# Caring for Persons with Problematic Alcohol Use in a Hospital Setting: Nurses and their Experiences

by

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## DEDICATION PAGE

This thesis is dedicated to my family who have been a great support to me throughout this process. My husband, Richard Novak, who has been proud and supportive of my work and shared the many uncertainties, challenges, and sacrifices necessary for completing this work. My mother and father, Joan and Kent Murphy, who have always emphasized the importance of education, been my role-models for hard work, persistence and personal sacrifices, and instilled in me the inspiration to set high goals and the confidence to achieve them. My sister, Kate Murphy-Robinson, who has been my emotional anchor through not only the vagaries of graduate school, but my entire life.

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# ABSTRACT

Registered Nurses (RN) care for individuals living with problematic alcohol use on a daily basis. There is limited knowledge available that describes the nurse-patient relationship in the context of problematic alcohol use. The purpose of this study was to describe the RNs' experiences caring for persons with problematic alcohol use on a medical inpatient hospital unit.

Qualitative Descriptive Methodology guided by Peplau's theory of Interpersonal Relations was used to conduct this inquiry. Nine participants were recruited to participate in semi-structured interviews. Two themes with related subthemes were identified through thematic analysis: *Nurse Patient Relationship Harmony and Disharmony,* and *Struggling to Care.*

Study participants acknowledged that stigmatizing attitudes persist in the care of persons living with problematic alcohol use, and did not associate the establishment of the nurse-patient relationship with reducing stigma. Participants called for improved knowledge of the disease, and the the use of evidence-based protocols to improve care.

## LIST OF ABBREVIATIONS USED

| | |
|---|---|
| BI | Brief Intervention |
| BScN | Bachleor of Science in Nursing |
| CAGE | Cutdown, Annoyed, Guilty, Eye Opener |
| CIWA-AR | Clinical Intsitute Withdrawal Assessment for Alcohol Revised |
| CLM | Clinical Leader Manager |
| DT | Delerium Tremors |
| ED | Emergency Department |
| GABA | Gamabutyric Acid |
| MAST | Michigan Alcohol Screening Test |
| NMDA | N-Methyl-D-Aspartate Glutamate |
| NNSA | National Nurses Society on Addictions |
| RCT | Randomized Control Trial |
| REB | Research Ethics Board |
| RN | Registered Nurse |
| WHO | World Health Organization |

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# CHAPTER ONE: INTRODUCTION

Registered nurses (RNs), regardless of the health care settings in which they practice, frequently care for people experiencing the effects of problematic alcohol use (Canadian Nurses Association, 2011). Providing nursing care in the context of problematic alcohol use can raise questions and/or issues for RNs and may have an impact on the provision of care (Canadian Nurses Association, 2011). Overwhelmingly, research evidence suggests that RNs tend to hold negative opinions of persons experiencing problematic alcohol use and as a consequence, avoid or dismiss their alcohol issues when interacting with these individuals (Carroll, 1995; Howard & Chung, 2000; Foster & Onyeukwu, 2003).

Research studies focused on the exploration of the lived experiences and/or perspectives of persons experiencing problematic alcohol use and their interactions with RNs have revealed that RNs often reflect the dominant view of society in which there is an acceptance of alcohol consumption but a rejection of the person whose use of alcohol is in some way out of control (Smith, 1997). Problematic alcohol consumption is a disease that is stigmatized by society, and the attitudes of RNs who care for individuals experiencing problematic alcohol use are influenced by society through personal feelings, experiences, beliefs, values, and knowledge (Allen, 1993). Reasons that have been cited for this stigma are associated with the links between problematic alcohol use and criminal activities such as theft, driving under the influence of alcohol, and violence (Lovi & Barr, 2009).

Stigma is defined as the identification and labelling of differences (i.e. behaviours) in another as negative or discrediting (Fortney et al, 2004; Kelly &

Westerhoff, 2009; Lovi & Barr, 2009). The presence of these attitudes is known to prolong the effects of stigmatization and discourage individuals from seeking necessary care for many health issues, including problematic alcohol use (Lovi & Barr, 2009). From my personal experience, I have found that my nursing colleagues have provided necessary care for individuals with problematic alcohol use, but I have seen two common issues:1) the alcohol use issue was overlooked or hidden by the person, and a withdrawal situation developed in which patients exhibited dangerous alcohol cessation side effects (i.e. seizures) and, 2) the individual identified their problematic alcohol use, made sure that the RN was aware of it, and the individual was then labelled as the "alcoholic in bed three".

Alcohol is a popular, legal psychoactive drug that holds significance socially and culturally in Canada (Canadian Centre on Substance Abuse, 2007). The use of alcohol often accompanies meals, is incorporated into religious ceremonies, and the celebration of joyous events such as weddings, births, or holidays (Canadian Centre on Substance Abuse, 2007). In 2002, 79.3 % of Canadians over the age of 15 reported consuming alcohol, with the majority of these individuals drinking alcohol moderately (Collin, 2006). Whether or not alcohol use becomes harmful depends upon the consumer; how much, how often, where, and why it is consumed (Brown et al., 2007).

The harm that alcohol use creates often goes overlooked due to the acceptance of casual consumption by Canadian culture and society (Brown et al., 2007). Documented harm related to alcohol use includes personal injury, risky sexual behaviour, chronic disease (e.g. heart and liver disease), crime, violence, and other social problems (Brown et al., 2007). On a global scale, the World Health Organization (WHO) has estimated that

10% to 11% of illness and death in developed countries, such as Canada, can be attributed to alcohol (Cosper, 2010; Stevenson & Sommers, 2005). In Canada, there has been an increase in the rate of alcohol consumption since 1996 and the percentage of drinkers who reported drinking 5 or more drinks per occasion at least monthly has also increased (Giesbrecht, Patra, & Popova, 2008). Therefore, it can be inferred that the impact that persons with problematic alcohol use have on the Canadian health care system will increase over the coming years.

The cost of alcohol related hospital admissions to the Canadian healthcare system was estimated at $3.3 billion dollars alone in 2002 (Collin, 2006). Each year in Nova Scotia, Canada, 3100 hospital admissions and 230 deaths are the result of alcohol ingestion and/or alcohol related illnesses (i.e. liver disease) (Brown et al., 2007). In light of these statistics and the likelihood of either chronic illness or trauma occurring with alcohol use, health care professionals including RNs can expect to care for this patient population on a daily basis on medical and surgical units in acute care hospitals (Lussier-Cushing et al., 2007).

Nursing care in the study setting involves the identification of patients at risk of problematic alcohol use and carrying out the medical treatment of these individuals. The identification of the at risk patient is often left to one question on a nursing assessment form dedicated to addressing the patients' use of alcohol at home or by assessment tools such as the Michigan Alcohol Screening Test (MAST), and the CAGE questionnaire (cut down, annoyed, guilty, eye opener) an acronym for the following questions: have you felt you should cut down on drinking, have people annoyed you by asking about your drinking, have you felt guilty about your drinking, and have you had a drink in the

morning to get rid of a hangover or as an eye opener. In carrying out the medical treatment of these patients, RNs often utilize a form of the harm reduction philosophy in which small quantities of alcohol or benzodiazepines are used to prevent alcohol withdrawal while the patient is admitted. The limitations with both of these approaches include: 1) some individuals may find the MAST questions offensive, particularly because the tool has the interviewer ask about violent/criminal activity (i.e. Have you ever been involved in a physical fight while drinking?) (Russell, 1994) and 2) the harm reduction philosophy may not be congruent with a RNs' values or beliefs and this may influence his/her interaction with a patient prescribed alcohol or benzodiazepines. Limiting nursing care to the use of these questionnaires contributes to lost opportunities for nurses to establish therapeutic nurse patient relationships. In order for these patients to receive the care that a person without problematic alcohol use receives, it is of growing importance that research studies be conducted that contribute to an understanding of RN perspectives on the care of individuals experiencing problematic alcohol use. Exploring the perspectives and furthering understanding of individuals regarding a phenomenon of interest necessitates conducting this qualitative research study.

Qualitative research is situated in the naturalistic paradigm (Leininger, 1985) and is based on the assumption that in order to make sense of the world, human action is determined based on interactions with one another (Topping, 2006). Qualitative research methodologies explore the essences, feelings, attributes, values, meanings, characteristics or philosophical aspects of phenomena that are not readily measurable (Lenininger, 1985; Wuest, 1995). By utilizing qualitative research methodologies, the researcher seeks to: 1) view individuals as active agents who interpret their own experience; 2) assume a

dynamic and changing reality in which individuals have varying histories, present, and future; 3) assume truth is the interpretation of a phenomenon and the more shared that truth is, the more factual it becomes; 4) value and describe the subjective experiences of the individual; and 5) assume experience is ingrained with meaning and linguistic, social, and cultural patterning (Munhall, 1989).

Research conceptualized within the naturalistic paradigm seeks to understand; as opposed to the traditional scientific research methodology (i.e. quantitative research) that utilizes prediction and control (Topping, 2006; Wuest, 1995). In the naturalistic paradigm there is no one single, objective reality but multiple realities that are based upon subjective experiences and situations (Topping, 2006; Wuest, 1995). The acquisition of new knowledge, in the naturalistic approach, is generated in the interaction of the researcher with the study participants regarding the phenomenon of interest, and in this study that will be the experiences of RNs caring for patients identified as having problematic alcohol use (Wuest, 1995).

Qualitative description, as a research methodology, has a main purpose to provide a rich, straight forward descriptive summary of an informants' perception and experience of a phenomenon (Neergaard et al. 2009; Nusbaum et al., 2007). When using qualitative description in a research study, the researcher stays close to the data in the analysis and dissemination processes (Lamb & Pedan, 2008; Nusbaum et al., 2007; Sandelowski, 2000; Sandelowski & Barroso, 2003) and there is a minimal amount of conceptualization or reflective interpretation using existing theories (Nusbaum et al., 2007; Sandelowski, 2000) so that the descriptions are presented in as plain a language as possible (Lamb & Pedan, 2008; Nusbaum et al., 2007; Sandelowski & Barroso, 2003). The term plain

language implies that the researcher stays true to the everyday language that is used by the study participants to explain and describe their experiences (Sandelowski & Barroso, 2003). The assumptions of this methodology include: 1) conducting inquiry as close to the participants as possible, 2) engaging with participants to elicit their perspectives on a phenomenon, and 3) attention to the avoidance of the unilateral application of a priori theory (Sandelowski & Barroso, 2003). Qualitative description is well suited for this proposed research study because it focuses on the individual's experiences, and their views on the patient-professional interaction (Neergaard et al., 2009).

**Purpose**

The purpose of this study was to describe the RNs' experiences caring for persons with problematic alcohol use on a medical inpatient unit, analyze these descriptions to arrive at a set of themes that describe RNs concerns as well as responses to caring for persons experiencing problematic alcohol use. This description of concerns and responses, once formulated, could be packaged as exemplars, or learning modules to assist in the sensitizing of RNs as to how they are in their interactions and relationships with individuals experiencing problematic alcohol use. Study objectives included a) eliciting the perspectives of RNs in caring for individuals with problematic alcohol use, b) shedding further light on the stigma associated with the care of these persons, c) identifying factors that facilitate and hinder the care of these individuals, and d) discussing the implications of the findings for practice, education, and research.

**Significance**

There is limited new knowledge available that describes RN perceptions about caring for individuals experiencing problematic alcohol use which, superficially, would

indicate that this issue might have little significance to the nursing profession. However, in Canada, there has been an increase in the rate of alcohol consumption since 1996 and the percentage of individuals who reported drinking 5 or more drinks per occasion at least monthly has also increased (Giesbrecht, Patra, & Popova, 2008). It can be inferred that problematic alcohol use is on the rise, based on the previously stated statistics, and thus there is a strong likelihood of an RN encountering a patient on a hospital unit that is suffering from the complications of problematic alcohol use. Therefore, the perceptions RNs have regarding this patient population are important to illicit for many reasons, but one important reason is that their perceptions may have an effect on the manner in which they interact with individuals experiencing problematic alcohol use.

The significance of this study is to further our understanding of RN experiences in the care of individuals with problematic alcohol use so as to contribute to improved care for individuals as well as satisfaction for nurses. These experiences are situated within the nurse-patient interaction and the relationship that an RN has with his/her patient that is experiencing problematic alcohol use. An assumption held by this researcher is that the fostering and development of a therapeutic relationship with patients is intrinsic to nursing care, as this relationship provides a foundation for quality nursing care delivery and is the basis of nursing practice (Hagerty & Patusky, 2003). Therefore, it can be surmised that a great deal of the RNs' practice occurs during their interactions with patients (Peplau, 1997) and this work "goes beyond the solitary provision of physical care to encompass personal interaction" (Ramos, 1991, p. 502).

The nurse-patient relationship has been a preeminent focus of nursing inquiry (Aranda & Street, 1999) with interactive theories developed by Orlando (1961),

Travelbee (1966), and Wiedenbach (1964) that were inspired by the theorist Hildegard Peplau (Ramos, 1991). Peplau constructed a theoretical model of nursing as an interactive process in which the nurse-patient relationship evolves through four phases (Peplau, 1952). Qualitative descriptive methodology guided by Peplau's theory of Interpersonal Relations was used to conduct this study. Further explanation of Peplau's theory, and the research methodology are outlined in Chapters two and three respectively.

# CHAPTER TWO: LITERATURE REVIEW

The literature review for this study was conducted by searching *Cinahl*, *Ebsco-host, Psych-info, Medline*, and *PubMed* databases using the following key terms: nursing, practice, experiences, alcohol, problematic alcohol use, dependency, stigma, treatment, intervention, assessment, and nurse-patient relationship. These terms were used in combination with *and*, *or*, and *not* that limited, expanded, and excluded items in the literature search (Davies & Logan, 2008). The search yielded articles for studies that were conducted between the mid-1990s to 2008, which makes many of these studies and subsequent research articles dated. This created difficulty in ascertaining whether or not these studies were indicative of the current realties for RNs when caring for persons experiencing problematic alcohol use. Which it is why it is timely for a qualitative study on this phenomenon. The Health Canada website provided the most current statistics on alcohol use and the costs associated with problematic alcohol use to the Canadian health care system.

This literature reviewed focused on the following topics: problematic alcohol use (Bailey, 2004; Giesbrecht, Patra, & Popova, 2008; Harrington-Dobinson & Blows, 2006; Kopnisky & Hyman, 2002; Lussier-Cushing et al., 2007; McCormick et al., 2010), stigma perceived by persons experiencing problematic alcohol use (Fortney, Mukherjee, Curran, Fortney, Han, & Booth, 2004; Gassman & Weisner, 2005; Kelly & Westerhoff, 2010; Lovi & Barr, 2009; Smith, Dawson, Goldstein, & Grant, 2010), the attitudes nurses hold regarding persons with problematic alcohol use in specialty areas such as the emergency room (ER) and/or mental health (Bendtsen, Holmqvist, & Johansson, 2007; Carroll, 1995; Foster & Onyeikwu, 2003; Howard & Chung, 2000; Lock, Kaner, Lamont, &

Bond, 2002), nursing responsibilities such as the nursing assessment for the person with problematic alcohol use, the use of the Clinical Institute Withdrawal Assessment for Alcohol Revised (CIWA-AR), brief interventions in which patient education and referral were the core of the nurse-patient interaction, and nursing care using the harm reduction philosophy in which individuals continued to use alcohol or a substitute medication (i.e. benzodiazepines) in a supervised setting (Antai-Otong, 2006; Boyle & Davis, 2006; Centre for Addictions & Mental Health, 2002; Cheung, 2000; Fowler, 2006; Gauthier, Palacois-Boix, Charney, Negete, Pentney, & Gill, 2011; Holbrook, Crowler, Lotter, Cheng, & King, 1999; Holloway, Watson & Starr, 2006; Pittman, Gueorguieva, Krupitsky, Rudenko, Flannery, & Krystal, 2007; Kaner, Dickinson, Beyer, Pienaar, Schlesinger, Campbell, Saunders, Burnard, & Heather, 2009; McCormick, Docherty, Segura, Colom, Gual, Cassidy, Kaner, & Heather, 2010; Reoux & Miller, 2000; Reoux & Oreskovich, 2006; Stuppaeck, Barnas,Falk, Guenther, Hummer, Oberbauer, Pycha, Whitworth, & Fleischhacker, 1994; Sullivan, Sykora, Schneiderman, Naranjo, & Sellers, 1989) and the nurse-patient relationship (Aranda & Street, 1999; Olson & Hanchett, 1997; Ramos, 1991; Williams, Nolan, & Keady, 2009). These topics serve as the headings for the literature review as they provide relevant background information on what is known about problematic alcohol use, and nursing care of individuals living with problematic alcohol use, as well as assisting in the identification of areas where more research is required. The summary of this literature review highlights what is known about RNs' experiences caring for persons with problematic alcohol use, illustrates gaps in the published literature about this topic, and makes the case for this study. The chapter

concludes with the presentation and explanation of Peplau's Theory of Interpersonal Relations and how this theory informed this study.

**Problematic Alcohol Use**

In Canada, there has been an increase in the rate of alcohol consumption since 1996 and the percentage of drinkers who reported drinking 5 or more drinks per occasion at least monthly has also increased (Giesbrecht, Patra, & Popova, 2008). Surveys conducted of everyday, general inpatient admissions reveal that between 16% and 33% of patients drank alcohol in a risky, problematic, or dependent way (McCormick et al., 2010). These statistics indicate that problematic alcohol use is on the rise, and the likelihood of a nurse encountering a patient that suffers from complications of problematic alcohol use is high.

Problematic alcohol use can be defined as a primary, chronic disease with genetic, psychosocial, and environmental factors influencing its development and manifestations (Lussier-Cushing et al., 2007). Problematic alcohol use is often progressive and fatal with characteristics that include: continuous or periodic impaired control over drinking, preoccupation with alcohol, use of alcohol despite adverse consequences, and distortions in thinking (Lussier-Cushing et al., 2007). Physically, problematic alcohol use may result in "an adaptive state that develops as a homeostatic response to repeated drug administration" (Bailey, 2004, p. 17) and is characterized by incremental and insidious damage to an individuals' body resulting in chronic illnesses (i.e. cirrhosis) (Harrington-Dobinson & Blows, 2006). The physical symptoms that a person may experience from acutely stopping alcohol use include: anxiety, shaking, sweating, trembling, nausea, vomiting, headaches, insomnia, depression, and irritability (Harrington-Dobson & Blows,

2006). These symptoms are caused by a decrease in the inhibitory neurotransmitter gamabutyric acid (GABA) and an increase in the excitatory neurotransmitter N-methyl-D-aspartate glutamate (NMDA) (Bailey, 2004). As a result of the changes in these neurotransmitters, physical symptoms (i.e. agitation, or tremors) and emotional symptoms (i.e. dysphoria or anxiety) can manifest in individuals that abruptly stop their alcohol consumption (Bailey, 2004; Kopnisky & Hyman, 2002).

Further complications that may result from problematic alcohol use include impaired social, occupational, interpersonal, or recreational functioning, and continued alcohol consumption despite the knowledge of negative consequences (Antai-Otong, 2006). Some psychosocial complications that might result from problematic alcohol use include: a) repeatedly neglecting responsibilities at home or work due to drinking, b) using alcohol in situations where it's physically dangerous, such as drinking and driving, c) experiencing legal issues related to drinking, d) continuing to drink even though alcohol use causes problems in personal relationships, and e) drinking as a way to relax or de-stress (Antai-Otong, 2006). Ultimately, problematic alcohol use may cause an individual to no longer function without alcohol and the persistent cravings for it make ceasing or cutting down on alcohol consumption difficult (Lussier-Cushing et al., 2007).

To augment the neurobiological component of problematic alcohol use, there also exists a social construction of addiction that reflects societal norms and values (Suissa, 2003). While the consumption of alcohol is socially acceptable and it is used to decrease social inhibitions and promote social interactions, the concept of the person with problematic alcohol use is stigmatized and often hidden socially (Cosper, 2010). Problematic alcohol use is a multi-faceted, challenging health care phenomenon due to

the physical, emotional, and societal implications that necessitates knowledge related to problematic alcohol use as well as communication skills to care for this vulnerable patient population.

**Stigma**

Stigma is defined as the identification and labelling of differences (i.e. attribute, behaviour, or reputation) in another individual as negative or discrediting (Fortney et al, 2004; Kelly & Westerhoff, 2009) and has been widely researched in the context of healthcare and various illnesses such as cancer, epilepsy, tuberculosis, obesity, and mental illness (Lovi & Barr, 2009). In the instance of problematic alcohol use, many researchers have found that nurses hold some stigmatizing attitudes toward these individuals and these attitudes have manifested as nurses identifying persons experiencing problematic alcohol use as deficient, defective, or being without skills (Lovi & Barr, 2009). As well, the stigmatization of persons with problematic alcohol use differed from unit to unit within hospitals with those nurses working in medical/surgical units having the most negative attitudes toward these individuals (Carroll, 1995). This was reported to be due to the non-specialty nature of the general medicine unit, a lack of addictions training in initial nursing programs and post nursing school, and a lack of clinical nurse specialists in addictions that work on medical units in the hospital (Carroll, 1995). These findings are alarming because RNs play a key role in assisting patients to achieve health, are at the bedside working with this patient population, and the influence that these stigmatizing attitudes may have is disheartening to consider.

Smith et al. (2010) attempted to identify a race and stigma correlation in their study on ethnic groups and stigma perceived in health care. The authors found that race

had a modest effect on the presence of stigma, but it was the problematic alcohol use itself that lead to a greater perception of stigma and a reduced quality of life for individuals. This study used a quantitative approach and a scale to ascertain stigma scores for each ethnic group. This data collection method and the quantitative methodology did not account for the subtle nuances, thoughts, and impressions that can be discovered with a face to face interview using open-ended questions. The study participants' perceptions and experiences would ideally be obtained by using a qualitative interview approach regarding this phenomenon, instead of structured scale responses that were utilized in the Smith et al. study.

Kelly and Westerhoff (2009) sought to determine whether the terms/labels "substance abuser" or "having a substance use disorder" created stigmatizing judgements by mental health professionals toward patients. These researchers used study vignettes in which an individual was under the influence of alcohol while driving, the two vignettes were identical except for the use of the two terms/labels (i.e. substance abuser or person having a substance use disorder) in the descriptions. The participants were then given a questionnaire to complete which included a scale for them to rate whether they agreed or disagreed that the character in the vignettes should have therapeutic or punitive actions, was a social threat, and if the character was capable of regulating their actions (Kelly & Westerhoff, 2009). The researchers conducted their study at a mental health conference with a large sample (N=516), had no eligibility criteria, and collected a limited amount of demographic information on participants (i.e. varied professional backgrounds, ages, ethnicities) (Kelly & Westerhoff, 2009). Their findings revealed that the term "substance abuser" perpetuated stigma and judgemental attitudes (Kelly & Westerhoff, 2009).

Another interesting finding in this study was that the label "substance abuser" insinuated that the individual was personally responsible and that "punitive measures should be taken" (Kelly & Westerhoff, p. 202). Similar to many research studies on health care professionals and stigma, this study used a quantitative approach and scale to derive information on a subjective concept (i.e. attitudes). The results of this study may have been enhanced with the addition of qualitative methods to enable participants to describe subjectively what it means to them to use the terms "substance abuser" versus "person living with substance abuse".

The mixed methods (i.e. qualitative and quantitative) study conducted by Gassman and Weisner (2005) investigated the contrast between persons with problematic alcohol use and persons with problematic drug use as viewed by community service workers. The interviewees in Gassman and Weisner's study included individuals that worked in mental health, public and private clinics, welfare and criminal justice institutions, substance abuse counsellors, clergy, therapists, and physicians. The results of this study showed that participants considered only severe problems when acknowledging alcohol and drug issues and that drug issues were far worse for an individual to experience than problematic alcohol use (Gassman & Weisner, 2005). Therefore, the stigma of drug and alcohol issues was reserved for individuals that overtly exhibited the stereotype of a person with problematic alcohol or drug use, and many individuals that had substance use issues were overlooked because they were forced to hide their addictions for fear of stigma (Gassman & Weisner, 2005). The results regarding the stigmatization of those individuals that overtly displayed addictions were not mentioned in the other studies on stigma included in this literature review. These findings suggest

the needs of many individuals with problematic alcohol use could go unidentified, and if the problematic alcohol use was identified these individuals would enter into a health care setting feeling embarrassed, guilty, and fearful of what reactions they will be met with on the part of health care professionals. Therefore, the perceptions that nurses have regarding the care of persons with problematic alcohol use are important to explore in order to mitigate the stigma that may be present.

In summary, this literature review on stigma depicted a lack of understanding regarding the stigma associated with problematic alcohol use and the individuals that it affects. The studies included in this review on stigma were conducted with quantitative methods. However, the qualitative approach to discovering the meaning of phenomena for participants is more suited to eliciting intimate or sensitive information such as stigmatizing attitudes. Findings that are worthy of note here are: a) health care professionals felt that the person experiencing problematic alcohol use was deficient, defective, or being without skills (Lovi & Bar, 2009) and b) the most negative views of these persons were held by nurses working on general medicine units (Carroll, 1995). This knowledge supports the necessity of exploring the experiences that RNs have had with these individuals.

**Nurses' Attitudes**

Overwhelmingly, research evidence suggests that nurses tend to hold negative opinions towards persons with problematic alcohol use and tend to avoid or dismiss their alcohol issues in their interactions with these individuals (Howard & Chung, 2000; Foster & Onyeukwu, 2003). Lack of education and experience have been reported as reasons for nurses' negative views of this patient population but it is unclear why these views

have developed (Lock, Kaner, Lamont, & Bond, 2002). Nurses tend to view problematic alcohol use as highly emotional and they find it difficult to discuss these lived experiences with their patients (Lock et al., 2002). These research findings are perplexing, considering that nurses interact on a daily basis with these individuals more than any other group of health professionals, and much of nurses' practice is dependent on open communication and trust (Howard & Chung, 2000). Generally, it is difficult to ascertain if these research findings are still valid in today's healthcare environment, especially given that these studies were conducted from 1995 to 2003 and very little research on this topic has been conducted in recent years.

Many research studies have been conducted on emergency department (ED) nurses' attitudes toward persons with problematic alcohol use. Often, persons experiencing problematic alcohol use come to the ED with traumas, and exacerbations of chronic diseases associated with their alcohol use. The ED may be the entry point to accessing healthcare for many of these individuals. From these studies on ED nurses attitudes, it has been reported that "the drunk and the drugged were disliked because of their disruptive behaviour" (Howard & Chung, 2000, p. 1230). These attitudes imply that nurses felt their work flow was disrupted by caring for the person with problematic alcohol use. This study was conducted in one ED, and the researchers spent time (270 hours over 3 months) observing and talking informally to the staff nurses (3 to 4 nurses per shift) (Howard & Chung, 2000). Specific patient incidents were not identified in this study, and this would have helped to understand the nurses' accounts of these incidents. ED nurses also identified that "Substance misusers were less rewarding to work with…" (Howard & Chung, 2000, p. 1231). A description or examples of the nurses' experiences

in this study may have provided insights or explanations as to why working with these individuals was less fulfilling. The nurses' quotes that were used in the report by Howard and Chung did not include a description of the nurse-patient interaction or how the nursing care was delivered on that unit. This would have provided more information and a better understanding about what it means to care for a person experiencing problematic alcohol use in that ED. Discussion regarding the impact that the nurses' attitudes had on the care of the person with problematic alcohol use was also absent in this study article, for example, did any patients leave against medical advice due to the attitudes exhibited by the nurses. As evidenced by Howard and Chung's article, there is a need for further research on RNs' experiences caring for persons with problematic alcohol use on an inpatient medical unit as opposed to continuing to conduct studies that focus on reporting the attitudes that nurses' hold.

Carroll (1995) conducted a study designed to ascertain the attitudes of generalist nurses (i.e. not ED or mental health) caring for persons with problematic substance use, not specifically individuals living with problematic alcohol use. The setting in Carroll's study is similar to this study setting, but the focus in my study was on persons with problematic alcohol use. Carroll found that nurses were judgemental and at times punitive toward individuals experiencing problematic drug use, because nurses were involved with these patients "by accident more than design" (Carroll, 1995, p. 36). Carroll cited the reasons for these punitive judgements were that more time was required to treat these patients and the impact of personal values on their work. An interesting finding from this study was that the attitudes nurses had toward persons with problematic substance use became more rigid with age, and the nurses were less empathetic when

working with a person experiencing problematic alcohol use (Carroll, 1995). Carroll used a Likert scale in this study that included 30 descriptive statements and a five point "agree-disagree" range to score attitudes. This study had a response rate of 46% ( 82 out of 177 potential candidates) described by the researcher as poor, which was attributed to a heavy workload on the nursing units and nurses' eligibility for the study. The Likert scale data collection method did not provide for individual accounts of nurses experiences in caring for persons with problematic drug use. An optional data collection method for this study could be interviews, which may have elicited more information on the attitudes that were found.

The breadth of the available literature exploring nurses' attitudes toward patients experiencing problematic alcohol use is focused on specialty areas (i.e. ED). The perceptions that nurses hold are important to describe and to understand for many reasons and these perceptions should include much more than a superficial report of attitudes. Many RNs have regular responsibility in the care of persons with problematic alcohol use, often on a daily basis. The responsibilities associated with the care of these individuals are important to describe. Therefore, new knowledge on the RNs' perceptions about their experiences with this vulnerable patient population is needed in order to enhance the current care of persons with problematic alcohol use.

**Nursing Responsibilities**

It is well known that nursing encompasses many roles, especially in direct patient care. The nursing care of the individual experiencing problematic alcohol use may include: a tailored set of nursing assessment skills, the use of assessment tools for alcohol withdrawal such as the CIWA-AR, utilizing brief intervention techniques as a venue to

discuss alcohol use, and the practice of the harm reduction philosophy to alleviate withdrawal symptoms. These nursing activities have been the subject of a considerable amount of research and published literature about caring for persons with problematic alcohol use.

**Nursing Assessment**. The American agency, the National Nurses Society on Addictions (NNSA), has delineated a description of nursing activities necessary for the care of patients with substance addictions. The NNSA's description includes five activities regarding the role of the nurse in caring for patients with substance use problems and these activities are: identifying patients with substance use issues; communicating with the patient and healthcare team about the substance use problem; educating the patient about substance use, addiction, and dependence; counselling the patients' family and significant others about substance use, addiction, and related health problems; and referring the patient for treatment (Kinney, 1996). Absent from this directive is the mention of the realities that RNs face when working with patients experiencing substance use issues and their perceptions about their experiences in providing addictions education, referring patients to addictions services, and communicating with patients experiencing problematic alcohol use in such a manner to suspend any judgements that they may possess.

The early recognition and identification of a patient with problematic alcohol use is paramount for successful patient outcomes, prevention of serious complications, and early recognition may be achieved by the utilization of screening tools (Lisanti, 2001). Various tools are available to RNs for screening patients about alcohol problems, such as the CAGE questionnaire, the MAST tool, and the more widely used Clinical Institute

Withdrawal Assessment for Alcohol Revised scale (CIWA-Ar) (Ewing 1984; Lisanti, 2001). These questionnaires, tools, and scales may identify the patients that are at risk; however, the usefulness of any instrument rests with the ability of the nurse to establish the nurse-patient relationship in order that a patient feels safe to self-identify problematic alcohol use.

**Clinical Institute Withdrawal Assessment for Alcohol Revised (CIWA-AR).** CIWA-AR is a brief, uncomplicated and useful tool for the screening and ongoing assessment of the symptoms associated with problematic alcohol use (Pittman et al, 2007; Reoux & Miller, 2000; Reoux & Oreskovich, 2006; Stuppeck et al, 1994; Sullivan et al, 1989). This tool provides objective rationale for the administration of medication in an attempt to prevent complications from the withdrawal of alcohol (Reoux & Miller, 2000). The CIWA-AR scale has been described as the gold standard for providing a systematic quantification of alcohol withdrawal severity in clinical settings and is a parallel representation of the DSM-IV criteria for alcohol withdrawal (Reoux & Oreskovich, 2006).

The CIWA-AR consists of ten symptoms: 1) nausea and vomiting, 2) tremor, 3) paroxysmal sweats, 4) anxiety, 5) agitation, 6) tactile disturbances, 7) auditory disturbances, 8) visual disturbances, 9) headache fullness in the head, 10) orientation and clouding of sensorium (Reoux & Oreskovich, 2006). Each of these symptoms is measured on a scale from 1 to 7, with 7 being the most severe, as scored by the RN and based upon what they observe or what the patient reported to them (Reoux & Oreskovich, 2006). The higher the CIWA-AR score, the higher association with alcohol withdrawal symptoms (Reoux & Oreskovich, 2006).

In a study conducted by Reoux and Oreskovich (2006), the investigators conducted 135 chart reviews regarding the use of the CIWA-AR tool at an addictions facility. The researchers found that guidelines for the pharmacological management of patients experiencing problematic alcohol use recommend the use of a standardized withdrawal assessment scale for patients in a clinical setting (Reoux & Oreskovich, 2006). The findings of the study supported the use of the CIWA-AR tool to assess for the severity of alcohol withdrawal but cited several limitations. One such limitation was the patients' co-morbidities and their ability to answer the questions on the CIWA-AR scale due to these co-morbidities. Another limitation noted was the need for health professionals to have good clinical judgement to identify the need for modifications to the tool in order for it to fit into certain practice situations.

Reoux and Miller (2000) conducted a chart review of 172 patients that were admitted to the medicine, psychiatric and addictions units of a health sciences centre in Seattle, Washington. The chart reviews identified patients that received pharmacological treatment based on the scores obtained through the administration of the CIWA-AR tool. Specifically, the chart review ascertained that the symptom triggered approach (i.e. use of the CIWA-AR) resulted in fewer doses of benzodiazepines administered, and shorter durations of medication administration (Reoux & Miller, 2000). Conversely, the approach of scheduled dosing of benzodiazepines created longer durations of drug administration and the necessity to taper off the medication (Reoux &Miller, 2000). The authors make note of some important considerations in their discussion, particularly about the need for flexibility in the management of persons experiencing problematic

alcohol use, and the need for further research studies regarding the implementation of the CIWA-AR scale in many hospital settings (Reoux & Miller, 2000).

By examining research reports on the CIWA-AR tool critically, the validity of the tool is not questioned, but the research articles did not explore the therapeutic nurse-patient relationship. These screening tools may affect the trust that the patient has in an RN, especially if that patient feels offended by the questions. The lack or presence of trust may affect how the patient chooses to answer the questions that are asked during the screening process. There is a potential risk for the patient to deny subjective withdrawal symptoms (i.e. hallucinations or anxiety) when they feel they cannot trust the RN causing a potential to miss early withdrawal symptoms that otherwise could have been treated.

**Brief Intervention for Problematic Alcohol Use.** Brief intervention (BI) is an opportunity for the RN to identify patients in need of intervention for their alcohol use and has proven to be effective with individuals that moderately drink alcohol (Antai-Otong, 2006). Kaner et al. (2009) suggests:

> BI is grounded in social-cognitive theory and typically incorporates some or all of the following elements: feedback on the person's alcohol use and any alcohol related harm; clarification as to what constitutes low risk alcohol consumption; information on the harms associated with risky alcohol use; benefits of reducing intake; motivational enhancement; analysis of high risk situations for drinking and coping strategies; and the development of a plan to reduce intake (p. 302).

The use of BI in acute care has two aspects: 1) interventions are delivered by a generalist health care provider, that is a professional that may not have special training in addictions or mental health, and 2) BI targets a population of hazardous and harmful drinkers who tend not to be seeking help for reduction in their alcohol consumption (Kraner et al., 2009). As well, BI frequently involves health education, stress management, and appropriate community referrals (Antai-Otong, 2006; Holloway, Watson & Starr, 2006) when used in acute care settings because the interventions typically occur opportunistically as the drinking problems are generally not the primary reason for the patient to be admitted (Kaner et al., 2009)

BI methods include: booklets, verbal advice, counselling, and behavioural change techniques provided to the patient by the RN in order to aid them in considering their current alcohol consumption and contemplate strategies to change their behaviours (i.e. lowering alcohol intake) (Bendtsen, Holmqvist & Johansson, 2006; Holloway, Watson, & Starr, 2006). The literature on BI supports the use of screening tools such as the MAST screening tool to identify patients with alcohol issues (Boyle & Davis, 2006) but the use of these tools may affect the therapeutic relationship that RNs must cultivate in order to provide quality care to this patient population. The use of these tools is encouraged due to the limited time that a nurse would have to spend with individual patients on a busy hospital unit (Boyle & Davis, 2006; Kaner et al., 2009).

In the study conducted by Gauthier et al. (2011), the researcher examined the effectiveness of BI compared to standard therapy (e.g. longer detox programs) for drug and alcohol dependence in an outpatient treatment program. The researchers randomized participants into a BI group (n=19) that had 5 sessions with a counsellor delivered on a

weekly basis, and a conventional treatment option group (n=21) that was 6 months in duration (Gauthier et al., 2011). Their findings indicated that both groups fared well at the 6 month follow up in terms of abstinence and that BI was an effective addiction treatment for this patient population (Gauthier et al., 2011). The obstacles to BI as discussed by these researchers were: health care practitioners' attitudes toward patients with substance dependence, absence of resources, and lack of educational preparation for health care practitioners (Gauthier et al., 2011). These obstacles reinforce the need for a therapeutic approach on the part of RNs in their care of persons experiencing problematic alcohol use.

Kaner et al. (2009) conducted a systematic review to determine the effect of BI compared with other interventions used in primary care such as inpatient detox, and longer stays, the type of drinkers BI was effective for, whether BI outcomes differed between efficacy and effectiveness trials, and the impact of extended intervention compared with BI in primary care settings. The review focused on randomized control trials (RCT) involving patients in primary care settings who were identified as heavy, problematic, and excessive drinkers (Kraner et al., 2009). The results showed that BIs were effective at reducing excessive drinking in primary care settings, with two limitations: there was a paucity of data regarding young drinkers aged 18 to 30 years old and seniors, and 70 % of the studies focused on men only. These limitations may be indicative of the settings to which patients with problematic alcohol use are admitted. The review also found that the duration of the BI did not matter as much as the content of the dialogue within the intervention, and that BI is more effective for early stage problematic drinking (Kaner et al., 2009). BI was found to be clinically relevant to the "real world" of

practice, but more research needs to be completed on the relationship that develops between the health care professional and the patient (Kaner et al., 2009).

Various studies have indicated that education for nurses should include gaining an understanding of the patients' life, their choices, priorities, and reasons for problematic drinking to increase the chances of successful behaviour change during BI (McCormick et al., 2010). There have been criticisms about BI regarding the influence on workload, how it may increase workload for the nurse, and suggestions that this may affect the nurse-patient relationship with some patients (McCormick et al., 2010). Furthermore, the more training the individual has on BI the greater the likelihood of success with the implementation of BI (McCormick et al., 2010).

Ultimately, BIs are designed to quickly assess the readiness for learning and change that a patient possesses, and then provide an intervention (i.e. referral for counselling) for patients as needed (Fowler, 2006). Many studies found that this style of intervention was not reliable for individuals with severe problematic alcohol use, due to the broader spectrum of alcohol related issues (i.e. cirrhosis) (Smith, 1997). These individuals would need greater support and medical follow up than the brief intervention could provide. Generally, the research studies on BIs focused on the techniques involved, and did not pay much attention to the perspectives of the RNs' conducting the actual interventions. Absent from most of the BI literature is any discussion about the nurse-patient relationship and how it is employed during the BI and how a relational approach contributes to the quality of nursing care provided.

**Harm Reduction.** Harm reduction is a philosophy for working with persons with problematic alcohol use that is designed to reduce substance related harm without

requiring the absolute cessation of the substance (Centre for Addictions and Mental Health, 2002). For example, a person with problematic alcohol use may be prescribed an alcoholic beverage (i.e. beer, wine) in a limited quantity by a licensed physician in order to prevent withdrawal symptoms. This approach is believed to be patient centred and respects the individual's decision making and responsibility for alcohol use (Cheung, 2000).

Harm reduction treatment includes the administration of controlled quantities of alcohol to patients and the nurse must maintain neutral and non-judgemental behaviours when providing care to persons experiencing problematic alcohol use (Centre for Addictions and Mental Health, 2002). By achieving this neutrality, the patient will fully benefit from the harm reduction program and the patient will receive necessary medical attention while in hospital (Centre for Addictions and Mental Health, 2002). Similar to the studies conducted on brief interventions, research studies that focused on nurses' experiences utilizing the harm reduction model were limited. Further research in which nurses' describe their use of harm reduction strategies would be helpful to provide evidence to advocate for its' use within the nurse-patient interaction.

In summation, the popular approaches to care currently practiced by RNs include the use of the above mentioned screening tools to assess for a patients' alcohol use as well as brief intervention and harm reduction. Absent from the studies is the discussion of a nurse-patient relational approach, particularly, the therapeutic relationship that develops when nursing activities are conducted in a manner that is self evaluative for the RN. This self awareness is in keeping with the theoretical model of interpersonal

relations enacted between the patient and nurse that is engaging and authentic (Peplau, 1952).

**Nurse-Patient Relationship**

In order for the nurse-patient relationship to be achieved, it is crucial for RNs to come to know patients as more than a set of disease symptoms and demonstrate compassion in their interactions (Williams, Nolan, & Keady, 2009). This compassion is based upon "empathy, respect and recognition of the individual as unique and a willingness to engage in a relationship with them that acknowledges limitations, strengths, and emotions of all parties" (Williams, Nolan, & Keady, 2009, p. 53).

In a qualitative study conducted by Aranda and Street (1999), the researchers explored the nurse-patient relationship in the context of life-threatening or terminal illness. The researchers conducted focus groups and individual interviews with nurses to explore the representations of their stories as "being authentic" or "being a chameleon" when describing their nurse-patient interactions. The groups of nurses described and associated "being authentic" with being real, genuine, or original (Aranda & Street, 1999). This group of nurses described "being a chameleon" as a way to become the individual that the patient needed at the time (Aranda and Street, 1999). This study provided some important information to the known body of knowledge about the development of a therapeutic relationship between the nurse and the terminally ill patient.

This research by Aranda and Street (1999) provided historical views of nursing and the nurse-patient relationship. Interestingly, at the turn of the 20th century the nursing focus was confined to the medical surveillance of the patients' body (Aranda & Street, 1999). Due to the predominant role of the nurse in the medical surveillance of the

body, the nurse had little regard for knowing the patient or focusing on the therapeutic relationship with the patient (Aranda & Street, 1999). As the nursing profession evolved, the task-oriented routines in the hospital allowed for limited time to develop therapeutic relationships with patients, keeping the focus on the task. Through the 1960s and into the current health care climate, the patient has "...emerged as a complex subject, rather than object, of nursing understanding and care" (Aranda & Street, 1999, p. 77). Therefore, the nurse-patient relationship became a central focus of nursing theory development and nursing research (Aranda & Street, 1999).

Evidence of the importance of the nurse-patient relationship is provided in a study conducted by Olson and Hanchett (1997) to examine relationships between nurse expressed empathy and two patient outcomes: patient perceived empathy and patient distress. The study sample was 140 participants: 70 staff nurses and 70 patients and the outcomes were measured using existing tools to measure empathy. The study was guided by Orlando's 1961 nursing model and focused on the relationship between nurses' responses to situations of patient distress and the influence that these responses had on patient outcomes. Orlando's model describes nursing as addressing patient distress through an interactive process that implies the need for a nurse to provide some validations for the patient's perceptions (Olson & Hanchett, 1997). The findings of the study demonstrated that "there was a negative relationship between nurse-expressed empathy and patient distress ($r=-.71$, $p<.001$), a negative relationship between patient perceived empathy and patient distress ($r=-.71$, $p<.001$), and a positive relationship between nurse-expressed empathy and patient-perceived empathy ($r=.35$ to $.47$, $p<.05$)" (Olson & Hanchett, p. 75). Ultimately, the researchers noted that support exists for the

relationships that Orlando suggested needed to occur between accurate perceptions of patients' needs (nurse-expressed empathy and patient perceived empathy) and distress (Olson & Hanchett, 1997).

Ramos (1992) conducted an exploratory study of nurse-patient relationships. The study sample included 15 nurses that were interviewed twice each about their experiences regarding bonding with their patients. Ramos found that "while nurses have always thought that their bonds with patients are important, these clinicians were consistent in saying that their relationships with patients are absolutely central to their professional satisfaction and health" (p.504). During the interviews, the nurses made note of the constraints created by the institution that they worked in and how their time was limited, which made the establishment of a therapeutic relationship difficult (Ramos, 1992).

In summary, the nurse-patient relationship is important to the identity of the nursing profession, its' historical roots, and the future of clinical nursing practice and research (Peplau, 1997; Ramos, 1992). The articles retrieved for this literature review about nurse-patient relationships were dated, with most of the research studies conducted in the late 1990s or early 2000s. As well, there were scant articles located that addressed the nurse-patient relationship in the context of addictions. Therefore there is a need to conduct a research study on the experiences of RNs in the care of individuals with problematic alcohol use and to remain open to what participants say about the nurse-patient relationship in describing these experiences.

**Literature Review Summary**

This literature review addressed problematic alcohol use, stigma experienced by persons with problematic alcohol use, nurses' attitudes on providing care to persons with

problematic alcohol use in specialty care areas, and nursing responsibilities such as: nursing assessment, the use of the CIWA-AR in assessing alcohol withdrawal symptoms, the use of brief intervention, and the harm reduction model in the provision of care for these individuals and the nurse-patient relationship. Among this literature, there are descriptions about the approaches RNs employ while caring for persons with problematic alcohol use but given the persistence of stigmatising attitudes with this population, the time is right to generate knowledge regarding RNs' experiences when caring for this vulnerable patient population. The literature included in this review has obvious gaps, most notably the near absence of qualitative studies focused on RNs' experiences caring for persons with problematic alcohol use and the interactions that unfold with the nurse-patient relationship.

The nurse-patient relationship is considered to be the essence of nursing, yet there exists limited research on it in the context of problematic alcohol use. The RN has a great influence on the professional relationship that develops with the individual experiencing problematic alcohol use. The RN is ideally suited to help patients to identify problems with alcohol use that they may have, and thus they need to manage any judgemental attitudes they may hold. There is a noted dearth in the published literature regarding RNs' experiences when caring for persons with problematic alcohol use on a general medicine unit. New knowledge is necessary regarding RN experiences in caring for persons with problematic alcohol use. Therefore, this study was intended to elicit the perceptions of RNs in caring for persons with problematic alcohol use, shed further light on stigma associated with the care of these patients, identify factors that facilitated and hindered the care of these individuals, and discusses the implications of the findings for nursing

education, practice, and research. This qualitative descriptive study was informed by the assumptions of the naturalistic paradigm outlined in Chapter 3, as well as the theoretical perspective of Peplau's Theory of Therapeutic Nurse-Patient Relationships.

**Theoretical Perspective**

The theoretical framework that informed this study was that of an early nursing theorist, Hildegard Peplau (1952). The locus of Peplau's theory is the therapeutic relationships that develop between an RN and patient as they interact with one another (Peplau, 1952). According to Peplau, "interpersonal relations' concepts provide a framework for understanding many of the dilemmas that patients experience and that lie within the domain of professional nursing" (Peplau, 1997, p. 162). Peplau described the interpersonal process as stages by which the patient gains insight into health issues, and through which the nurse guides the development of the patient's self-awareness. The degree of patient self-awareness is contingent upon that of the nurse (Peplau, 1952

Peplau (1991) encouraged the RN to go beyond the physical caring of a patient and meet the entire needs of the patient. This includes knowing the patient as more than a medical diagnosis (Peplau, 1997). In doing so, the RN and patient would establish a therapeutic relationship or as Peplau described, a "shared experience". Peplau (1997) described this relationship as mutual, where the RN has put all judgmental attitudes aside, to care for the patient as an agent. RNs demonstrate this relationship by becoming close to their patients in order to gain insight on their current health experience. Peplau went on to further describe her theoretical standpoint on the art and science of nursing. According to Peplau (1997): "The artistic aspect includes, but is not limited to tender care, attentive compassion and concern, advocacy and various hands on practices to enhance the

comfort and well being of sick people" (p. 162). Peplau also conceptualized the scientific aspects of nursing care: "The scientific component of nursing includes the knowledge applied for understanding of a broad range of human problems and psychosocial difficulties, as well as health restoration and maintenance" (p. 162). Peplau's description of the art and science associated with nursing is congruent with my vision for this research study and the manner in which I conduct my professional nursing practice. Meaning, the RN has the sound educational preparation to care for the individual experiencing problematic alcohol use and their physical health needs, but also the empathy and compassion to see beyond the stigma that might be associated with this illness.

Peplau (1997) advises that both the nurse and patient gain self-awareness in the interpersonal process. The four phases that Peplau developed to facilitate the nurse-patient relationship are: a) Orientation**,** in which the nurse and patient come together to form a union and work together on a problem, b) Identification**,** in which a patient feels a sense of belonging and responds to those who meet their needs; actively participates in goal-setting, c) Exploitation**,** where the patient participates in care and takes full advantage of others who can help their needs, and d) Resolution, this phase occurs when all the other phases have been completed successfully (Townsend, 2005). This theoretical framework of phases embodies the essence of the nurse-patient relationship (Peplau, 1997).

Incorporated into the phases of Peplau's theory is the importance of modes of observation, which include: patient and nurse relations (i.e. connections or bonds), empathetic linkages or the ability to feel in one's self the emotions experienced by

another person in the same situation, and how RNs appropriately communicate these empathetic linkages to patients (Peplau, 1997). Peplau make these modes translucent in noting that "nursing care cannot proceed effectively toward beneficial outcomes for patients without the nurse having adequate information about the patient as a person and about the prevailing health conditions" (p. 163). This theory and its constructs are congruent with how I believe RNs need to engage in patient care. Research to date casts the nurse-patient relationship in the care of individuals with problematic alcohol use in an unfavorable light, therefore conducting a study informed by this perspective contributed to the conception of the data collection and analysis of the study phenomenon. The congruence of Peplau's theory with the study methodology will be discussed in chapter three.

In summation, Peplau ascertained the importance of regarding the nurse-patient relationship as mutual (Peplau, 1952). Therefore, the nurse must gain awareness of personal values, beliefs and prejudices. Acceptance of the other is integral to professional practice. Prejudice or pre-judgement has been cast in a positive light by Gadamer (1977) who advanced the notion that the acknowledgement of prejudice provides the opportunity for the furthering of understanding for the holder of prejudice. It is with this in mind that the term prejudice is used in this thesis.

# CHAPTER THREE: Methodology and Methods

This chapter presents the methodology and methods that guided this research study. The chapter begins with a discussion of the qualitative research paradigm, followed by a discussion of the role of the researcher in qualitative studies, and presentation of my location as a researcher. Subsequently qualitative descriptive methodology is explained as well as the congruence of the methodology with Peplau's theory. This is followed by a description of the study setting, the sample and sampling procedures, recruitment, data collection, data analysis, methods to ensure trustworthiness, and ethical considerations.

## Qualitative Research

> Denzin and Lincoln (2005) explain qualitative research as follows:
>
> Qualitative research is a situated activity that locates the observer in the world. It consists of a set of interpretative, 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 the self. At this level, qualitative research involves an interpretive, naturalistic approach to the world. This means that qualitative researchers study things in their natural settings, attempting to make sense of, or interpret, phenomena in terms of meanings people bring to them (p. 3).

Qualitative research is the appropriate approach to use in studies designed to learn about the experiences of groups or individuals from their point of view and in their own words or from an emic perspective (Morse & Field, 1995). Thus, this methodology was utilized

in this research project to assist the researcher in describing the care of persons experiencing problematic alcohol use from the perceptions of the participants.

Topping (2006) stated that qualitative research fits within an interpretivist tradition that is based on the assumption that in order to make sense of the world, human behaviour is interpreted in interactions with one another. To further this point, Munhall (1989) described the philosophical underpinnings of qualitative research as reflecting the beliefs, and values of human beings, the environment, and the interaction between the two. In using a qualitative methodology, the researcher seeks to view individuals as active agents who interpret their own experience; assume a dynamic and changing reality in which individuals have varying histories, present, and futures; truth is the interpretation of a phenomenon and the more shared that truth is, the more factual it becomes; the subjective experiences of the individual are valued and described; experience is ingrained with meaning and linguistic, social, and cultural patterning (Munhall, 1989).

Qualitative research methodologies explore the essences, feelings, attributes, values, meanings, characteristics or philosophical aspects of phenomena that are not readily measurable (Lenininger, 1985; Wuest, 1995). The emphasis in the qualitative methodologies is "placed on the importance of accurately knowing, understanding, and interpreting the nature and meanings of past and current events or situations" (Lenininger, 1985, p. 9). Qualitative methodologies aim to make sense of human behaviours and the interactions of individuals with the world around them (Topping, 2006). Conversely, the quantitative research method "stresses mechanistic and logico-positivistic inferences to obtain objective knowledge and deterministic or causal

explanations" (Lenininger, 1985, p. 9) and has a tradition of distancing the researcher from the study participant (Topping, 2006) in order to minimize the impact that values and experiences have on the research (Tilley, 2007). In this research study I utilized a qualitative descriptive methodology because traditional scientific research methods (i.e. quantitative methodology) do not adequately elicit the subjective experiences of RNs in the care of persons with problematic alcohol use.

**Role of the Researcher in Qualitative Studies**

The researchers' role in qualitative studies is to engage with the study participants to capture their perceptions about a phenomenon, in such a way that the phenomenon is extensively explored (Creswell, 2007). There is an obligation for the researcher to maintain confidentiality and respect when interacting with the study participants during an extensive discussion about a specific phenomenon. The researcher needs to be open, honest, and sensitive to their study participants' experiences so that deeper reflections are enabled and a greater description of their perceptions is achieved (Denzin &Lincoln, 2005).

Qualitative research involves fieldwork, in which the researcher physically goes to the people, setting, site, or institution to observe or record behaviour in its natural setting (Creswell, 2007). The qualitative researcher is the primary instrument for data collection and analysis (Creswell, 2007; Topping, 2006). Therefore, data collection is negotiated through this human instrument rather than inventories or questionnaires (Topping, 2006) and this aspect is in keeping with a naturalist approach.

As a novice researcher, I developed an understanding of the qualitative descriptive methodology, the process of interviewing, and conducting thematic analysis. I

recognize that I am a novice researcher, particularly when conducting interviews and asking probing questions for more in-depth responses from participants. I listened to the accounts that the RNs provided for me, interacted with them to facilitate their comfort in responding, in order to lessen the distance between myself as the researcher and the RNs as study participants (Creswell, 2007). In their candid discussions, these individuals enabled me to further understand their perceptions about caring for persons experiencing problematic alcohol use and to eventually describe the experiences that they live on a daily basis. This was a privilege for me and I am greatly indebted to them for the time they took to be interviewed by me.

**Locating Myself in the Research Study**

I became interested in understanding the challenges and successes of caring for vulnerable patient populations during my first few years of RN practice working in an inner city hospital in Toronto. I cared for patients with many different types of addictions on the general internal medicine unit that I worked on but the patients with problematic alcohol use always seemed to interest me. I often wondered how other RNs felt about these patients, what influence factors such as personal values had on their care of these individuals, and how the nurse-patient relationship was influenced by the alcohol issues.

The individuals experiencing problematic alcohol use always seemed to me to be tragic in some ways, often isolated, and I noticed that very few family members came to visit them while they were admitted. Problematic alcohol use is a confusing, complex illness. I often questioned the how, and why an individual developed a drinking problem. The person is not "doing something illegal" and social drinking is deemed acceptable by the general population. But somehow, when the problem drinking becomes a lifestyle,

and the person is in a dangerous situation health wise, their friends and family that once enjoyed the social aspects of drinking with that person seem to leave them.

During my nursing practice on an internal medicine unit I also noticed that occasionally persons with problematic alcohol use would be admitted and their symptoms would be missed leading to devastating delirium tremors (DTs) or even seizures. This was traumatic for me to witness, as I grappled with understanding the life choices that these individuals made. I personally have not had alcohol use problems, but individuals in my family and friends have had these problems in the past. Needless to say, this aspect was what prompted me to try to understand the distress that the patient felt, but also to understand the perspectives of my co-workers when they were providing nursing care to these individuals.

As I carried on with my academic endeavours, I worked on my Bachelor of Science in Nursing (BScN) and I continued to work full time on that internal medicine unit, ultimately taking on more of a leadership role as a Clinical Nurse Educator. In this position there were a lot of opportunities to mentor new nurses, and participate in working groups for policy development. Taking note of the frequency of admitted patients with problematic alcohol use and the increasing occurrence of missed symptoms of alcohol use with our patients, my Clinical Leader Manger (CLM) approached me to conduct focus groups to glean some perspective from medical students, residents, and nurses about these patients. The focus groups concentrated on the improvement of clinical care of this patient population. These focus groups led to a more in-depth study and the development of pre-printed orders for the care of persons experiencing problematic alcohol use on the interanl medicine unit. In order to ensure buy in on this

project, I facilitated extensive education sessions and follow up, in partnership with the unit pharmacist, for the nurses, residents and medical students that worked on the internal medicine unit about problematic alcohol use and the pre-printed orders.

In my preparation for graduate studies at Dalhousie University, I considered what aspects of nursing practice interested me as a focus for my thesis work and arrived at the conclusion that I had a gap in my own knowledge regarding the perspectives that RNs hold in caring for persons with problematic alcohol use. Clinically, I had the opportunity to discuss the care of individuals experiencing problematic alcohol use previously in my clinical educator role. However, I never really had the opportunity to learn more about the experiences and realities that RNs face on a daily basis with this group and how the RNs feel about the nurse-patient relationship with this population. I knew the struggles that I have had professionally when caring for this population, especially with my acceptance of the fact that not all individuals are ready to stop drinking, despite the admission to a hospital as a result of years of alcohol consumption.

In a practice sense, I make it a point to engage on a personal level with my patients, and to establish therapeutic relationships. Often in the development of these relationships I try to take cues from them. If the person wants to divulge information to me, regardless of whether it is about alcohol or other addictions issues I make every possible attempt to listen attentively to their concerns and address these concerns with the patient. As well, I believe there is a need for all professional nurses to be a role model for new nurses, and a source of guidance and support. This is especially important when learning to address sensitive issues with patients, such as problematic alcohol use.

**Researcher Assumptions**

In order to research a phenomenon, there is an implied particular interest or vantage point in life (van Manen, 1998). As a researcher, I have an interest in learning about RN experiences and the issues that they encounter when caring for persons with problematic alcohol use. As I embarked on this research project, it was my intention to learn more about how RNs felt about problematic alcohol use, their relationships with these individuals, and how educationally prepared they felt to look after these patients. Van Manen (1998) noted that awareness of one's own personal experiences regarding a phenomenon may provide the researcher with ways in which to orient one's self to the research topic. As such, this may make it possible to see the similarities of one's own experiences to another individual's experiences.

It is essential for me to examine my assumptions, biases, and questions I have had prior to engaging in my research project. As previously stated, I have had many opportunities to care for individuals experiencing problematic alcohol use. I believe that an important part of the care I have provided to these persons includes the fostering of a therapeutic relationship in which the patient: a) trusts me, b) feels confident in my nursing practice, and c) will benefit in some way from the care that I provide.

I have an assumption that many RNs feel the same way about the need for a therapeutic relationship with this patient population that I do, and want to provide the best care that they can to their patients. I believe that this care includes treating individuals with respect and dignity in their communications with them. Throughout my nursing career, I have questioned what other RN experiences were with persons experiencing problematic alcohol use, and what motivated some of the actions and comments that I have witnessed over my 12 years of nursing practice that were not

therapeutic or helpful to the patients' situation (i.e. stigmatizing comments, or overmedicating with benzodiazepines).

**Philosophical Assumptions**. In keeping with the naturalistic approach, the philosophical assumptions held by the researcher need to be discussed as "... researchers bring their own world views, paradigms, or sets of beliefs to the research project, and these inform the conduct and writing of the qualitative study" (Creswell, 2007, p. 15). It is important for the researcher to examine their point of view and locate themselves within their research study, which I have done in the previous sections of this chapter. It is also important to examine the philosophical assumptions held by the researcher therefore, in the following section I describe my ontological, epistemological, and axiological assumptions.

***Ontological***. This assumption pertains to the researcher's "...stance on the nature of reality" (Creswell, 2007, p. 16). I assume that the experiences of caring for persons with problematic alcohol use are multiple and subjective, constructed, and holistic, that the RNs' understanding of this experience is bound within a particular context (Creswell, 2007; Lincoln & Guba, 1985). I believe that there are multiple realities and perspectives in which a concept can be understood and/or experienced. I assume that the experiences of other RNs shape their practice, and how or why they develop relationships with their patients may be different than my own. Qualitative researchers embrace this assumption regarding multiple realities and aim to report these realities by incorporating verbatim quotes provided by study participants in their reports of the research study (Creswell, 2007).

***Epistemological***. This assumption is associated with "... how the researcher knows what she or he knows" (Creswell, 2007, p. 16). I assume that there may be similar points of view between myself and the RNs in my research study. I have worked as an RN on a general medicine unit and have experienced situations similar to those I am asking my study participants to discuss. I believe that I took a collaborative approach to the interviews, discussing the topic in a manner in which the participants found relevant while ensuring that the questions I developed for my interview guide were discussed. I believe that I also addressed this assumption by conducting my interviews on the medical unit and spent time in the research setting with the participants. By taking these steps I lessened the distance between myself and the study participants, and this provided more context within which to understand the RNs' point of view (Creswell, 2007).

***Axiological***. This assumption concerns the "...roles of values in the research" (Creswell, 2007, p. 16). As a burgeoning qualitative researcher, I acknowledge that there is a value laden aspect to my inquiry of RNs experiences caring for persons with problematic alcohol use. (Creswell, 2007; Lincoln & Guba, 1985). To address the potential bias, I ensured that I was transparent about my own biases and values as well as the value laden perspectives of my study participants (Creswell, 2007). Certain aspects of my personal values have influenced my choice of this research topic. I value equity in patient care. I encourage my patients to discuss all aspects of their illness whether deemed socially "good" or "bad". I respect personal choice however I would prefer that everyone follow health promotion practices and illness prevention. I believe that in order to help individuals with problematic alcohol use, health professionals require more knowledge to better understand their experiences. I value education and am a firm

believer in the need for continued education in the nursing profession. While I know that education is not the only answer for the issues that face this patient population (i.e. the stigmatizing behaviours), more education provides the opportunity for RNs to be self reflective and perhaps make alterations to their current practice in order to incorporate more therapeutic approaches.

Voicing my own personal point of view and philosophical assumptions about this research topic helped to prevent me from imposing my agenda on the study participants during the interviews. In doing this, I believe I am allowing the research data to speak, and the participants voices to be heard and accurately analyzed. According to Sandelowski (2000), the goal of the qualitative description researcher is to be able to describe a phenomenon as it is encountered rather than as the researcher would have them occur.

**Qualitative Description**

In order to facilitate the description of RNs' experiences in caring for individuals with problematic alcohol use, I used qualitative description methodology. Sullivan-Bolyai, Bova & Harper (2005) explain that the goal of qualitative description is "not thick description (ethnography), theory development (grounded theory) or interpretative meaning of an experience (phenomenology) but a rich description of the experience depicted in easily understood language" (p. 128). The allure of this methodology is that the researcher remains close to the information and descriptions gleaned from the study participants, and these descriptions are presented in as plain a language as possible (Lamb & Pedan, 2008; Nusbaum et al., 2007; Sandelowski, 2000; Sandelowski & Barroso, 2003). The term plain language implies that the researcher stays true to the everyday

language that is used by the study participants to explain and describe their experiences (Sandelowski, 2000). Therefore, within the report of the findings, direct quotations from the study participants were used to substantiate the themes, and to lend credibility to the explanation offered about RNs' perceptions of caring for persons with problematic alcohol use.

Qualitative description, as a methodology is intended to provide a descriptive summary of the phenomenon that is organized in such a manner that is relevant to the study participants and furthers understanding of the study phenomenon (Nusbaum et al., 2007). Gathering the data and using descriptions from those who are experiencing it themselves offers a valuable opportunity to gain "inside" knowledge and to learn about how participants perceive the world. Furthermore, qualitative description allows for a comprehensive survey of a phenomenon, and allows a researcher to achieve a descriptive, accurate account of the perceptions of the people that experienced it (Sandeloski, 2000).

Qualitative description research assumptions are congruent with Peplau's theory of Interpersonal Relations. These assumptions include conducting inquiry as close to the participants as possible, engaging with participants to elicit their perceptions on a phenomenon, and attention to the avoidance of the unilateral application of a priori theory. It could be argued that all mention of Peplau's theory should be avoided in the conceptualization of this study, however given the close alliance between such interpersonal factors as being present with patients, developing trusting relationships, and the privileging of the researcher-participant relationship in qualitative work it is important to make explicit this congruence up front. It remains that Interpersonal Relations theory informed this study yet I was careful in the data collection, analysis, and

writing process to look beyond this particular theory in describing and understanding the study data, analysis and findings.

Peplau's (1952) theory promotes the centrality of the nurse-patient relationship in helping patients to gain more self-knowledge. This theory of interpersonal relations is described as an educational process in which the patient can gain self-awareness and in that process is encouraged by the nurses' sharing of self-awareness.

Van Manen (1998) remarked that participants in research studies often have an interest in the research topic, and by participating in the research interview there may be an opportunity for increased awareness, moral stimulation, and a sense of liberation. By discussing what it means to care for patients experiencing problematic alcohol use, the participants had an opportunity to reflect upon their relationships with patients and the stereotypes that they might possess toward these patients. Therefore, this research study utilized qualitative description methodology guided by Peplau's theory of Interpersonal Relations to elicit the RNs' perspectives in caring for persons with problematic alcohol use.

**Setting**

The setting for this research study was the in-patient general medicine unit of a tertiary care hospital in Atlantic Canada. The centre has 385 beds and is a teaching hospital. The general medicine unit has 38 beds and provides care to a varied patient population, on average the patient ages range from 18 to 80 years old. The patients are admitted to general medicine with many different diagnoses or for different investigations, and many patients also have a dual diagnosis of problematic alcohol use that accompanies their chief complaints or diagnosis. Therefore, it can be surmised that

all of the RNs that work on the general medicine unit, at some time in their employment on this unit, have cared for a patient with problematic alcohol use.

For the purposes of this research study, the term "person with problematic alcohol use" was understood to encompass a patient admitted to the general medicine unit that had been identified as drinking alcohol daily or at a higher frequency and quantity than the norm. The current approaches to the care of persons experiencing problematic alcohol use on this unit include a form of the harm reduction philosophy in which small quantities of alcohol or benzodiazepines are used to prevent alcohol withdrawal while the patient is admitted. The assessment of alcohol use is completed during the initial nursing admission assessment. This assessment consists of one question on the nursing assessment form dedicated to addressing the patients' use of alcohol at home. There are no formal guidelines, policies, or order forms dedicated to the care of this patient group on this unit. The medical management is left up to the individual doctor to prescribe benzodiazepines in an effort to prevent withdrawal symptoms. The assessment of the need for benzodiazepines is done by the individual RN and is dependent on their assessment skills, knowledge base, and awareness of problematic alcohol use.

**Sample**

For the purposes of this research study, the term "nurses" refers to RNs who have had experience in caring for individuals that have experienced problematic alcohol use. The study participants were residents of Atlantic Canada and were licensed to practice in their province of residence. There is an emphasis in qualitative research on prolonged contact with research participants and the data, therefore smaller samples are typically adequate in order to capture themes identified from discussion of the phenomenon of

interest (Polit & Hungler, 1997; Sandelowski, 1986). Sample sizes in qualitative research are difficult to predetermine, but in consultation with my thesis committee, it was felt that the goal sample size for this study was 5 to 10 participants in order to gather sufficient data and description about RNs' experiences caring for persons with problematic alcohol use (Morse, 2000; Sandelowski, 1986). The goal with this sample size was to collect rich descriptions of the perceptions of the participants until the amount of data gathered saturated my identified themes (Proctor & Allen, 2006).

**Demographic Data**. The sample for this research study consisted of 9 RNs. All the RNs were female and ranged in years of nursing experience from 2 to 34. The participants reported having worked on various units, which included: general medicine, neurology, geriatrics, neurosurgical intensive care, intensive care, palliative care, aging veterans, community health, and emergency. One participant, Janice, reported working in northern Canada, in Inuvik, Northwest Territories, where she worked in the emergency department of a hospital. For the purposes of this thesis, each participant was given a pseudonym to preserve confidentiality. The pseudonym is known only by the researcher, as each of the interviews was numbered 1 to 9 for the transcriptionist, and no names were used during the interviews.

Table 1. Participant demographic data including pseudonyms, gender, years of nursing exeperience, and previous units where they were employed

| Pseudonyms | Gender | Years of Nursing Experience | Previous Units Worked on |
|---|---|---|---|
| Meredith | Female | 11 | Internal Medicine |
| Amy | Female | 34 | Internal Medicine, Neurology, Palliative Care, Intensive care |
| Janice | Female | 5.5 | Internal Medicine Unit, Community, Emergency |
| Miranda | Female | 5 | Internal Medicine, Neurology |
| Hannah | Female | 15 | Internal Medicine, Geriatrics, Neurology, Neuro-Surgical Intensive Care, Veterans Affairs |
| Kim | Female | 6 | Internal Medicine |
| Beth | Female | 2 | Internal Medicine |
| Julie | Female | 13 | Internal Medicine |
| Pamela | Female | 15 | Internal Medicine, Cardiovascular |

According to Sullivan-Bolyai et al. (2005) a qualitative descriptive study of this kind should be conducted until saturation is reached. Saturation is reached when the participant data from additional interviews does not add new information to the data already gathered (Creswell, 2007). I felt I reached saturation after I interviewed 9 RNs, and this was discussed with my thesis supervisor.

**Inclusion Criteria**. The qualities of a good participant include: 1) experiencing the phenomenon of study, 2) ability to reflect and provide detailed information regarding a phenomenon, 3) willingness to critically examine their experiences and their response to those experiences, and 4) ability to participate in a lengthy interview process that requires uninterrupted time (Morse, 1991). In order to be eligible for this study, the participants had to: 1) be an RN, 2) have been the primary nurse assigned to care for an individual with problematic alcohol use, and 3) currently employed on the general medicine unit at the study site. These inclusion criteria did not create limitations in the number of RNs that participated in the study and they were necessary to ensure keeping with the aim of the study.

**Sampling Technique**

Purposeful sampling was utilized in order to obtain in-depth accounts from RNs on their experiences in caring for persons with problematic alcohol use (Morrow, 2005). Purposeful sampling involves selecting participants that have had exposure to the study phenomenon, and for this research study this included RNs that have cared for persons with problematic alcohol use (Brown, 2009; Proctor & Allen, 2006). After the interviews, each RN was encouraged to suggest the study to other potential participants; thereby utilizing the snowball sampling technique in order to obtain as many interview participants as necessary (Davis & Logan, 2008). This assisted me in gaining more study participants. Two of the nine participants were recruited using the snowball sampling technique. Purposeful and snowballing sampling techniques allowed the researcher to seek out participants that had the ability to provide informative descriptions about their

experiences caring for persons with problematic alcohol use (Creswell, 2007; Proctor & Allen, 2006).

Thorne, Kirkham, and MacDonald-Emes (1997) explain that purposeful sampling in qualitative description research means seeking participants whose stories have some shared elements with others. As well, Thorne, Kirkham, and Macdonald-Emes state that the researcher should also differentiate between the "eccentricities" and the "commonalities" of data by expanding the description of the phenomenon (p. 174). I looked for RNs that had varying years of experience, and varying types of career experiences such as working on various units. As discussed previously, demographic information was obtained from the RNs regarding their gender, years of nursing experience, and the various hospital units where they have been employed to further illustrate the variation in the sample.

The study participants volunteered to take part in this research study. The individual RNs contacted the researcher via e-mail and interview dates/times were set up after being mutually agreed upon. One interviewee had to reschedule twice due to personal conflicts. There was no known bias in the sampling of RNs for this research study, all the participants volunteered by contacting the researcher to be enrolled in the study.

**Recruitment**

Prior to recruitment of study participants, Research Ethic Board (REB) approval was obtained from the study site. As well, before recruitment activities began, the researcher met with the manager of the internal medicine unit to discuss the study and

gain approval to recruit RNs. The REB approval process will be discussed later on in this chapter.

Participants were recruited from the internal medicine unit at this study site due to the variety of patients that are admitted to the unit and the likelihood of being able to recruit RNs who have cared for patients experiencing problematic alcohol use. A recruitment letter was posted on the unit in order to explain the study and the characteristics of the desired study participants (Appendix A). The recruitment of potential participants was initiated at this step, with the recruitment letter posted on the unit in areas of heavy traffic (i.e. medication room or staff lounge) so that as many RNs as possible had the opportunity to contact the researcher to volunteer to be part of this study. A copy of the recruitment letter was also posted in the internal medicine unit communication binder, which is read by the unit RNs frequently and used as a source of unit updates.

## Methods

### Data Collection

**Interviews**. The data collection for this study took place between March 2012 and December 2012 on the inpatient medicine unit. Interviews were conducted in a conference room that was on the internal medicine unit, located away from a lot of the unit noise. This interview setting was chosen because it was comfortable and convenient for the participants, which is in keeping with the qualitative approach (Davis & Logan, 2008).

As a novice researcher, I believe it is important to create rapport with participants so that as much description as possible is elicited about their experiences. In order to

achieve this rapport, it was necessary to spend a sufficient amount of time in the participants' environment creating an interview milieu that was conducive to open and honest discussion (Morrow, 2005). Also, to ensure participants comfort, I made sure to explain to them the rationale for why I was taking notes during the interview. I explained to the interviewees that my notes would be a part of my analysis, to remind me of topics/questions to further probe, to capture some of my personal thoughts that occurred during the interview, and a component of my reflective journaling. I wanted to prevent any misunderstandings that might arise as a result of my note taking during the interviews.

The audio-recorded interviews were one on one, conversational and dialogical, which allowed the RNs the freedom to tell their stories and describe their experiences openly. I completed 10 interviews with 9 participants, the interviews ranged from 13 minutes to 90 minutes in length with the average interview length being 40 minutes. The first study participant required a second interview to be conducted due to my novice research interviewing skills. The first interview was short, and after consulting with my thesis supervisor, I reviewed the interview skills that were required for a qualitative researcher. The subsequent interviews improved, as did my interviewing skills. Each participant's interview with the researcher was captured on a digital voice recorder.

During the interviews an interview guide (Appendix B) was utilized to aid discussions and probing questions were used as necessary to gain as much description and clarification as possible (Davis & Logan, 2008). The use of a semi-structured interview guide was congruent with the qualitative description methodology that informed this study (Neergard et al., 2009). The guide allowed for the same general areas

of inquiry to be discussed with each participant. The semi-structured approach of using an interview guide allowed participants to have some control over the dialogue that was generated and what was discussed in the interview but the guide kept the flow of the interview on course with the aims of the study (Creswell, 2007).

The interviews began with the question: "Tell me what you know about problematic alcohol use". The questions did follow a specific order, but some questions were asked that were not on the interview guide depending upon the discussion with the RN. Each interview was tailored to the participants' responses and how they felt about caring for persons with problematic alcohol use. I often followed the participants lead, and asked follow up questions to clarify participants' statements.

The guide was comprised of open ended questions that were developed with the assistance of my thesis committee to ensure that the questions were congruent with the aims of my study. Peplau's theory of Interpersonal Relations was considered in the formulation of the interview questions. The interview guide was dynamic, meaning that as additional interviews were conducted, questions were added or changed to reflect different areas to probe (Appendix C). Changes to the interview guide were made usually after a participant brought up a key point that was important enough I felt should be asked of the other participants.

Responsive interviewing was used in the data collection in order to 1) generate a depth of understanding of the participants' point of view, 2) maintain flexibility in the interviewing, and 3) foster the formation of a relationship with the participants (Rubin & Rubin, 2005). In using this interview style, I ensured that participants were aware of my experiences, emotions, biases, and interests if they desired to know this information

(Rubin & Rubin, 2005). During the interviews, none of the participants asked me directly what my point of view was on the care of persons with problematic alcohol use. Had they asked about my experiences, I would have told them my attitudes and assumptions as this transparency helps to establish rapport with study participants. It was important to remain sensitive and tolerant during the interviews, especially to others' points of view that may not have been in alignment with my own.

**Data Analysis**

Qualitative descriptive methodology calls for the description of a phenomenon by study participants and that inferences made by the researcher not impede this description (Lamb & Peden, 2008; Nusbaum et al., 2008; Sandelowski, 2000; Sandelowski & Barroso, 2003). The RNs' perceptions were described and analyzed using thematic analysis and a constant comparative method. While typically associated with grounded theory research, the constant comparative method requires that the researcher categorizes data through a process of comparing new codes to previously created codes. As such, following the transcription of each interview, data were coded and themes identified. In subsequent interviews, if the themes identified in the previous interviews were not elicited, participants were asked about existing themes to see if they resonated with them. In this process, the data and subsequent themes were compared to ensure that there was a good fit (Lathlean, 2006). This occurred in this study through constant comparison of participant responses and by reviewing or examining researcher notes in order to identify common themes (Lamb & Peden, 2008; Lathlean, 2006; Lincoln & Guba, 1985).

Data analysis commenced with the onset of data collection and included researcher field notes that were analyzed in addition to participants' data (Creswell,

2007). A reflective journal was maintained by the researcher; thus providing a venue for the researchers thoughts and emotions that occurred during the interviewing process. This journal also served as a component of the data audit trail to ensure the maintenance of scientific integrity in this qualitative study.

The participant interviews were transcribed verbatim and reviewed by conducting a thematic survey (Sandelowski & Barroso, 2003) which was then coded (Nusbaum et al., 2008). Analysis of the study data was done by researcher, and all was done by hand. I read and re-read the transcribed interviews prior to beginning the coding process. I listened and compared the audio files to the transcribed interviews to ensure the transcription was complete. Coding the data required the development of a code, which is essentially labelling the data. Recurring and significant codes were grouped to identify themes in the data (Nusbaum et al., 2008).

To begin the analysis, I formulated the initial codes in this research study so that they reflected the "spoken word" of the participants. The codes were unique identifiers for the participants' statements. The process of analysis began by saving the transcribed interviews into a Microsoft word document, then, I was able to use the track changes option as a way of organizing the codes in the document. I used action words in the formulation of the codes and tried to use the same initial codes as often as possible to categorize the data from all the interviews and to identify patterns in the data. The first two interviews were submitted to my thesis supervisor to ensure that the coding was appropriately done. Feedback that was received was incorporated into the analysis of the remainder of the data. After the third interview, major themes were evident in the data.

The codes were studied separately for similarities, differences, and recurring patterns, so that themes reflecting broader concepts could be identified (Nusbaum et al., 2008). During my analysis, I transcribed the codes that I formulated in the Word documents to index cards. This assisted in my visualization of how the codes fit together, and assisted me in the development of themes. Themes were developed from the participants stories that illustrated what it was like to experience caring for persons with problematic alcohol use. As such, these themes represent the experiences of nurses caring for individuals with problematic alcohol use. The themes were then considered in relation to Peplau's Theory of Interpersonal Relations.

**Scientific Integrity**

There are many documented axioms regarding the scientific integrity of sound qualitative research. Guba and Lincoln (1994) believe that a research study is plausible when readers who are confronted with the experiences described in the study recognize them. Sandelowski (1986) believes that artistic integrity of qualitative research is achieved when the researcher is able to communicate the rich and diverse human experiences that are under study. Streubert Speziale and Carpenter (2007) affirm that the goal of rigour in qualitative research is to accurately represent study participants' experiences. Alternately, many qualitative researchers believe that a more appropriate term to use for rigour in good qualitative research is "Trustworthiness" (Davis & Logan, 2008). Trustworthiness refers to how qualitative research is conducted in order to maintain integrity in the process and believability in the results (Davies & Logan, 2008).

In order to achieve trustworthiness in this research study, the criteria that were observed were: credibility, confirmability, dependability, transferability, and reflexivity

(Davies & Logan; Guba & Lincoln, 1994; Morrow, 2005). By attending to meeting the criteria for trustworthiness in this study, I aimed to capture an accurate description about RN's experiences caring for persons with problematic alcohol use. Ultimately, I hope that this description adds to the body of knowledge on this topic.

**Credibility**. Credibility refers to the internal consistency of the research data (Morrow, 2005) and the fit between participants' views and the researchers' representation of them (Topping, 2006). This was addressed by member checking with the participants to obtain their input after the data had been transcribed and coded. This was done to ensure that the data descriptions were a true representation of the RNs' experiences caring for persons with problematic alcohol use. This method calls for the maintenance of extended engagement with the participants in the field, well after the interviews were completed (Morrow, 2005). Member checking with the study participants ensured not only the descriptions RNs' attached to their experiences is understood, but also that the context in which their experiences occurred was considered (Morrow, 2005). Member checking allowed for further clarification of themes with the RNs and the preparation of a descriptive narrative (Davies & Logan, 2008). As a result of member checking, I decided to complete a second interview with my first participant as the information I gathered in that interview was not as descriptive as I would have liked and the interviewee felt that more information could be added to the interview.

The maintenance of researcher engagement with the study participants in the field as long as necessary created quality relationships and thus enhanced the description of their experiences (Morrow, 2005). In order to address this, I ensured that I took my time with interviews, and gained a sense of the unit that my study participants worked on,

particularly, after the first interview and the feedback of my thesis supervisor and first interviewee.

Credibility is also further advanced when the researcher describes their own beliefs and experiences (Sandelowski, 1986). To address this, I was explicit in sharing my experiences, beliefs, and assumptions where indicated regarding the care of individuals experiencing problematic alcohol use. As well, during data collection and analysis I was mindful of the ways in which my experiences and values shaped this thesis.

**Confirmability and Dependability**. Confirmability refers to the management of subjectivity during the research process and the clarity of the link between data findings and the interpretation (Topping, 2006). It is usually achieved when credibility, transferability, and dependability are met (Guba & Lincoln, 1994). Dependability refers to the consistency in the research process by which data are collected (Morrow, 2005), the ability of others to audit the research findings (Morrow, 2005), and the transparency of the research process (Topping, 2006). These two criteria were met by the maintenance of an audit trail that was examined and reviewed by my supervisor (Morrow, 2005). In this thesis report, I outlined my decisions regarding research and detailed the manner in which I completed my data analysis. Aside from the interview data, the audit trail was comprised of my field notes and reflective journal, in which I recorded emergent assumptions, biases, reactions and experiences that developed during the data collection phase (Davies & Logan, 2008; Morrow, 2005).

**Transferability**. Transferability refers to the extent that a reader is able to use the information gained from a research study for their own practice, educational, and/or

research endeavours (Lincoln & Guba, 1985; Morrow, 2005). For this study, I addressed this by providing adequate information about myself, the study context, study setting, and the research process, as well as the researcher-participant relationship in the reports and the final thesis preparation (Morrow, 2005). As well, in the findings and discussion chapters of this thesis, the themes are supported by participant quotes. This will assist the reader's understanding of the RNs' experiences in caring for persons with problematic alcohol use and thereby allow him/her to decide if the knowledge generated is transferable to his/her situation (Davis & Logan, 2008).

**Reflexivity**. Reflexivity is a technique in which the awareness of assumptions and biases is made explicit during the research study (Morrow, 2005). I ensured that this was addressed by the maintenance of a reflective journal in which I recorded my personal thoughts that occurred during the interviews. Directly after each interview, I recorded any thoughts, feelings or musings that I had regarding the interview in the journal. This journal was maintained in order to serve as a venue for my self-reflection, which I believed was necessary during the course of this study due to the potential for conflict between a participant's perceptions and my own (Morrow, 2005).

## Ethical Considerations

**Research Ethics Board Application**. Prior to data collection, an application was submitted to the Research Ethics Board (REB) at the study site (January 23, 2012) and approval for my study was obtained (March 1, 2012). The application process included: the completion of the REB application form, the identification of a site investigator, and the completion of an 8 hour online course for the *Tri-Council Policy Statement on Ethical Conduct for Research Involving Humans: Course on Research Ethics* (TCPS 2: CORE)

by myself and my site investigator, meeting with the manager of the general medicine unit and obtaining her signature on a letter of approval, meeting with the director overseeing my site investigator and obtaining his signature on a letter of acknowledgement, a meeting with the study site manager and obtaining her signature on a letter of acknowledgement, submission of my curriculum vitae and my site investigators curriculum vitae, and submitting my thesis proposal in its entirety with my informed consent form, recruitment advertisements, and interview guide. The REB application was designated to an expedited review as it posed minimal risk to the study participants, and thus was reviewed by one individual from the study site REB committee.

**Informed Consent**. The ethical consideration of seeking consent, as well as maintaining and protecting the confidentiality of the participants is important to the integrity of the research study (Creswell, 2007). I strived to establish a supportive and open relationship with the study participants; respect their privacy, and their right to withdraw from my study at any time (Creswell, 2007). As well, I was sensitive to the fact that RNs were asked to discuss their experiences relating to a vulnerable patient population and their discussions about problematic alcohol use may be difficult for a variety of reasons.

Informed consent was obtained from each RN before the start of the interviews. The informed consent form was based on the template and requirements of the site REB (Appendix D). It included a cover letter explaining the participants' rights, background information on the study topic, the purpose of the study, the procedures of the study, participant risks, consent for the use of direct participant quotations, and contact

information for the researcher and site investigator. As well, a signature sheet was required to be signed by the participants and a copy of these forms was given to the study participants.

The informed consent process was conducted as follows. First, I reviewed all the sections of the informed consent form and discussed the commitment that the RNs would have to agree to in order to be enrolled in the study. Second, I asked the RNs if they had any questions for me and responded to those questions as necessary. Third, I asked the RNs to repeat back to me what they thought the purpose of the study was, and what their commitments would entail in their own words. Fourth, the signature page was filled out by me, the participant, and a witness.

**Data Handling and Storage**. The data generated in the interviews was recorded on a digital voice recorder, transferred to the researcher's laptop, and saved as MP3 files onto a password protected memory key. In order to transcribe the data, a professional transcriptionist was hired. The University file drop system was used to transfer the mp3 files to the transcriptionist. The transcriptionist was asked to complete a confidentiality form that was kept with all the documents for this study for the required 7 years and a copy was given to the transcriptionist for her records (Appendix E).

Assurance of confidentiality was explained to the study participants and this explanation included how the data were handled after they were obtained. Data are stored on a pass code protected memory key, with the password known only by the researcher. The data, both mp3 files and Word document text, were heard and viewed by a transcriptionist, the researcher, and the thesis supervisor. The memory key containing the mp3 files and the transcribed word documents will be kept for a period of 7 years post

study in keeping with site REB requirements. Audio recordings and all electronic files will be deleted and the memory key will be reformatted once the 7 years have elapsed, and all transcriptions will be shredded after 7 years.

## Chapter Four: Findings

The purpose of this qualitative descriptive study informed by Peplau's theory was to describe in thematic format the experiences of 9 RNs in caring for persons with problematic alcohol use. This design was chosen because I wanted to learn more about the challenges and successes that RNs encountered in their care of these persons and offer a description of their perceptions in caring for persons with problematic alcohol use. An important aspect of RN practice on a daily basis is the development of therapeutic relationships with their patients. Therefore, Peplau's interactional theory was well suited to inform this qualitative descriptive study, and will be discussed in relation to the findings in the next chapter. I used qualitative descriptive methodology to "provide a rich, straight description of an experience or an event in a language similar to the informants own language" (Neergaard et al., 2009, p. 2). Within this chapter, I will present the study findings in thematic format illustrated by the use of direct quotes from the study participants in order to link the findings with their spoken words and in keeping with the tenets of qualitative descriptive methodology.

Qualitative descriptive methodology worked well for this study in which 9 RNs were interviewed during the data collection process. Each RN participated in a face to face interview, and a second interview was conducted with Meredith, the first participant, because her initial interview was quite short and there were data that needed to be clarified. During these interviews, the RNs candidly discussed their perceptions, struggles, successes, and beliefs surrounding the care of individuals experiencing problematic alcohol use.

Data analysis resulted in the identification of two themes: *Nurse-Patient Relationship Harmony and Disharmony,* and *Struggling to Care*. Each of these themes has two sub-themes. *Nurse-Patient Relationship Harmony and Disharmony,* the first theme was constituted by two underlying sub themes: (a) *Reflective Practice* and (b) *Judgemental Reactions*. During the analysis, these two subthemes were identified as distinct, yet captured the variation in what the participants were experiencing related to the nature of the relationships that RNs developed and witnessed, and which have shaped their practice. The second theme, *Struggling to Care,* was constituted by two sub themes: (a) *Knowledge Related to Problematic Alcohol Use,* and (b) *Learning by Trial and Error.* The first theme, *Nurse Patient Relationship Harmony and Disharmony*, depicts the variation in nursing practice in the development of the therapeutic nurse-patient relationship. The subsequent subthemes: (a) *Reflective Practice,* captures what fosters the relationship, and (b) *Judgmental Reactions* captures what derails the relationship. The second theme, *Struggling to Care,* represents the challenges that the participants faced daily when caring for a person with problematic alcohol use. The associated subthemes: (a) *Knowledge Related to Problematic Alcohol Use*, captures the variation and overall limitation in participant understanding of problematic alcohol use and (b) *Learning by Trial and Error* which reflected the manner in which informants learned about caring for this patient population. These themes and associated subthemes will now be presented and supported by the data. All names used in presenting the findings are pseudonyms to maintain the confidentiality of the study participants.

**Nurse-Patient Relationships Harmony and Disharmony**

Participants in this study offered many candid descriptions of their relationships with individuals experiencing problematic alcohol use. Some participants described the need for a therapeutic relationship with their patients. In order to achieve this, participants believed that professionalism was required on the part of the RN when caring for the individual with problematic alcohol use. The need to, as one respondent offered, "check yourself at the door" prior to caring for these patients was considered a necessary aspect of this relationship. The use of the phrase 'check yourself at the door' described the reflexivity that some participants exercised in their practice. Participants who were reflexive identified their values and beliefs and acknowledged their prejudices and the impact of these prejudices on their practice. Therefore, this theme *Nurse-Patient Relationship Harmony and Disharmony* reflected the relationship between nurse and patient in the context of problematic alcohol use, and whether participants were reflexive in their practice. The variation in the relationships established by the participants was illustrated in the subthemes: (a) *Reflective Practice* which was associated with recognizing the importance of the nurse-patient relationship to ensure that the best care possible was provided to patients, and (b) *Judgmental Reactions* in which RNs described situations they witnessed involving other health care professionals with persons experiencing problematic alcohol use that were judgmental.

**Reflective Practice**

*Reflexivity in Practice* is the process whereby the practitioner becomes consciously aware of the values and beliefs that guide their nursing practice. Reflective practitioners recognize their prejudices and biases, and though this process of recognition of prejudices, the participants attempted to avoid acting on them.

Participants who established a relationship with patients were reflective in their practice and acted on their values. Meredith reflectively captured the benefits of establishing the nurse-patient relationship in saying: "*it was absolutely essential to be able to build that relationship to gain a better understanding into his history in order to figure out what was going on*". The understanding gained through developing a relationship with patients permitted Meredith to know that "*he was just not purposely trying to give trouble to the staff, he really was in trouble*". Miranda recounted that "*deep conversations with them made me feel like I related to them on a personal level*". This reflection in Miranda's nursing practice assisted her in understanding the patient on a more personal level.

Julie reflected on her practice, acknowledging that she practiced in an institution "*that doesn't turn people away at the doors because we disapprove of how they got sick*", and explained "*I think you owe it to your patient to care for them no matter what*". Julie recognized the nurse has a responsibility to the patient to meet their health needs when admitted to the hospital, and that establishing the nurse-patient relationship is central to meeting patient needs.

Amy's reflection on her practice revealed her engagement with her patients and to her remarking that "*just talking with them, it helps them*". Amy believed that the patient felt secure with the development by the nurse of "*a good relationship with the person".* and that the nurse needed to *" show sympathy, talk to them, be kind"* and that this would" *help[s ]them to get over the hurdle with their alcohol*". These participants reflected on their values as the basis of understanding the patients in their care. As such, the nurse

patient relationship was described by these participants as essential to nursing care for this patient population.

In summary these participants (Meredith, Julie, and Amy) disclosed their reactions to the person with problematic alcohol use, and realized the effect that these reactions might have on the patient. These participants described moments within their daily practice where they were reflective in their actions, and worked to their capacity to establish the nurse-patient relationship. In these instances participants honoured the needs of patients with problematic alcohol use and promoted harmony within the nurse patient relationship.

Several other participants also revealed that they were reflective in their practice by acknowledging that they held stigmatizing attitudes about patients experiencing problematic alcohol use. Hannah remarked "*You wouldn't be human if your own personal experiences didn't color the way you are*", indicating that previous experiences that she had with patients that had problematic alcohol use influenced how she approached subsequent patients with this issue. But Hannah's statement that as nurses, "*we should be professional enough that that doesn't come into play with care*" revealed the belief that personal experiences need to be examined in establishing a therapeutic relationship. Hannah commented that stopping to think about what is happening in the moment with the patient is important to the establishment of the nurse-patient relationship, and central to the care of these individuals.

To be a reflective practitioner, Miranda recounted the need to "*take the whole picture into account*" and to understand the needs of the patient when caring for a person with problematic alcohol use. As a way to connect with the patient and promote harmony

within the nurse patient relationship, Miranda believed that "*collaboration*" with the patient was key to the care of this population. Miranda also asserted that "*everyone has a different story*" and viewed the person as a unique individual. Miranda's recognition of the uniqueness of the individual was revealed in her belief that you "*can't force*" your view on patients. As such, being professional requires reflection on personal values to enable the nurse to establish the nurse-patient relationship.

Reflection in practice was also illustrated by Kim and Julie. Kim remarked that she "*can't imagine how it would feel to be in a place where you needed help but someone was judging you for your problems*". Julie reported:

> *...the idea that you could refuse to care for somebody when they are sick is pretty repellent to me and the idea that somebody can stand outside your life for 3 seconds and judge you on how you got sick just smacks of intolerance.*

These participants were reflective in their practice and developed a conviction that they would not be this way in their care of patients living with problematic alcohol use. This is an example of the professional self-awareness that Peplau calls nurses to develop.

**Judgemental Reactions**

*Judgmental Reactions* were described by the study participants as contributing to relationship disharmony between the RN and patient. This sub-theme illustrates the actions of participants that led to disharmony in the nurse-patient relationship, and lost opportunity for contributing to client self-awareness. In every interview conducted for this study, participants discussed the judgemental reactions that they had perpetrated or witnessed over their years of nursing practice. The 'professionals' in the scenarios described by the study participants covered the gamut of health care professionals and

included fellow nurses, doctors and allied health professionals such as physiotherapists, and occupational therapists.

Participants described being guarded with the development of a nurse-patient relationship. This meant that getting to know the patient and establishing a relationship was not routinely a part of practice, particularly with problematic alcohol use patients because "*they give you lip service in that they do what they have to while in the hospital but as soon as they are discharged they will drink again*". Hannah did not dismiss all patients with alcohol use issues and confirmed this by saying "*I felt sorrier for the ones who really would make a change*", however she held a basic distrust of these patients based on her past experiences. She also reported the outward distrust she had experienced in relating that a patient viewed her "*help with great suspicion*" and "*a fair bit of paranoia*". The patient in this instance was questioning Hannah's motive for wanting to discuss his alcohol use. As such, Hannah attributed the mistrust to the patient "*having a chip on their shoulder*", and that the patient believed that Hannah thought she "*was better than him"*. Hannah's failure to establish a relationship with her patients fueled this mistrust, however she did not always recognize how her prejudice toward these patients contributed to the mistrust she experienced. It is noteworthy that in the study data Hannah's narrative illustrated moments of reflective practice as well as those of being judgmental. This finding is important and illustrates that some participants held judgmental attitudes.

Similarly, Beth described her experiences in caring for patients with problematic alcohol use as challenging. Beth mirrored Hannah's perceptions of patients who were problematic alcohol users reporting that the "*health education*" she provided to these

patients had "*fallen on deaf ears or you know whatever you say or do will not encourage them to quit drinking*". Beth also reported the same mistrust that Hannah experienced stating "*sometimes the patients don't trust you and don't think that you are saying or acting in their best interest*". These participants decided these patients were not to be trusted and could not see that the prejudices they held for the patients related to their alcohol use perpetuated mistrust, and precluded developing a therapeutic relationship that may have benefitted their patients.

Some participants explained outright that they did not establish a relationship with patients experiencing problematic alcoholic use as a way to maintain professionalism and/or neutrality. For example, Janice believed that she should not connect or engage with these individuals. As such she described how she purposefully avoided "*that kind of bond with patients*" and that she made conscious decisions to "*try to avoid it*". She discussed the ease with which she made conversation with individuals that "*might have had a heart attack or something*" but when she cared for individuals that have problematic drinking, she was reluctant and "*didn't really know*" if she would initiate or "*go over and start a conversation with them*". Janice asserted that she believed that she could set her prejudices aside when in reality her actions revealed them. She was selective in who she would establish a relationship with and those experiencing problematic alcohol use did not have a chance to benefit from a therapeutic nurse-patient relationship.

Miranda captured some of the remarks that other professionals made to patients in her statement "*I have actually seen them tell a patient that if they hadn't drank alcohol to begin with, they wouldn't be here at all*" referring to the reason why this particular

patient was admitted to hospital. Miranda described feeling "*stunned* " and "*embarrassed*" at witnessing this treatment of a patient. She described her concern that the patient would paint all health care professionals with the same brush, since she believed that "*one nurse on the floor represents us all*" and that "*one bad nurse makes a patient think we are all bad*". Mirandas' account of the treatment of patients illustrates how professionals impose stereotypical attitudes.

Meredith claimed to have witnessed other health care practitioners blaming the patient for alcohol use by saying *"you chose to drink...now you have such and such problems because of it*". Blaming the patient for problematic alcohol use transmits to the patient they are being judged and hampers the establishment of the nurse-patient relationship. Meredith reported that patients "*felt like nobody was caring and nobody was listening*" to them when they were honest and upfront about their alcohol use. Meredith went on to say that nurses who dismiss, blame, or are critical toward patients "*kind of stick out, and those are the ones you remember*".

Kim described witnessing judgmental actions and described the "*negativity that you hear from other nurses around you*" about alcohol use and the individuals involved. Kim described other nurses as having "*the attitude that they [patients] did it to themselves*". Meaning, that the individual with problematic alcohol use is now a patient because of their drinking, and that this individual does not deserve the care the nurse provides. Julie described the negative attitude she heard in her experiences and stated that she "*hear[d] that at work....like what's the point, they just want to leave and go to the liquor store*". This attitude was also described by other study participants, who overheard their colleagues refuse to care for patients with alcohol issues.

One participant (Beth) remarked that if she "*had a choice in assignment, she would choose to not look after a person with alcoholism*". Beth described her reaction to the patient with problematic alcohol use as "*indifferent*", and that her response to finding her assignment included a person with problematic alcohol use would be: *'Oh great!' this person is going to be agitated and will be difficult to deal with*". This participant was clear in her judgments of patients experiencing problematic alcohol use and did not see the need to reflect on her practice or the need to establish the nurse-patient relationship because in her assessment the source of the problem was the patient.

Resoundingly, study participants recounted perpetrating as well as witnessing judgmental comments and reactions on the part of healthcare professionals toward those persons that have problematic alcohol use. The existence of the judgments described above left little place for the establishment and maintenance of the nurse-patient relationship. Accordingly, the lack of establishing this relationship means that there would be little hope that the patients in their care would make any progress in addressing their problematic alcohol use.

This theme, *Nurse-Patient Relationship Harmony and Disharmony* reflected the general state of the relationship between nurse and patient in the context of problematic alcohol use, and that some participants were responsive in their practice and others were reactive, and still others demonstrated some degree of reflection. The aim of the nurse patient relationship is to foster the trust between the nurse and patient. However, some of the RNs in this study discussed the lack of trust within this relationship and being guarded with the development of the nurse-patient relationship. The need for empathetic and open communication was described by some participants, yet others described the

judgemental reactions they have perpetuated as well as witnessed by their peers. The variation in the establishment of relationships with patients was illustrated in the subthemes: (a) *Reflective Practice* which was associated with being reflexive and developing therapeutic relationships, and (b) *Judgmental Reactions* in which participants described reactions that contributed to the derailing of a therapeutic relationship with persons experiencing problematic alcohol use.

**Struggling to Care**

The second theme identified from the study data depicts the struggles of the participants in the care of patients experiencing problematic alcohol use. Although the participants described successes in the delivery of care to patients experiencing problematic alcohol use in the presence of a therapeutic nurse-patient relationship, this was not always the case. The development of this theme is important because it illustrates the consequences of the inadequacies to attend to the development of the nurse-patient relationship.

Participants in this study consistently discussed what they believed to be their responsibilities in the care of an individual with problematic alcohol use. These responsibilities included: patient assessment, medication administration, being knowledgeable about problematic alcohol use, and communicating with patients about problematic alcohol use. While undertaking these responsibilities, participants described the struggles that they encountered. *Struggling to Care* was constituted by two sub-themes: (a) *Knowledge Related to Problematic Alcohol Use* which was associated with the participants perceptions about what caring for patients with problematic alcohol use involved as well as what problematic alcohol use meant, and (b*) Learning by Trial and*

*Error* the second sub-theme revealed the manner in which RNs' learned about caring for patients with problematic alcohol use. Both of these sub-themes revealed variation in nursing knowledge and ability in the care of persons with problematic alcohol use.

**Knowledge Related to Problematic Alcohol Use**

**Clinical Assessment Skills and Knowledge**. Participants in this study revealed their knowledge regarding problematic alcohol use through their accounts of the clinical assessment skills, and knowledge required in the care of these patients. Participants frequently referred to clinical assessment as one of the many skills needed in the care of persons with problematic alcohol use. Participants believed that the assessment skills an RN possessed were crucial to the recognition and subsequent care of persons with problematic alcohol use. Meredith captured the importance of the clinical assessment of a person experiencing the withdrawal symptoms associated with the absence of alcohol use while hospitalized saying: "*... he was very agitated, and had an extremely high heart rate, and was sweating, and having a lot of symptoms of withdrawal like tremors, and apparently had a seizure during the night*". Meredith's assessment of her patient and their situation reflected a firm understanding of the symptoms of withdrawal, and she went on to remark that the patient had experienced a seizure during the night, and "*the nurse said that it had lasted a short time and that they really didn't do anything for it*". This demonstrated that the nurse from the previous shift failed to recognize and therefore did not address the withdrawal symptoms the patient was presenting with and that Meredith recognized on the her shift.

Amy explained the importance of assessment skills by stating "*The big thing is trying to recognize the symptoms, because sometimes the symptoms of alcohol can also*

*be symptoms of different diseases*". Amy recognized that determining the presence of problematic alcohol use was not simple and straightforward, and that it necessitated a certain knowledge base, accompanied by good clinical assessment skills. Similarly, Beth remarked "*you definitely need to have good assessment skills to pick up on the subtleness*" and that alcohol withdrawal can mimic or "*sometimes look like a variety of other issues*". During the interviews, the participants paid particular attention to the importance of the RN in the assessment and recognition of withdrawal symptoms.

Hannah described missing the symptoms of withdrawal in her patient "*My patients' roommate rang his call bell, when I walked in the room, he said 'Lady, He's in DTs!*". In a further description of the need for a thorough assessment, Hannah remarked on the differences from RN to RN in that "*some nurses are better about it depending on where they worked and what their life experiences were....I think in some ways it is easy to miss*". The subtleties of alcohol withdrawal were a challenge for some RNs to identify, and the clinical assessment skills that an RN possesses were believed key to the quality of care that patients received.

In discussing the clinical assessment of an individual with problematic alcohol use, Kim remarked that sometimes the assessment "*gets lost in the agitation or irritability of the patient*". Kim described the frustration that she felt when trying to care for a person with problematic alcohol use when they "*were aggressive*" (i.e. "*kicking or striking out* " at her) with her: "*Truthfully care was minimal in that situation*". Kim also remarked that she tended to avoid what she believed to be an aggressive patient, and thus, her clinical assessment and monitoring of the patient was affected.

Participants in this study were very candid in their descriptions of the struggle they encountered related to their general knowledge not only regarding the disease but with the tools and treatments associated with the care of these patients. Hannah described a patient scenario in which she advocated for her patient however "*the order was completely inadequate. I called the doctor and said " 'Can you come up?' ...this medicine is not touching him*". The doctor did come up to see that patient and the order received subsequently provided the patient relief. This relief was the goal that Hannah had in mind for this particular patient and although she advocated on behalf of the patient she did not feel she had the knowledge and understanding of the disease needed to provide evidence-based care required for his comfort.

Many participants described a lack of evidence-based approaches for treating problematic alcohol use in their hospital setting and this caused struggles for the nurses when recommending treatment approaches to the physicians. Amy illustrated this in reporting "*there isn't much written that can help you deal with patients with alcohol use issues*". Thus, Amy relied on her 34 years of nursing experience to pick up on the patient clues that they may be in withdrawal and used her "*nursing experience*" to obtain what she believed to be an appropriate doctors' order to prevent side effects of withdrawal. RNs reported experiences with medications that varied widely, depending upon different experiences they had at other health care institutions. As such, participants within this study setting were advocating based upon what they knew about problematic alcohol use, or following a physician's order trusting that the order was appropriate for that patient.

Participants descriptions revealed that they were aware that evidence based protocols existed for the care of persons with problematic alcohol use. Participants that

had worked at hospitals other than the study site and cared for persons with problematic alcohol use at these hospitals were familiar with the CIWA-AR scale as one such evidence-based assessment protocol. This scale was described as an ideal assessment tool that delineated withdrawal symptoms, and provided suggestions on medication that may be appropriate for the treatment of withdrawal symptoms. Janice described her experience using this protocol at other institutions as follows: "*It was pretty easy to objectively score these people and then you would just basically follow the algorithm of the protocol*". Janice further described the ease she felt in using this assessment tool:

> *... If you were above a certain number, you'd have to have your seizure precautions in place, and whether they were medicated...and also in terms of medication, if X, Y, and Z were in place on blood work then you would use Ativan or you would use Valium.*

The positive patient outcomes from the use of protocols similar to CIWA-Ar in other institutions lead Janice to remark on her disappointment that there were no formal protocols in use at the study site: "*I'm kind of a little sad that we don't have a good protocol to follow because you do kind of get good at asking the questions and knowing certain subtle cues that you're looking for that might make you think that things might be starting to escalate*". In order to remedy this, Janice used the protocol in an informal way, "*I still kind of use CIWA because I've used it before and I'm comfortable with it... So it still very much guides, you know, my assessment and my charting, and also my medication of a patient*". The past experiences that Janice had guided her current practice. She used an evidence-based guideline to assess for problematic alcohol use and to initiate medication administration.

The participants reported that the lack of a protocol for the clinical assessment and medical treatment for persons experiencing problematic alcohol use at the study site created unease for them. In the absence of a protocol, the difference in knowledge related to the assessment of problematic alcohol use and advocacy for the medicinal treatment of these individuals varied widely. For example, while discussing a patient care situation, Beth remarked that she was "*not sure where the [Doctor] got the number [dosage] from...it just seemed to have been randomly chosen*" while she was describing the process of obtaining an order from the doctor for medication for a patient with problematic alcohol use and how the doctor decided upon a dosage and frequency for that medication. When further discussing this patient encounter Beth continued: "*I felt I didn't know what to look for, like if he needed more drugs or not*". This unease left Beth to struggle to care for the patient the best way she knew how rather than according to best practice.

Most of the participants described feeling frustrated with fulfilling their responsibilities to the patients. This frustration born of the lack of knowledge and evidence-based care caused participants to *struggle in the care of* patients with problematic alcohol use. Accordingly, this struggle affected their ability to establish the nurse-patient relationship.

**Disease Understanding**. The knowledge levels and understanding of problematic alcohol use varied among the study participants. Overall participants expressed the need to believe there were some underlying conditions that precipitated problematic alcohol use. In order for some participants to believe that problematic alcohol use is a disease process, they needed to believe in plausible explanations of how an individual takes up

the injurious use of alcohol (e.g. coping with traumatic life experiences). This sub-theme represents the variation in participants' understanding of problematic alcohol use.

Participants cared for patients every day that had problems with the use of alcohol. These patients were admitted to various hospital units with diagnoses such as congestive heart failure, or acute exacerbations of a chronic obstructive pulmonary disease. The focus of the care for these patients was on the medical diagnosis and attention to their problematic alcohol use was often minimized or avoided. The admission to hospital exposes the individual with problematic alcohol use to the likelihood that the substance abuse problem will be uncovered. This fear of exposure causes the patient to experience a heightened level of anxiety. This state of anxiety can result in patient behaviors such as aggression, or avoidance unless the nurse is able to therapeutically engage with the patient to help reduce the anxiety and feeling of vulnerability in the patient.

Generally participants' knowledge related to problematic alcohol use ranged from a description of problematic alcohol use as a disease that could affect anyone, the result of traumatic life events, and included negative profiling of patients. For example, Meredith remarked "*that it (problematic alcohol use) is not specific to any type of individual. It could be anybody. It's not just a specific population*". This demonstrated Meredith's understanding that problematic alcohol use is not a disease exclusive to a particular group of people. Similarly, Julie agreed with Meredith in this saying that problematic alcohol use "*cuts across all socio-economic and cultural dimensions*".

Understanding of problematic alcohol use varied among participants. For example, Amy described problematic alcohol use as a disease like diabetes: "*It's just like,*

*you know somebody that comes in with diabetes or you know, heart attack or different things like that*". Janice recognized alcoholism as a disease and had considerable experience in caring for persons with problematic alcohol use in rural, northern hospitals where she expressed the "*overwhelming difficulty*" and struggle she had in caring for these patients when admitted to the hospital knowing that once discharged they "*had no safe, sober environment to go to*". The knowledge that the individual the nurse is caring for had few options to help manage the disease also caused participants concern for these patients on discharge.

Some participants illustrated their knowledge related to problematic alcohol use as a consequence of traumatic life experiences. For example, Amy attributed problematic alcohol use to loneliness and experiences such as divorce: "*I find a lot of people go to alcohol after say a bad divorce or separation. It is their way of dealing with this stressful situation in their life*". Amy's description suggests that the individual is using alcohol to medicate themselves as a coping strategy for life stresses.

Hannah's knowledge regarding problematic alcohol use was revealed in her depiction of it as a form of self-medication:

> *...it's like self-medication, they don't know...they're depressed, they have anxieties, you know, a whole bunch of unresolved issues and they don't know how to go about getting help for that. So the closest thing they can do is drink alcohol. It kind of makes them forget or whatever*.

Hannah described problematic alcohol use as resulting from traumatic life events or experiences. As such, the problematic substance use was viewed as a way for the patient to cope with the overwhelming stress associated with these events. In these instances

Hannah wanted to "*help more*" the individual that had a traumatic life experience, which she described as "*something happening in their childhood or whatever*" where "*they couldn't deal with their emotional needs and responsibilities*" and as such, turned to alcohol use as a coping strategy. These individuals, in her eyes, were tragic and deserving of the time she spent with them. Conversely, she had less empathy for the individual that she believed, once discharged from the hospital, would "*not make it to the corner before they want or have a drink*". Hannah reported that she disconnected from those in the latter category because these individuals would not "*change their ways*". In other words her knowledge of problematic alcohol use was limited and led her to act on her prejudice toward patients she saw as not deserving nursing time. Hannah did not engage with the patients she saw as non-deserving and unknown to herself contributed to stigmatization of these patients.

Participants not only described problematic alcohol use as related to personal circumstances they also negatively profiled individuals that have problematic alcohol use. Some participants described individuals with problematic alcohol use as being unworthy and/or unclean. These participants also believed that the individual with problematic alcohol use was more likely to be a middle aged male, with unstable employment. This profiling was captured by Hannah in her description of the individual as "*usually in his 40s, unemployed*" and "*a typical welfare bum*". In her description of the person with problematic alcohol use Beth believed that "*they [persons with problematic alcohol use] are often dishevelled, jobless, and sometimes homeless*". She went on to describe in detail that they "*generally look unwell, their clothes are shabby, they might have a cauliflower nose and often they are deathly skinny*". Participants in this study described the person

with problematic alcohol use as marginalized and stigmatized in keeping with the published literature on problematic alcohol use. Homelessness or being homeless was a label placed upon patients with problematic alcohol use by most of the participants. For example, Miranda explained that "*alcohol and homelessness go hand in hand*" and that problematic alcohol use may cause the homelessness or alcohol "*abuse has led them to that situation*".

Participants who recognized problematic alcohol use as a disease recognized the need to care for these patients, however felt ill equipped based on limitations related to knowledge and clinical assessment skills. Those who did not understand that problematic alcohol use is a disease experienced greater struggle because their prejudice told them these patients were unworthy, however they were also guided by beliefs that some people do fall on hard times and that it is okay to make exceptions to their prejudices. The lack of understanding of problematic alcohol use by study participants meant these patients were not getting help with their disease, and contributes to perpetuating the stigmatism associated with the disease.

**Learning by Trial and Error**

The subtheme *Learning by Trial and Error* is defined here as the way in which RNs learned about problematic alcohol use, and the manner in which they cared for these individuals. The participants reported three ways in which they learned about problematic alcohol use: personal experience, employment experience, and formal learning. The most common way in which the RNs in this study described learning about problematic alcohol use was by learning through caring for these patients. Consistently the RNs

described the need to actually interact with this patient population in order to gain knowledge about problematic alcohol use and how to care for individuals experiencing it.

**Personal Experiences**. Participants discussed the ways in which they learned about problematic alcohol use, one of which was by personal experience. For example, Hannah explained:

> *... we all have friends or people that we know and love who drink too much. And you realize all of a sudden it's gone beyond being like a fun kind of thing where we're all out getting drunk in a bar and dancing and singing to wow, such and such has a problem*.

These personal experiences led to learning for the individual nurse, particularly when it came to considering the holistic needs of patients. Hannah remarked that her personal experiences "*helped with relating to the patients*". By having a close friend learn to manage problem alcohol use, Hannah was able to better connect with her patients that had the same problem.

**Practical Experience**. The majority of participants described the practice environment as the source of their learning. Meredith remarked: "*I would say that I basically learned from my work experience and from observation within the hospital*". In further describing how challenging she found the care of the person experiencing problematic alcohol use as a beginning practitioner Meredith added:

> *...I felt that maybe I didn't have all the skills needed to be able to talk to these patients about their issues. I feel that as nurses we have to be able to read people really well, but it was something I didn't have when I first started*.

In this statement Meredith described lacking the interpersonal skills needed to discuss problematic alcohol use with her patients when she first started her nursing career, and this was learned through her experience in the practice setting. Beth recounted "*informally learning at work*" where "*senior nurses, doctors or residents kind of told me about what I should look for and what I should be doing*". She also explained that she received some "*in house education that went along with problematic alcohol use*" when she was employed at another health care facility.

**Formal Learning**. Formal education on alcohol and addictions was rarely reported by the participants in this study. When asked how educationally prepared the participants felt directly after nursing school, most participants described feeling unprepared. Hannah reported feeling "*not very well prepared at all*". Hannah's perception about her formal nursing education was reflected by other participants. Meredith stated that when she first began her nursing career, she "*didn't feel prepared at all*". Similarly, Miranda also noted that only when she "*was working did I come across it*". Meaning she did not learn about problematic alcohol use in her program of study or in clinical experiences prior to beginning to work as a nurse. Julie on the other hand not only recognized her lack of knowledge she made an effort to improve her knowledge by "*taking advantage of … reading on my own time*". She reported reading articles as a way to learn as much as she could about problematic alcohol use.

Study participants descriptions of formal education about problematic alcohol use revealed that the education was not part of their nursing program of study. They did not find the education received helpful to their current practice. For example Amy described her clinical experiences in a "*detox program*" but she "*did not find that much help*" to her

because "*the patients were there to get education*" and were not in active withdrawal or admitted to an acute care setting. Kim also remarked that her formal education consisted of some material being "*covered in mental health courses*" but "*just a small portion really*". Janice also had clinical experience in a detox centre "*where she played cards and chatted with the patients*" which she asserted did not prepare her for the realities of caring for an acutely ill individual with problematic drinking.

From one study participant to the next, there were differences across the knowledge base in terms of how they approached their care of these individuals. In general, all participants acknowledged the number of instances in which they cared for an individual that was experiencing problematic alcohol use. The frequency with which participants cared for this patient population was expressed by Miranda who stated "*oh, it's a big problem*" and Janice remarked "*it is a large problem*" when they described the frequency with which they encountered problematic alcohol use. Overall, the participants described problematic alcohol use as a common healthcare issue, but acknowledged that they struggled to provide the care these patients required.

This theme, *Struggling to Care*, revealed the participants' challenges in knowing what was involved in the care of patients with problematic alcohol use. Participants described struggling to care for these patients based on limited knowledge related to clinical assessment skills to identify withdrawal symptoms, general knowledge of the disease, and a lack of evidence based protocols and tools for use in the care of this patient population. As well, this theme revealed no consistent manner in which nurses are educated about their responsibilities in caring for patients with problematic alcohol use in a hospital setting.

**Summary of Themes and Sub-themes**

The theme *Nurse-Patient Relationship Harmony and Disharmony* described the relationships that participants established with persons experiencing problematic alcohol use and consisted of two subthemes: (a) *Reflective Practice* and (b) *Judgmental Reactions*. Each of these sub-themes highlighted the relationship between participants and patients. The first sub-theme illustrated how exercising reflection in practice enabled the participants to establish therapeutic nurse-patient relationships. The second sub-theme *Judgmental Reactions* illustrated how acting on prejudices held by participants led to mistrust between participants and patients and ultimately derailed the nurse-patient relationship. These subthemes reflected the participants' perceptions of the harmonious relationships they had with patients experiencing problematic alcohol use when participants were reflective in their practice; and the disharmony or absence of a nurse-patient relationship experienced when judgemental actions were both perpetuated and witnessed in the care of patients.

*Struggling to Care* reflected the study participants' perceptions of their challenges in the care of the individual with problematic alcohol use, and was characterized by two sub-themes; *Knowledge Related to Problematic Alcohol use*, and *Learning by Trial and Error*. Sub-theme one captures the struggles participants encountered associated with a lack of knowledge of problematic alcohol use as a disease. This limited knowledge was compounded by the fact that participants reported most of their learning related to problematic alcohol use was gained in the practice environment.

These two major themes considered together contributed to our understanding of how patients experiencing problematic alcohol use continue to be stigmatized, and how

the disease continues to be under-treated. Inadequacies in establishing therapeutic nurse-patient relationships limits the possibility for these patients to connect with health care providers and to receive the care required. Lack of general knowledge about the disease, and evidence based practice, along with acting on personal prejudices hampered the comfort level of the nurse with the patient and contributed to the derailment of the nurse patient relationship.

**Summation of Findings**

This qualitative descriptive study informed by Peplau's theory of Interpersonal Relations was focused on describing participants' experiences when caring for persons with problematic alcohol use. This design was chosen because I wanted to learn more about the challenges and successes that RNs encountered in their care of these persons. The participants described variability in successful development of nurse-patient relationships, and how they 'struggled to care' for persons with problematic alcohol use due to lack of knowledge, evidence-based practice, and prejudice.

The first theme, *Nurse-Patient Relationship Harmony and Disharmony* and associated sub-themes depicted their relationship with the patient in a practice environment that RNs faced daily. The sub-theme *Reflective Practice* revealed the self-awareness and reflexivity that is necessary for the nurse to foster a therapeutic relationship with patients. The second sub-theme, *Judgemental Reactions* revealed examples that participants observed in their work environment which were judgemental toward this vulnerable patient population.

The second theme, *Struggling to Care* depicted the challenges that the RNs in this study faced while providing care to this patient population. These challenges related to

the clinical and interpersonal expertise deemed necessary for the care of the individual with problematic alcohol use. This theme spoke to the challenges that participants faced related to their knowledge about problematic alcohol use, and how they learned about caring for these patients. These challenges contributed to disharmony within the nurse-patient relationship. The sub-theme, *Knowledge Related to Problematic Alcohol Use* illuminated the lack of knowledge, and evidence-based practice protocols in the care of this patient population. Although some participants understood problematic alcohol use as a disease many did not. Those who did not explained that they cared for these patients because they believed that the patients had no control or used alcohol as a coping mechanism for traumatic life events (i.e. divorce). The second sub-theme, *Learning by Trial and Error* revealed that participants learned about problematic alcohol use primarily in the clinical practice setting. Lack of knowledge related to problematic alcohol use, and limited formal learning by participants, increases the likelihood that care for persons with problematic alcohol use is compromised. Accordingly, the satisfaction of both patients and nurses involved in the relationship is diminished.

The themes identified in this study contribute to our understanding of the care experiences of both patients and nurses in the context of problematic alcohol use on one internal medicine unit. Central to the establishment of effective nurse patient relationships is reflexivity as well as enhanced nursing knowledge and evidence-based practice. Reflexivity in action was practiced by Janice during her interview in which she revealed how she stigmatized problematic alcohol users based on the descriptors she used. When I asked her why she felt that way she responded " *Huh, that's interesting. I really don't know why I believe that. And I hadn't thought about it that way before*". It

became apparent during the interview that Janice was reflecting upon her practice and questioning why she believed as she did. Consciousness raising in the context of problematic alcohol use was a major reason why I chose to conduct this study, and it is my hope that the study findings assist other nurses in evaluating their practice. The next chapter provides a discussion of these findings in relation to Peplau's Theory and to the literature. I will also discuss the implications of these findings for education, practice and research.

# Chapter Five: Discussion

Qualitative descriptive methodology is situated in the Naturalistic Paradigm (Sandelowski, 2010) which is characterized by acknowledging the existence of multiple realities, the partnered construction of findings by the researcher and participants, and as such the two cannot be separate (Lincoln & Guba, 1985). When conducting research within the natural setting, the researcher is the instrument, through which the findings are interpreted and communicated, the context in which research is conducted matters, and is value laden (Lincoln & Guba, 1985). This qualitative descriptive study involved semi-structured interviews to further the understanding of 9 RNs experiences in caring for persons with problematic alcohol use on an internal medicine unit. Thematic analysis was used in identifying two major themes: (a) *Nurse-Patient Relationship Harmony and Disharmony* and (b) *Struggling to Care*. Sub-themes associated with *Nurse-Patient Relationship Harmony and Disharmony* were: (a) *Reflective Practice* and (b) *Judgemental Reactions.* Sub-themes associated with *Struggling to Care* were: (a) *Knowledge Related to Problematic Alcohol Use*, and (b) *Learning by Trial and Error*. This study was informed by Peplau's Theory of Interpersonal Relations, and the concepts of the theory are used in the interpretation and discussion of the findings. In this chapter the meaning of the themes and sub-themes is discussed using Peplau's theory, and relevant literature; implications for practice, education and research are discussed; followed by the conclusion.

**Peplau's Theory of Interpersonal Relations**

Peplau (1952), a nurse scholar, theorized the formation of the therapeutic nurse-patient relationship as embracing an educative process. Peplau's theory was informed by

Harry Stack Sullivan's Interpersonal Theory with its emphasis on the need for security in finding life satisfaction, and the need for self-awareness in this search. Sullivan presupposed that overwhelming anxiety can interfere with life satisfaction. Building on this Peplau advanced the notion that nursing practice should aim to reduce anxiety (Vacarolis & Halter, 2010). Peplau conceptualized the practice of nursing as a therapeutic interaction where "mutuality, respect for the patient, unconditional acceptance, and empathy" are present and assumed to facilitate patient self-awareness (Vacarolis & Halter, 2010). Peplau (1952) considered self-clarification as a critical element in fulfilling the purpose of the therapeutic relationship.

According to Peplau (1952), the nurse patient relationship consists of four phases: (a) Orientation, in which the patient seeks assistance, and the nurse responds by assisting the patient to identify problems and to use available resources; (b) Identification, where the appropriate assistance is identified and the patient gains a sense of belonging and feels capable of addressing their health concern, (c) Exploitation, where the patient is actively drawing upon and seeking help from the nurse, and (d) Resolution, whereby the patient needs have been met by the collaborative effort of the nurse and patient and the therapeutic relationship is terminated (Peplau, 1952; Peplau, 1991). Throughout these phases, the self-awareness of the nurse is vital to the relationship (Varacolis & Halter, 2010). For example, during the orientation phase, there are a number of factors that influence the nurse-patient relationship such as: values, culture, beliefs, past experiences, expectations, and preconceived ideas (Peplau, 1952). In reflecting on her/his practice, the nurse can bring into consciousness her/his values, beliefs, and prejudices, and examine how nurse-patient relationships are shaped by them.

Key concepts from Peplau's (1952) interpersonal theory of nurse-patient relations that were manifested in the findings of this study included: (a) self-awareness by the nurse, and (b) how values, beliefs, and prejudices influence the nurse-patient relationship (Varacolis & Halter, 2010). These concepts are of central importance to this study because the findings represent how the presence of these concepts varied. For example these concepts were (a) enacted and demonstrated in some participant narratives (b) enacted in part by participants, or (c) were absent in the participants' descriptions of their experiences caring for patients experiencing problematic alcohol use. Accordingly, the following discussion considers these concepts of Peplau's theory as they relate to the study findings.

**Peplau's Theory and Study Findings**

**Nurse-Patient Relationship Harmony and Disharmony.** *Nurse-Patient Relationship Harmony and Disharmony* as described by the study participants revealed variation in the cultivation of a therapeutic relationship with individuals experiencing problematic alcohol use. Some participants described being reflexive and making an effort to be open with their patients. As such, *Reflective Practice* as a sub-theme was illuminated in the data. Other participants recounted judgemental reactions such as avoiding patients or being guarded in their relationships with patients as well as witnessing or enacting stigmatizing attitudes in their practice environments. Therefore, the sub-theme *Judgemental Reactions* was revealed.

The variation in reflection in practice influenced the enactment of the four phases of Peplau's theory for two of the participants (1952) (i.e. Orientation, Identification, Exploitation, and Resolution). For example, during the orientation phase, the patient is

seeking assistance and needs to sense that they can connect with the nurse. The nurse needs to be aware of her/his own values, beliefs, and prejudices (reflexive) during the initial phase of the therapeutic relationship in order for the patient to sense the nurse cares. However, based on the descriptions that participants provided in this study, reflexivity was not routinely practised. The participants that were reflexive, described positive interactions, and expressed satisfaction in the care of patients. Participants who chose to avoid patients or were guarded within the nurse-patient relationship missed the opportunity to reflect and thereby did not enact the orientation phase of the interaction. Participants that missed the opportunity to enact the nurse-patient relationship provided accounts of relationship disharmony. In the absence of a therapeutic relationship participants withdrew from patients displaying aggression and unknowingly contributed to patient anxiety and potentially the perpetuation of prejudices toward patients experiencing problematic alcohol use. This is troublesome, given that the nurse-patient relationship is the essence of nurses' work.

Although variation in the establishment of nurse-patient relationships existed, one participant revealed a lost opportunity to establish a therapeutic relationship with patients experiencing problematic alcohol because of pre-judging of these patients as difficult. She saw no need for reflexivity in her practice, and asserted she would prefer not to care for persons with problematic alcohol use. By regarding the individual with problematic substance use in this manner, the nurse demonstrated little understanding of the need for the patient to have a sense of belonging (Varacolis & Haltor, 2010). This participant's description depicted a missed opportunity for the patient to learn about their problematic

substance use and for the nurse to assist the patient in gaining an awareness of the problem.

The importance of the nurse-patient relationship is central to Peplau's interactional theory because people need relationships; relationships confirm self worth, provide connectedness with others, and reinforce self-esteem (Peplau, 1997). Peplau (1997) remarked that the nurse-patient relationship is *unscripted*. As such, nurses and patients both influence how the relationship unfolds due to the values and beliefs that they bring to the relationship (Beagan & Ells, 2007; Macdonald & Murray, 2007; Pauly, 2008; Ramos, 1992). Recognizing the influence of personal values is paramount to the harmony of the nurse-patient relationship because as "relationships constitute the social fabric of life" (Peplau, 1997. p. 166), the support and acceptance of the patient experiencing problematic alcohol use is contingent on the RNs' level of self reflection.

**Struggling to Care**. Study participants described the struggles they faced in caring for persons with problematic alcohol use in the internal medicine practice setting. From the participants' descriptions, the theme *Struggling to Care* describes the complexity of attending to the development of the therapeutic nurse-patient relationship. The related sub-theme, *Knowledge Related to Problematic Alcohol Use*, revealed knowledge deficits described by participants in relation to their responsibilities in the care of persons with problematic alcohol use. These responsibilities included: clinical assessment, being knowledgeable about problematic alcohol use, and development of the therapeutic nurse-patient relationship. The second sub-theme, *Learning by Trial and Error*, revealed that participants learning occurred primarily in the practice environment.

A tenet of Peplau's theory is that illness presents a unique learning opportunity for the patient where opportunities for personal growth are facilitated by the nurse (Varacolis & Hatler, 2010). In order for the nurse to facilitate this growth a solid knowledge base about problematic alcohol use is necessary. Coupled with this knowledge, the nurse must be willing to establish a therapeutic relationship through which the patient has the opportunity to gain awareness about their substance use and its consequences. Few of the 9 participants discussed the use of the therapeutic relationship in terms of patient self-understanding, rather they focussed on communication with persons that experience problematic alcohol use to figure out the quantity of alcohol consumed.

Participants described the absence of evidence-based protocols in the study setting to address withdrawal symptoms. This resulted in inconsistencies in care, and left participants at a disadvantage when trying to advocate for their patients. An evidence-based care working environment in which nurses employed a practice guideline in the care of persons experiencing problematic alcohol use may contribute to enabling the development of a therapeutic interpersonal relationship with these individuals. In the absence of disease related knowledge as well as evidence-based protocols participants struggled in the care of patients living with problematic alcohol use.

Most of the participants reported that they learned what they knew about problematic alcohol use through experiences in their practice environment. The nature of this learning was by trial and error. However, learning needs to be informed by nurses values, relevant theory, and research, hence a solid knowledge base. Peplau (1992) stated that "the interpersonal relations theory is based on the assumption that what goes on between people can be noticed, studied, explained, understood, and if detrimental

changed" (p-14). Accordingly, the learning that takes place in the practice environment needs to be evaluated over time, deconstructed, and improved as necessary.

**Findings Related to the Literature**

The findings of this study confirm and extend the literature on nurses' experiences in caring for persons with problematic alcohol use. The first theme, *Nurse-Patient Relationship Harmony and Disharmony*, and associated sub-themes although discussed frequently in the current body of published research, has not been reported in the literature reviewed related to problematic alcohol use. The second theme, *Struggling to Care*, has been the subject of research based upon the assessment of the individual with problematic alcohol use. However, there is limited literature with a focus on the manner in which nurses learn about problematic alcohol use. The themes identified in this study will now be discussed in light of the current research.

**Nurse-Patient Relationship Harmony and Disharmony.** Within the heart of modern-day health care lies the need for professionals to practice in partnership with patients and their families (Hagerty & Patusky, 2003; Olson and Hanchett , 1997; Williams, Nolan, & Keady, 2009). In order for this partnership to be achieved, it is crucial for RNs to come to know patients as more than a set of disease symptoms and demonstrate compassion in their interactions (Williams, Nolan, & Keady, 2009). This compassion is based upon "empathy, respect and recognition of the uniqueness of individuals and a willingness to engage in a relationship with them that acknowledges limitations, strengths, and emotions of all parties" (Williams, Nolan, & Keady, 2009. p. 53). As such, the RN is required to demonstrate the willingness to be self-reflective, and

acknowledge any prejudicial attitudes that she/he may have about problematic alcohol use.

The participants in this study offered many candid descriptions of their relationships with individuals experiencing problematic alcohol use. Some participants described the need for a therapeutic relationship with their patients, and emphasized the relevance of nurses' self-examination when caring for the individual with problematic alcohol use. While other participants in this study avoided patients exhibiting problematic alcohol use increasing the likelihood of patients distrusting the nurse, and preventing the establishment of a therapeutic relationship.

Evidence from published research and this study revealed the need for a therapeutic relationship between nurse and patient. Macdonald and Murray remarked that nurses have a responsibility to foster health through the therapeutic relationship (Macdonald & Murray, 2007). The variation in how participants spoke about patients with problematic alcohol use raises the question of the ability of nurses to establish the therapeutic relationship.

*Judgemental Reactions* described in this research study reflected the current published literature on this topic. Researchers have found that the stigmatization of persons with problematic alcohol use differed from hospital unit to hospital unit, with nurses practicing on medical/surgical units having the most negative attitudes toward these individuals (Carroll, 1995). The participants in this study were employed on a general medicine unit and reported witnessing as well as perpetuating prejudice related to problematic alcohol use. How this stigmatization happens has not been reported in the literature. However, given the lack of knowledge related to the care of persons with

problematic alcohol use described in previous research as well as in this study, this lack of knowledge may be a contributing factor.

**Struggling to Care.** Overwhelmingly, published research suggests that nurses tend to hold negative opinions towards persons with problematic alcohol use and to avoid or dismiss the alcohol use in their interactions with these individuals (Howard &Chung, 2000; Foster & Onyeukwu, 2003). This was evident in the descriptors used by participants in this study such as disheveled, homeless, and unemployable, and in the work of (Fortney et al, 2004; Kelly & Westerhoff, 2009). Participants' knowledge of problematic alcohol use was based in part on a belief that the substance abuse was caused by a traumatic event such as a divorce and dismissed the problematic alcohol use by describing it as a way to deal with traumatic events that might occur in one's life (i.e. divorce). In earlier research, nurses reported caring for persons with problematic alcohol use to be highly emotional and they found it difficult to discuss these behaviours with their patients (Lock et al., 2002). These earlier findings, while perplexing, were also described by the participants in the current study. Participants varied widely in their knowledge of the importance of the therapeutic nurse-patient relationship and often limited communication with patients to simply ascertain the amounts of alcohol ingested by patients.

The nursing care of the individual experiencing problematic alcohol use was described by the study participants as including a comprehensive nursing assessment and that doing this assessment necessitated a therapeutic relationship. Kinney (1996) noted that the identification of problematic alcohol use in a patient and the relationship with individuals experiencing problematic alcohol use were two important aspects of the

nurses' assessment. As well, Lisanti (2001) found that the early recognition and identification of a patient with problematic alcohol use was paramount for successful patient outcomes, and prevention of serious complications. The findings in this study were consistent with Lisanti in that participants recounted missed opportunities for recognition of problematic alcohol use that could have had serious consequences.

The lack of an evidence-based protocol for the care of patients with problematic alcohol use was evident from the findings of this study. Participants reported frustration with how medication was ordered for patients, and not knowing when to medicate the patients to prevent withdrawal symptoms. In the published literature, there are a number of scales and assessment tools for use in the assessment of patients with problematic alcohol use. One such tool is the CIWA-Ar scale, which has been described as a brief, uncomplicated and useful tool for the screening and ongoing assessment of the symptoms associated with problematic alcohol use (Pittman et al., 2007; Reoux & Miller, 2000; Reoux & Oreskovich, 2006; Stuppeck et al., 1994; Sullivan et al., 1989). Evidence-based nursing practice is a standard and practice settings need to incorporate an instrument such as the CIWA-Ar. These instruments need to be administered with sensitivity that promotes patient self-awareness.

**Implications for Practice**

The results of this study revealed the centrality of the nurse-patient relationship (Peplau, 1952) in the context of caring for patients with problematic alcohol use. The importance of relating with patients was reported in this study in order to meet the challenges experienced in the care of individuals with problematic alcohol use and this was reported earlier by other researchers (Murray & Li, 2008). In this study, participants

described the struggles they encountered because of the lack of knowledge about the disease, the prejudices they held, and the lack of evidence-based protocols. These struggles ultimately affected the development of a therapeutic relationship.

The nurse-patient relationship needs to be valued and this is evident in the Canadian Nurses Association Code of Ethics (2008) in which nurses' self-reflection is clearly outlined. Peplau (1997) described there being nothing routine about nurse patient relationships because they are dependent upon nurses' self-awareness of their own values. There needs to be opportunities for nurses to learn self-reflection in order to support development of therapeutic relationships. In addition there is a need for opportunities for peer review, self reflection, and learning to develop the nurse-patient relationship.

**Implications for Education**

Findings from this study have illuminated the need to educate student nurses, newly graduated and experienced nurses on the issues of problematic alcohol use. Included in this education is self-reflection, developing the capacity to establish the therapeutic nurse-patient relationship, knowledge of the disease, and of protocols appropriate in the care of patients experiencing problematic alcohol use. Most of the participants believed that education would help to address the struggles they experienced in caring for persons with problematic alcohol use. As well, some participants reflected on their practice to the extent they believed that education would assist in recognizing prejudice, learning to avoid acting on prejudice and thereby promote harmony in their relationships with patients, and enhance their practice. Interestingly, the participants often reported how they should have responded to patients with problematic alcohol use, yet

their descriptions revealed different reactions to the patients they cared for that were living with problematic alcohol use.

The RNs in this study offered several educational suggestions to address some of the challenges revealed in this study. Based upon participants' suggestions the following recommendations were made for education in terms of approaches and topics : 1) didactic education on the issues of problematic alcohol use; 2) case studies on how to therapeutically interact with patients experiencing problematic alcohol use; 3) altering the nursing undergraduate education to include a required class on addictions; 4) incorporating non-violent crisis intervention into the education initiatives at the hospital; 5) providing more education on medications associated with the clinical treatment of withdrawal. The participants believed that the employment of these suggestions would increase both nurse and patient satisfaction.

**Implications for Research**

The nurse-patient relationship has been described by researchers as essential to patient care (Ramos, 1991). In light of this and the study findings, further research is required to understand how to construct this relationship in the context of problematic alcohol use. Such research should focus on how nurses' values inform the therapeutic relationship. As well, evaluative research needs to be conducted to determine how the patient benefits from the nurse-patient relationship, in the context of problematic alcohol use. For example, how does the use of a protocol for the care of the patient experiencing problematic alcohol use contribute to establishing the nurse-patient relationship? The nurse-patient relationship is unscripted. In light of this, research is needed on how self-reflection in nursing practice lends credibility to nurses' understanding of the script.

## Conclusion

Participants in this study did experience harmony as well as disharmony in their relationships with patients experiencing problematic alcohol use. Peplau's (1952) theory assisted in highlighting the importance of the nurse-patient relationship in accompanying patients in their self understanding of their disease. Largely absent from participant accounts of caring for patients experiencing problematic alcohol use was acknowledgement of the centrality of the nurse-patient relationship in providing care. The identification of themes offers direction in the provision of holistic care of the patient with problematic alcohol use through the development of the nurse-patient relationship.

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## Appendix A Recruitment Letter

CH Research Ethics Board
Template for Advertisements
Version 2
October 27, 2008

Capital Health

# Have you cared for a patient experiencing problematic alcohol use?

Would you be interested in talking about the challenges, learning opportunities, and the experiences you have had regarding the nursing care of persons with problematic alcohol use? If the answer to these questions are yes, then this researcher would like to discuss your experiences with you. The purpose of this qualitative study is to describe the experiences that nurses have had caring for persons with problematic alcohol use in order to gain new information regarding the care of this patient group.

Research participants for this study must be:

- A Registered Nurse
- Have been the assigned primary nurse for a patient experiencing problematic alcohol use
- Available for a one to one interview with the Primary Investigator that will be 30 to 60 minutes in length

If you are interested and want more information please contact Jennifer Murphy-Novak at 902-429-4563 or via e-mail at Jennifer.Murphy-Novak@cdha.nshealth.ca.

## Appendix B Interview Guide

1. Tell me what you know about problematic alcohol use.
2. Tell me how you came to learn what you know about problematic alcohol use.
3. Tell me a story about a time when you cared for a person with problematic alcohol use.
4. How prepared educationally did you feel in providing care for this patient?
5. Describe how you felt you performed when caring for a person with problematic alcohol use.
6. What recommendations would you suggest for the care of persons with problematic alcohol use at your health care facility?
7. Demographic data (gender, years experience, different nursing units)

   Probe Questions

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

## Appendix C Addendums to Interview Guide

Additional probe questions added to the interview guide:

- What is it like to care for a person experiencing problematic alcohol use?
- How would you describe a patient experiencing problematic alcohol us
- Are you personally affected by the assignment of caring for a person with problematic alcohol use? Do you feel distressed when caring for these individuals?
- Did you feel that the rapport that you had with your patient facilitated your confidence?
- Describe the "good" or "safe" care of a person with problematic alcohol use.
- Tell me the role that interpersonal relationships play in your care of the individual experiencing problematic alcohol use.

## Appendix D Informed Consent


Study Title: Caring for Persons with Problematic Alcohol Use: Nurses and their Experiences

Principal Investigator: Jennifer Murphy- Novak RN, BScN, CNN(C)
Queen Elizabeth II Health Sciences Centre
Halifax, Nova Scotia
(902)429-4563

### 1. Introduction

You have been invited to take part in a research study. Taking part in this study is voluntary. It is up to you to decide whether to be in the study or not. Before you decide, you need to understand what the study is about, what risks you might take, and what benefits you might receive. This consent form explains the study.
Please read this carefully. Take as much time as you like. If you like, take it home to think about for awhile. Mark anything you don't understand, or want to be explained better. After you read it, please ask questions about anything that is not clear.
The researchers will:

- Discuss the study with you
- Answer your questions
- Keep confidential any information which identify you personally
- Be available during the study to deal with problems and answer questions

### 2. Why is This Study Being Done?

The purpose of this study is to describe the experiences registered nurses have had caring for persons with problematic alcohol use on a medical in-patient hospital unit. Study aims include: eliciting a clear understanding of how nurses' perceive caring for persons with problematic alcohol use, shedding light on the experiences of nurses caring for these individuals, and discussing the implications of the findings for nursing education, practice, and research.

### 3. Why Am I Being Asked to Join This Study?

You have been asked to participate in the study because you are a registered nurse, and have previously cared for a person with problematic alcohol use, and currently work on a medical inpatient hospital unit.

### 4. How Long Will I be in The Study?

You will be asked to participate in interviews that will last 30 to 60 minutes in length, which will be recorded and later transcribed. You will be asked to review a summary of the findings from your interview at a later date to verify the information. This will be done in a manner that is convenient for you, either in person or through email. The interviews will be conducted over a few months, but you will meet with the Principal Investigator once or twice.

### 5. How Many People Will Take Part In This Study?

This study is only taking place at Capital District Health Authority (CDHA) in Halifax, Nova Scotia. It is expected to include 5 to 10 registered nurses that work on the medical inpatient hospital unit.

**6. How is The Study Being Done?**

You will be interviewed by the Principal Investigator about your experiences caring for persons with problematic alcohol use.

**7. What Will Happen If I Take Part in This Study?**

A one to one interview will be conducted with you at a time and place convenient for you. Your name will not appear in any study reports. A pseudonym will be given to the information you provided. Direct quotes from your interview may be used in reports or write ups and a pseudonym will be used. The transcriptions and audio recorded interviews will be kept locked in the **Site** Investigators' office for a period of 7 years according to CDHA ethics requirements. After 7 years transcripts will be shredded, electronic files deleted and hard drive/memory key used to store electronic files will be reformatted.

**8. Are There Risks To The Study?**

There are risks with this, or any study. You may not like all the questions that you will be asked. You do not have to answer those questions you find too distressing.

**9. What Happens at the End of the Study?**

You will have access to a summary of the study report, should you want it.

**10. What are My Responsibilities?**

As a study participant you will be expected to:

- participate in one 30-60 minute face to face interview, and review the written copy of the interview

**11. Can I be Taken Out of the Study Without My Consent?**

Yes. You may be taken out of the study at any time, if:

- There is new information that shows that being n this study is not in your best interests
- The Capital Health Research ethics Board or the primary researcher decides to stop the study
- You do not follow the directions of the Principal Investigator

You will be told about the reasons why you might need to be taken out of the study.

**12. What About New Information?**

It is possible (but unlikely) that new information may become available while you are in the study that might affect your health, welfare, or willingness to stay in the study. If this happens, you will be informed in a timely manner and will be asked whether you wish to continue taking part in the study or not.

**13. Will it Cost Me Anything?**

Compensation

You will not be paid to be in the study. It will not cost you anything to participate in this study.

Research Related Injury

If you become ill or injured as a direct result of participating in this study, necessary medical treatment will be available at no additional cost to you. Your signature on this

form only indicates that you have understood to your satisfaction the information regarding your participation in the study and agree to participate as a subject. In no way does this waive your legal rights nor release the Principal Investigator, the research staff, the study sponsor or involved institutions from their legal and professional responsibilities.

**14. What About My Right to Privacy?**

Protecting your privacy is an important part of this study. A copy of this consent will be given to you.

When you sign this consent form you give us permission to:

- Collect information from you
- Collect information from your health record
- Share information with the people conducting the study
- Share information with the people responsible for protecting your safety

Access to records

The Primary Investigator and members of the research team will see health and study records that identify you by name.

Other people may need to look at the health and study records that identify you by name. These might include:

- the CDHA Research Ethics Board and Research Quality Associate

Use of records

The research team will collect and use only the information they need to complete the Study. This information will only be used for the purposes of this study.

This information will include:

- Your gender
- The number of years you have been a nurse
- Different nursing units you have worked on

Your name and information will be kept secure by the researcher in Halifax, Nova Scotia. It will not be shared with others without your permission. Your name will not appear in any report or article published as a result of this study. Information collected from this study will be kept as long as required by law. This is 7 years according to CDHA Research ethics.

If you decide to withdraw from the study, the information collected up to that point will continue to be used by the research team. It may not be removed.

After your part in this study ends, we may continue to review your health records. We may want to follow your progress and to check that the information we collected is correct.

Information collected and used by the Primary Investigator will be stored in the office of Mary Ellen Gurnham, Site Investigator for this research study at Capital District Health Authority.

You may also be contacted personally by the Research Auditors for quality assurance purposes.

Your access to records

You may ask the Primary Investigator to see the information that has been collected about you. If the study is "blinded", you cannot see this information until the study ends. This is to prevent either you or the Primary Investigator from knowing with study arm you participated in.

**15. What If I Want To Quit The Study?**

If you chose to participate and later change your mind, you can say no and stop the research at any time. If you wish to withdraw your consent please inform the Principal Investigator. All data collected up to the date you withdraw your consent will remain in the study records, to be included in the study related analyses. A decision to stop being in the study will not affect any work performance evaluations you may have.

**16. Declaration of Financial Interest**

The Principle Investigator has no financial interests in conducting this research study. For further information about the study call Mrs. Jennifer Murphy-Novak. She is the Principal Investigator and her contact number is (XXX) XXX-XXXX.

**17. What Are My Rights?**

After you have signed this consent form you will be given a copy of the consent form. If you have any questions about your rights as a research participant, contact the **Patient Representative** at **(XXX)XXX-XXXX**.

*In the next part you will be asked if you agree (consent) to join this study. If the answer is "yes", you will need to sign the form.*

**17. Consent Form Signature Page**

I have reviewed all of the information in this consent form related to the study called: Caring for Problematic Alcohol Users in a Hospital Setting: Nurses and their Experiences I have been given the opportunity to discuss this study. All of my questions have been answered to my satisfaction. This signature on this consent form means that I agree to take part in this study. I understand that I am free to withdraw from the study at any time. I agree with the use of audio recordings and transcribed quotations.

| | | |
|---|---|---|
| _____ | _____ | ____/_____/____ |
| Signature of participant | Name (printed) | Year Month Day |
| _____ | _____ | ____/_____/____ |
| Witness | Name (printed) | Year Month Day |
| _____ | _____ | ____/____/_____ |
| Signature of investigator | Name (printed) | Year Month Day |
| _____ | _____ | ____/____/_____ |
| Signature of Person Conducting Consent Discussion | Name (printed) | Year Month Day |

I will be given a signed copy of this consent form

*Thank you for your time and patience!*

## Appendix E Confidentiality Agreement for Transcriptionist

Caring for Persons with Problematic Alcohol Use in a Hospital Setting: Nurses and Their Experiences

"I, agree not to share, discuss or transmit the electronic files and the information learned as a result of transcribing the interviews with anyone other than the primary investigator of the study entitled 'Caring for Persons with Problematic Alcohol Use in a Hospital Setting: Nurses and their experiences'. The electronic files of the transcriptions of the interviews will be password protected".
The electronic files will be returned to the primary investigator and the electronic file will be deleted from my computer within 30 days following the transfer of the files to the researcher.

_____ _____
Signature of Transcriptionist Date

_____ _____
Signature of Primary Investigator Date

*I have been given a copy of this agreement for my records.*