Chemically dependent nurses continue to use chemicals because of the pain in their lives. Stress increases the pain and the need for substance used; increased pain increases the speed of disease progression. As the disease progresses, they tend to use their chemical of choice (which may be alcohol) in private so as to protect their license. They will tend to avoid "street" drugs, but may tamper with medications on the unit, or abuse drugs legally obtained from a doctor's prescription. They tend to place a high value on their license and work, and will often protect their license to the exclusion of other areas of their lives. They are incapable of accepting responsibility for their situation, and will blame others. They do not possess healthy coping skills, and are not aware of their choices. The need to keep the addiction a secret causes increased tension and stress.

STAGES OF ADDICTION

Three states of chemical dependency have been identified: experience, commitment, and compulsion.

During experience, the initiating phase of the first drug use occurs. A connection is made when the use of the drug is associated with decreased pain. Through experimenting, a preferred drug of choice is selected.

During commitment, the decision to include drugs in the lifestyle occurs. Self-dialogue justifies use of the drug to get through the day. Bargaining is used to rationalize drug use by setting up conditions under which stopping drug use would occur ("if I ever do ...then I'll quit"). The defense mechanism of denial allows the nurse to believe that no problem exists, and ignores the consequences of continued use. Disengagement from society and former values occurs.

"Routinizing" is the step where drug use and strategies to obtain drugs are incorporated as an everyday part of life. Strategies may include transfer to work areas with less supervision, fewer co-workers, less alert patients, or where drugs are more readily accessible.

The disease eventually progresses to compulsion. The addict is possessed by the addiction and sees it as the only means of survival. The addict's view of reality is distorted, and eventually leads the addict to self-destruction by overdose, accident, or suicide.

If discovered to have a problem, the nurse is often immediately terminated and, if diversion of narcotics is involved, referred to the criminal justice system. Nurses may be fired for poor performance or poor attendance when addiction is actually suspected; this is known as the "throwaway nurse syndrome."

The nurse may also be offered the option of resigning with a neutral reference. The nurse may have a position before being found out, and go on to another facility to perpetuate his/her addiction.

ASSESSMENT AND INTERVENTION

As the disease of chemical dependency progresses, its effects become apparent in behavior and job performance Often the job setting is the last place that the effects of chemical dependency manifest themselves; the nurse puts all available energy into making everything look alright on the outside so that no one confronts her/him. Even when job performance begins to be affected, the nurse will make plausible excuses for behavior.

The nurse is aided in this by co-workers who accept these excuses, make excuses of their own with supervisors, compensate for the nurse's shortcomings, and/or tolerate abusive behavior. These actions, rather than helping the nurse, actually contribute to the problem by enabling the nurse not to be accountable for his/her actions, thus preventing the individual from seeking treatment until the disease has progressed and caused further deterioration of job performance.

Early indicators of chemical dependency in the work setting include absenteeism, tardiness, leaving early, and job shrinkage. Staff complaints will often occur before patient complaints. This may be explained by the nurse as a personality conflict; the nurse may request transfer to another shift or unit, and the problem will seem to get better. Eventually, however, complaints will resurface and closer investigation is required.

Behaviors warranting investigation may include:

- staff/patient complaints
- accidents, injuries, errors in practice or documentation
- increased visits to employee health or emergency room
- volunteering to take call for others
- arriving early/staying late to assist in narcotic count
- frequent absenteeism for days off, or for family emergencies
- irritability/mood swings
- job shrinkage (performing the minimum work required)
- inability to perform psychomotor skills due to tremors or shakes
- poor documentation
- volunteering to be medication nurse
- unwitnessed waste of narcotics
- using smaller dose forms, i.e. giving two 30mg tables when 60 mg available
- frequent job changes
- frequent absences from unit
- requesting different pain medication or increased dosage for patient
- change in personal appearance or grooming

It must be remembered that not every one of these behaviors necessarily indicate a problem. Requesting a different medication or increased dosage for pain, for example, is completely appropriate, if the ordered medication and dose is not adequate for pain control. Rather than single incidents, it is a pattern of behaviors that is indicative of a problem.

But they may indicate the need for a conference with the nurse. Management should be notified for support and to ensure the agency policy and procedure is followed for the safety and rights of all concerned. ❖

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