

The Attitudes of Nurse Educators in Oregon
Toward Chemical Dependency

by

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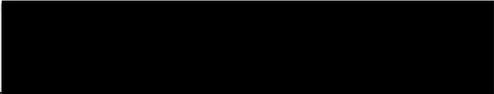
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CHAPTER I

INTRODUCTION

Chemical dependency is a significant problem for our health care system. For the purpose of this paper, the authors have adopted the Diagnostic and Statistical Manual of Mental Disorders III R definition of chemical dependency as follows: a cluster of cognitive, behavioral, and physiologic symptoms that indicate that a person has impaired control of psychoactive substance use and continues use of the substance despite adverse consequences. Estimates vary as to the magnitude of chemically dependent people who have contact with health care providers. In psychiatric patients, the prevalence of drug and/or alcohol use has been estimated at 80% (McKelvy, Kane, & Kellison, 1987). Another study reported that out of a sample of 20,000 adults, alcoholism was the most prevalent psychiatric diagnosis, and drug abuse/dependence rated third (Helzer & Pryzbeck, 1987). The direct costs for chemical dependency treatment and support combined with indirect costs of lost productivity have been estimated to cost in the billions of dollars (Kamerow, Pincus, & Macdonald, 1986). Needless to say, the high prevalence of chemical dependency upon our society would suggest the need for significant involvement by health care providers. Unfortunately, research suggests that people are not being readily identified and/or treated for chemical dependency (Adams, 1988; Menicucci, Wermuth, & Sorensen, 1988; Whitcup & Miller, 1987), or are being misdiagnosed (Safer,

1987; Spickard, 1986). Nurses are in an excellent position to identify and treat chemically dependent clients, but it is not apparent that they are doing this. Whether this failure in identification is influenced by an attitudinal component is unclear.

The nursing literature has documented both negative and positive attitudes toward chemical dependency (Cannon, 1987; Sowa & Cutter, 1974; Wechsler & Rohman, 1982). In 1972, the American Medical Association stated that the need for medical education on alcohol and drug abuse was urgent: "High priority should be given to pedagogical methods which will encourage the student to sort out their personal experiences and subjective feelings, and attain the goal of professional objectivity" (Council on Mental Health, 1972, p. 1747).

Research suggests that nursing schools have been slow to respond to the need for substance abuse education. In 1987, Hoffman and Heinemann surveyed nursing schools for information about current curricular offerings in chemical dependency. Although the return rate was only 36%, their studies showed that one to five hours of content instruction was the norm. In the State of Oregon, the largest baccalaureate nursing program does not offer specific courses or clinical training in chemical dependency on a regular basis. As of December 1989, only a two-credit elective was offered, and it did not include a clinical component.

Nurse educators are in the position to change curricula and influence attitudes. The literature identifies many variables which potentially have an effect on attitudes toward chemical dependency, but these variables have either not been included in the research and/or have not been studied with a nurse educator sample.

It is the purpose of this study to describe nurse educator attitudes toward chemical dependency. The relationship between attitudes and potentially influencing variables will be explored. These variables are: (a) personal use of drugs and/or alcohol, (b) co-dependency, (c) work experience in chemical dependency, and (d) education in chemical dependency.

Review of the Literature

Recognition and Treatment of Chemical Dependency

Spickard (1986) cites the World Health Organization as estimating that by the year 2000 chemical dependency will be the number one health problem in the world. He argues that the ability and willingness to identify and treat chemical dependency is shaped by personal attitudes, and that attitudes are shaped by social stigma, personal use of chemicals, negative perception of treatment outcome, role confusion, and denial.

Kamerow, Pincus, and Macdonald (1986) estimate that more than half of the patients with chemical dependency disorders receive care from non-psychiatric sources. In a survey done at a large, urban teaching hospital, they found that 40 percent of the medical

students and physicians did not consider drug abuse a disease. The identification and treatment of chemically dependent patients by nurses is complicated by the probable fact that the incidence of chemical dependency in nurses is 50 percent higher than in the general population (Shafter, 1988).

Although many studies have been done comparing the attitudes of nurses toward alcoholic patients, few studies have looked at attitudes toward chemical dependency as a whole. Of the studies viewing attitudes toward chemical dependency, Cannon (1987) showed generally supportive attitudes of registered nurses in Oregon toward chemical dependency, although they pointed to a wide range of scores with many individuals being negatively inclined. It is interesting to note that Oregon nurses felt less optimistic about chemical dependency treatment, were more inclined to stereotype chemically dependent people, were more likely to view chemical dependency as a moral issue, and held less permissive attitudes toward chemical dependency than other health professionals tested with the same attitude questionnaire (Chappel, Veach, & Krug, 1985).

Education in Chemical Dependency

Research correlating education with attitudes has resulted in differing viewpoints. In Cannon's (1987) study, nurses with baccalaureate or higher degrees showed more favorable attitudes, while in another study by Sullivan and Hale (1987), doctorally prepared nurses scored highest in designating *moral weakness* as

the etiology of alcoholism. However, Sullivan and Hale used a different tool, measured attitudes toward alcoholism only, and had a relatively low (34%) response rate as compared to the 79% response rate in Cannon's study. Neither found that clinical specialty contributed significantly to the variance in attitudes.

Perhaps the most significant findings relating specific chemical dependency education with attitudes was done by Chappel and Veach (1987). Their longitudinal study pre-tested and post-tested medical students after a course in substance abuse. During the course, the faculty concentrated on treatment optimism, and the students were exposed to many successfully treated clients. Results indicated that, although significant positive attitudinal change in treatment intervention occurred, attitude toward treatment optimism did not change in any systematic direction. The authors suggested that the cognitive aspects of attitudes were more easily influenced than the emotional aspects. A study by Clement (1986) supported the concept that positive attitudes toward alcoholics were related to alcohol education.

Work Experience in Chemical Dependency

Correlating work experience in the field of chemical dependency and nurse attitudes has produced differing results. One study showed that employees at an addiction treatment hospital held a generally negative viewpoint toward alcoholics and drug addicts (Sowa & Cutter, 1974), although since nurses were grouped with other professionals, their attitudes could not be isolated.

Other studies have shown that nursing clinical specialty has little influence on nurse attitudes toward substance abusers (Moodley-Kunnie, 1988; Chardorkoff, 1969), although both Ferneau (1967), and Harlow and Goby (1980) found positive changes in nursing students after experience working with alcoholics.

It is difficult to make an empirical connection between attitudes toward chemical dependency and behavior. At the University of Washington, alcoholism educational experiences were found to influence the behavior of nurses toward alcoholic patients (Gurel, 1976), and it was also noted that faculty participants were more inclined to support a nursing curriculum containing alcoholism related courses after exposure to educational experiences in alcoholism treatment.

It does seem apparent that the more negative the caregiver's attitude, the less time and interest will be provided to the client. However, the best measure of behavior is direct observation in clinical settings which, being both costly and time-consuming, has not been addressed in nursing research.

Personal Use and Co-dependency in Chemical Dependency

The variables *personal use* and *co-dependency* and their impact on attitude formation toward chemical dependency as a whole have been relatively ignored in both nursing and medical research. It is nationally estimated that six to eight percent of all nurses (120,000 to 160,000) are chemically dependent (Haack & Hughes, 1989). Although researchers hint at the connection between health

practitioners' chemical use and attitudes, a review of the literature shows that little research in this area has been done. Whether this is a result of legal or ethical implications is unclear. One study by Tolor and Tamerin (1975) used a Familiarity with Alcoholics scale and a Personal Drinking Behavior scale in evaluating their Attitudes Toward Alcoholism instrument. They found that in their sample of 135 graduate students, women expressed a significant relationship between familiarity with alcoholics and a "socially rejecting attitude." They also found a slight inverse correlation between the degree of acknowledged personal alcohol consumption and the *moral weakness* view of alcoholism in both the student sample and in alcoholic patients. In the same study, it was found that alcoholic patients themselves also demonstrated more socially rejecting attitudes toward alcoholics.

It is interesting to note that the clinical literature in chemical dependency has popularized the concepts of *denial* (pertaining to both one's own and other's use of chemicals) and *co-dependency* (pertaining to the effects of the disease on people involved in a close relationship with a chemically dependent person) as characteristics which negatively influence attitudes and relationships with chemically dependent people (Black, 1981; Schaef, 1986; Wegscheider-Cruse, 1985). The literature describing co-dependency is anecdotal, experientially descriptive, and frequently global in character. Co-dependency is most often

defined as a cluster of behaviors reflected in the behavioral outcome for individuals with low self-esteem (Zerwekh & Michaels, 1989) and/or for those who derive their self-worth from the opinion and approval of other people (Schaef, 1986). Beattie (1987) suggests that "a person with co-dependent traits is thought to be one who has let someone else's behavior affect him or her, and is obsessed with controlling other people's behavior" (p. 31).

Studies identify a high percentage of health care personnel as children of dysfunctional and chemically dependent homes (Thome, 1988). These individuals learn to care for others at the expense of their own needs and development. This evolves and is socialized in the nursing profession as the nurse-patient relationship (Haack & Hughes, 1989).

In summary, a review of the literature underscores the extent of the problem of chemical dependency for the health care system. Recognition and treatment of chemically dependent individuals is inconsistent and inadequate. Multiple complex variables probably impact attitudes and behavior toward the phenomenon of chemical dependency. The relationship between education and work experience and attitudes toward chemical dependency have been marginally addressed in the health professional literature, while the variables of personal use and co-dependency have not been studied. No research has specifically addressed the attitudes of nurse educators toward chemical dependency.

Conceptual Framework

The nursing profession has been slow to respond to the increasing numbers of patients with chemical dependency disorders or health problems associated with chemical dependency. Why? As recently as 1987, only 63 percent of nursing programs nationally were requiring one to five hours of chemical dependency instruction with no apparent clinical component (Hoffman & Heinemann, 1987). Hoffman and Heinemann (1987) argue that:

Nurses frequently encounter patients with drug and alcohol problems as well as those who are at high risk for their development, and can play a significant role in combating these major health and social problems. In order to do this, however, they must have adequate knowledge and skills which make it possible to intervene and they must have attitudinal dispositions which promote interventions (p. 282).

The nursing profession's response to the problems of chemical dependency are probably reflected in the conflicting and often negative attitudes reported in the literature. Since the relationship between attitudes and behavior is multidimensional, it becomes important to study the response of nurses to chemical dependency in a multidimensional way.

The relationship of attitudes to behavior is complicated and complex. Attitudes are thought to be principally shaped by knowledge, experience, and personality. In 1935, Allport defined attitude as, "a mental and neural state of readiness, organized

through experience, exerting a directive or dynamic influence upon the individual's response to all objects and situations with which it is related." During the intervening 50 years, social psychologists have repeatedly tried to empirically measure the relationship between attitudes and behavior in an attempt to prove causality. These attempts have been largely unsuccessful. Despite this, most investigators continue to regard "attitudes as primary determinants of a person's responses to an object, and any of these responses is assumed to provide an index of the person's attitude" (Ajzen & Fishbein, 1975, p. 343).

This study conceptualizes attitudes based on the model suggested by Kreck, Crutchfield, and Ballachey (1962). Attitude is defined as an enduring system of positive and negative evaluations, emotional feelings, and pro or con action tendencies, with respect to a social object. Attitudes encompass three constituent parts: (a) the cognitive component which includes beliefs about an object including evaluative judgments; (b) the affective component concerning likes and dislikes; and (c) action tendency, which includes readiness to act but not actual behavior. Attitudes function to satisfy wants and needs related to the individual's group affiliations, and also to the information to which she/he is exposed. Finally, attitudes reflect an individual's personality.

Since chemical dependency has often been regarded as a stigmatizing health condition, it follows that an attitude change

would require a much more intensive effort than with a more socially acceptable disease process. Hoffman and Heinemann (1987) describe research that suggests that *contact or information alone* are not sufficient to effect a positive attitude change in a stigmatized population. The critical aspect is the *combination* of *contact* and *information*. *Contact* is conceptualized as the variable work experience and co-dependency, and *information* is conceptualized as the variable education.

Although the previous discussion supports the conceptual framework of this study in regard to linking specific chemical dependency work experience and education with attitudes, the conceptualization of linking personal use and/or co-dependency with *attitudes* comes from the authors' personal experience in the field of chemical dependency, and from the quantity of recent literature by both recovering addicts and the *clinical professionals* in the chemical dependency field who support this connection.

The conceptual framework of this study (Figure 1) links nurse educators' attitudes toward chemical dependency with the variables: (a) work experience in chemical dependency (reflecting group affiliation), (b) education in chemical dependency (reflecting information to which an individual is exposed), (c) co-dependency (reflecting individual personality), and (d) personal use of drugs and/or alcohol (reflecting individual personality). It seems likely that the attitudes of nurse

educators influence whether they feel chemical dependency should be a required part of nursing education curricula. We hypothesize that both work experience and education in chemical dependency will show significant positive associations with nurse educators' attitudes toward chemical dependency. The relationship between personal use, co-dependency, and attitude toward chemical dependency remains a speculative one. The framework further conceptualizes that nursing education curricula influences student nurses' attitudes which, in turn, may influence the recognition and/or treatment of chemical dependency in health care settings; however, it is not within the scope of this study to include these factors as variables.

Conceptual Framework Model

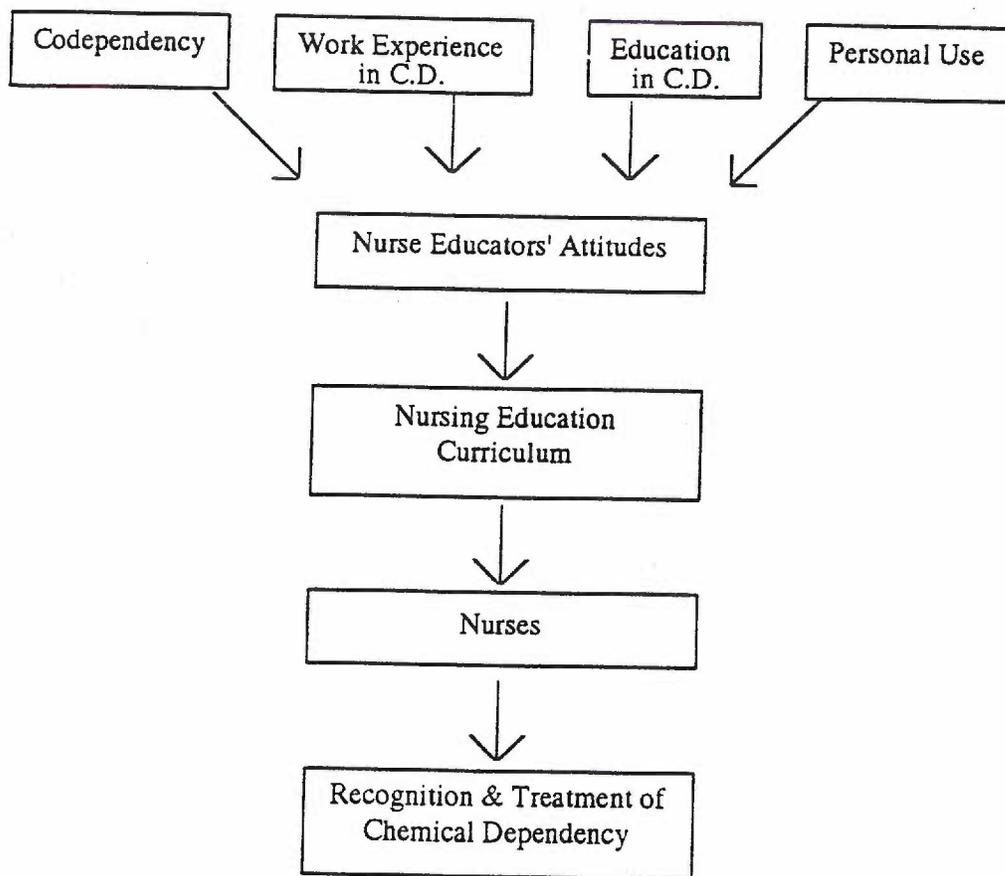


Figure 1

Statement of the Problem

The purpose of this study is to describe nurse educator attitudes toward chemical dependency and investigate the influence of education, work experience, co-dependency, and personal use on those attitudes. Stemming from the literature review and the conceptual framework for this study, three research questions and two hypotheses were tested. The research questions and the hypotheses were:

Research Question 1

What are the attitudes of nurse educators in Oregon toward chemical dependency?

Research Question 2

Is personal use of drugs and/or alcohol associated with the nurse educators' attitudes toward chemical dependency?

Research Question 3

Is co-dependency associated with the attitudes of nurse educators toward chemical dependency?

Hypothesis 1

The attitudes of nurse educators who have received education in chemical dependency will be significantly different from those who have not received education in chemical dependency.

Hypothesis 2

The attitudes of nurse educators who have had work experience in chemical dependency will be significantly different from those who have not had work experience in chemical dependency.

CHAPTER II

METHODS

Design

This partial replication of Cannon's (1987) study used a non-experimental design to explore multiple variables influencing nurse educators' attitudes about chemical dependency. Cannon's study explored the relationship between randomly selected Oregon registered nurses' attitudes toward substance abuse and toward impaired nurses in relation to demographic variables including age, length of employment, education, and experience with substance abusers. The variables for this study include: (a) general attitudes toward chemical dependency measured by the Substance Abuse Attitude Survey instrument, (b) specific work experience in chemical dependency, (c) personal use of drugs and/or alcohol, (d) characteristics of co-dependency, and (e) specific education in chemical dependency. Data were collected for extraneous variables including age, first and highest degrees in nursing, date received highest degree, and rank.

Sample and Setting

The target population was all nursing educators in AD, BSN, MS, and/or Ph.D. nursing programs in Oregon. Nursing educators included nurses who were full-time and part-time faculty involved in teaching, administration, and/or research in any part of the nursing curriculum. The target population was $N = 253$; the accessible population was $N = 250$; the sample N was 190.

A list of all nursing programs in Oregon was obtained from the State Board of Nursing. Nurse educator names and addresses for associate degree programs were obtained from the Oregon Council of Associate Degree Nursing Programs directory. Most baccalaureate faculty addresses were accessed through school directories. One baccalaureate program required that questionnaires be distributed to faculty via the school address. A letter was sent with a questionnaire explaining the purpose of the study, asking for participation, and directing the respondents to return the questionnaires anonymously. No records were maintained for any of the returned questionnaires. The subjects were instructed to avoid putting any identifying information on the questionnaire and/or return envelope to maintain their anonymity.

Data Collection Instruments

Data collection was done using an established Likert-type instrument, the Substance Abuse Attitude Survey (SAAS). The SAAS was developed by Chappel, Veach, and Krug (1985) to measure physicians' and medical students' attitudes toward substance abuse. Those authors felt there was a need for an instrument which combined alcohol and drug misuse and could be used to address the question of behavior and its relation to specific attitude scale scores. Chappel, Veach, and Krug (1985) did four separate analyses before arriving at five stable factors through factor analysis. These factors were Permissiveness, Treatment

Intervention, Nonstereotype, Treatment Optimism, and Nonmoralism. The Permissiveness factor included nine items such as "personal use of drugs should be legal in the confines of one's own home," and "It can be normal for a teenager to experiment with drugs." Treatment Intervention was made up of eight items such as "Family involvement is a very important part of the treatment of alcoholism or drug addiction" and "Group therapy is very important in the treatment of alcoholism or drug addiction." The Nonstereotype factor included ten items such as "Smoking leads to marijuana use, which in turn leads to drugs" and "All heroin use leads to addiction" (both reverse scored items). Treatment Optimism was a five-item factor including statements like "Drug addiction is a treatable illness," and "An alcohol or drug-dependent person who has relapsed several times probably cannot be treated" (reverse scored). The Nonmoralism factor included ten items such as "Clergymen should not drink in public," and "Alcoholism is associated with a weak will" (both reverse scored items). Each item is scored from five (strongly agree) to one (strongly disagree). The questionnaire and the scoring work sheet used for the SAAS are in Appendices C and D. These factors were derived by Chappel in a sample of criterion clinicians which included physicians, psychologists, social workers, and counselor-therapists who met the following criteria:

- (1) having at least six years or more experience in chemical dependency,
- (2) having a patient load of which at least 10%

consisted of these patients, (3) experiencing professional satisfaction in treating these patients as indicated by self-report measures, and (4) reporting some success in treating these patients as indicated by self report measures (Chappel, Veach, & Krug, 1985, p. 49).

Chappel, Veach, and Krug (1985) used the criterion clinician group for the purpose of assessing the validity of the instrument and to provide direction in setting attitudinal objectives in medical education. Construct validity was indicated by higher criterion group scores on Treatment Optimism and Treatment Intervention when compared to the non-criterion group, the clinicians who did not specialize in substance misuse treatment. Alpha reliability coefficients for the five factors ranged from .56 to .81.

Chappel's original Substance Abuse Attitude Survey contained 50 items. The authors of this study made revisions to the tool with Chappel's permission. Three items which pertained to the use of tobacco were eliminated because it was felt that although tobacco was an addictive substance, it did not meet our criteria for chemical dependency. Other revisions include substituting the words "other" and "illicit" for "hard" in items #9 and #17, as we felt the term "hard drugs" to be obsolete. In item #29, the original "People who dress in hippie-style clothing usually use psychedelic drugs" was changed to "A person's attire can be a good indicator of drug addiction," again to update the questionnaire. In #34, "he/she" replaced the "he" in the original survey. In

#35, "alcohol or drug abusers" was changed to "alcohol or drug misusers," as the authors of this study felt the word "abuse" could connote a more physiological treatment response than we felt Chappel originally indicated. In #46, we changed "physician" to "health provider" to update our society's present representation of health care providers.

During our data analysis, it was found that neither Chappel nor Cannon had included items #1, #3, #4, #5, or #6 in subscale groupings or data analysis. It was, therefore, decided to eliminate these items from our analysis. To compare the mean scores of the SAAS with Chappel's study, it was necessary to use a T-score conversion table.

The questions for personal use of drugs and/or alcohol and characteristics of co-dependence were developed by the authors of this study. The five questions concerning personal use of drugs and/or alcohol pertained to the biological and psychosocial aspects of chemical dependency. The questions were asked in a dichotomous yes/no format; yes = 1, no = 0. High score equaled greater personal use. An example of a personal use question was: "Has continued use of drugs and/or alcohol created problems for you physically, psychologically, or socially?"

The five questions concerning characteristics of co-dependency explored beliefs, feelings, and behaviors that the authors of this study believed were representative of characteristics of co-dependency defined by the clinical

literature. The questions were asked in a Likert-like format with response options of always, frequently, rarely, and never (always = 1, frequently = 2, rarely = 3, never = 4). A low score indicated greater co-dependency traits. An example of a co-dependency question was: "Do you find yourself taking responsibility for other people's moods and behaviors?"

Both the personal use and co-dependency questions were piloted twice with a sample of 20 respondents in order to determine the appropriateness of content, and time needed to answer questions. From the pilot study, we eliminated ambiguous questions and increased response options on the co-dependency questions from yes/no to the Likert format. Respondents completed the pilot study in a timely manner.

A demographic questionnaire accessed the variables of age, year received basic and highest nursing degree, highest educational degree, and rank. Other demographic information included questions about personal experience regarding information and/or instruction concerning drug abuse and alcoholism. Data for both type and amount of education in chemical dependency were collected. The data were categorized into formal education, continuing education, self education, and other education. Amount of education was measured in hours. Work experience in chemical dependency including research, clinical practice, consultation, administration, and teaching was measured in the form of a

dichotomous question. Space at the end of the questionnaire was provided for the respondents to make open-ended comments.

Procedure

Questionnaires were mailed to the entire sample simultaneously to ensure constancy of conditions. Each questionnaire was accompanied by a return-addressed, stamped envelope. A follow-up reminder was sent within ten days thanking them for their participation and/or encouraging them to reply if they had not already done so. Records of the returned questionnaires were maintained numerically. Return envelopes were thrown away before recording any data from the questionnaires. Return of the questionnaire constituted informed consent.

Human Subjects Consideration

There was no identifying information on the questionnaires. The questionnaires and information from the questionnaires were kept in a locked office. After all the data had been coded and entered into a computer program, the questionnaires were destroyed.

Data Analysis

To answer research question one, descriptive statistics were used to analyze the Substance Abuse Attitude Survey (SAAS) instrument which categorized attitudes toward chemical dependency into five subscales: Permissiveness, Treatment Optimism, Treatment Intervention, Nonmoralism, and Nonstereotype.

Research question two was analyzed using a t-test to determine if a significant relationship existed between personal use of drugs and/or alcohol and each of the five subscales of the SAAS. Personal use was coded as a dichotomous variable with yes = 1 and no = 0. Only the first question, "Have you ever tried to cut down or control usage of alcohol or drugs," was analyzed because few participants, less than 6 percent, answered the last four questions affirmatively. To answer research question three, correlations were used to determine if a relationship existed between co-dependency and the five subscales of the SAAS.

Research hypothesis one was analyzed using a t-test to determine if a relationship existed between having received education in chemical dependency and the five subscales of the SAAS. Education was coded as a dichotomous variable with yes = 1 and no = 0.

Research hypothesis two was analyzed using a t-test to determine if a relationship existed between work experience and the five subscales of the SAAS. Work experience was coded as a dichotomous variable with yes = 1 and no = 0.

The categories of formal education, continuing education, self-education, and other education were analyzed with frequencies, along with the demographic information.

CHAPTER III

RESULTS AND DISCUSSION

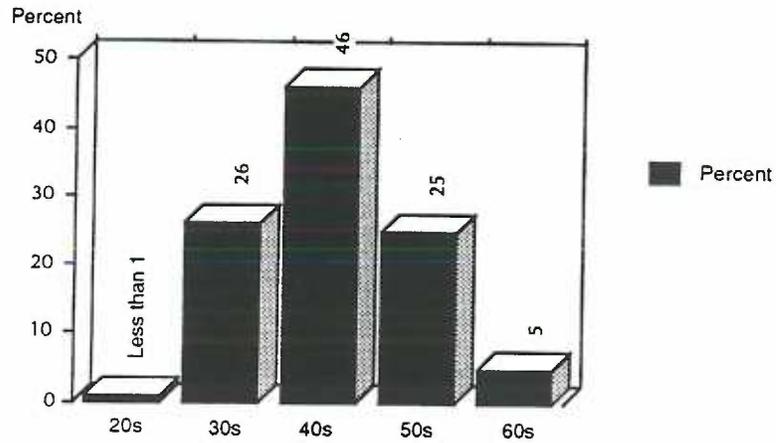
Description of the Sample

Out of the accessible population of 250 nurse educators in AD, BSN, MS, or Ph.D. programs, 190 returned the questionnaires for a response rate of 75 percent. The mean age of Oregon nurse educators surveyed was 46 years (Figure 2). The highest percentage of educators received their basic nursing education in the 1960s (Figure 3), with the greatest number receiving their highest nursing degree in the 1970s (Figure 4). Table 1 shows highest education degree and Table 2 shows academic ranks.

Ninety-one percent reported receiving information or instruction about alcoholism during their nursing career, and of those, 66 percent reported that nursing care was specifically discussed. Eighty-two percent reported receiving instruction or information about drug abuse during their nursing career; 49 percent of those reported that nursing care was discussed.

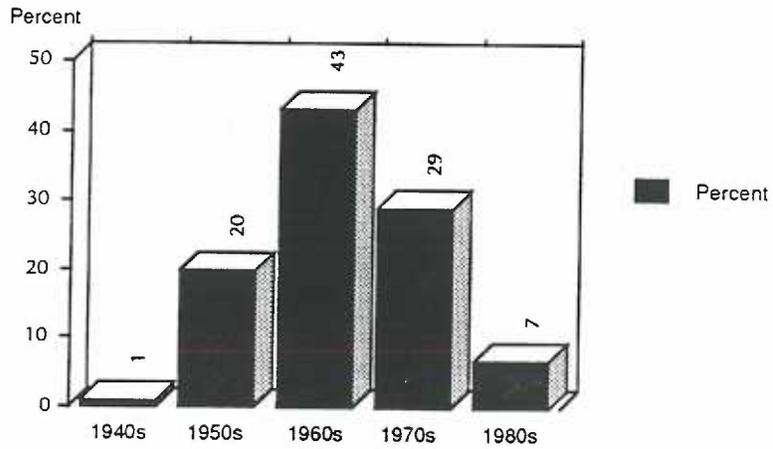
Of the sample, 94 percent thought that alcoholism information/instruction would help in their nursing practice, and 97 percent responded that drug abuse information/instruction would help in their nursing practice (see Table 3).

Figure 2. Summary of Ages of Nurse Educators



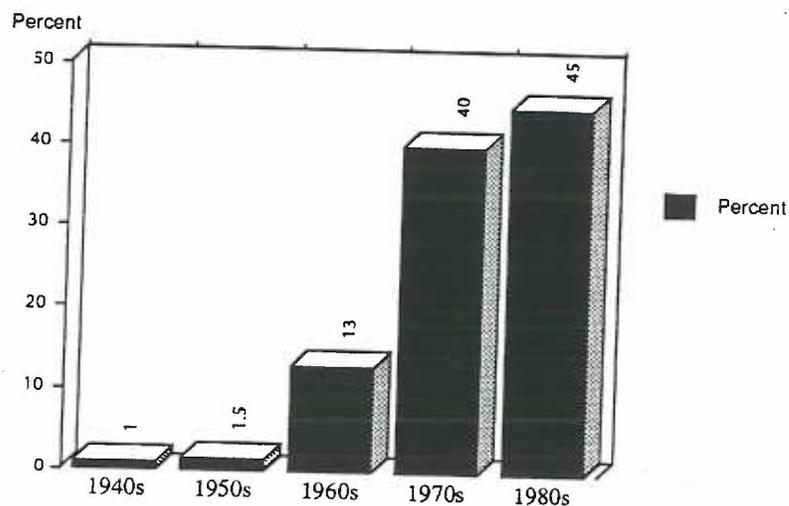
Mean: 45.70
 SD: 8.05
 Range: 26—69

Figure 3. Summary of Year Basic Education in Nursing Was Received



Mean: 66.11
 SD: 8.53
 Range: 1943—1987

Figure 4. Summary of Year Highest Nursing Degree Was Received



Mean: 77.21
 SD: 7.75
 Range: 1943—1988

Table 1

Highest Educational Degree Received By Percent (N = 190)

Degree	Percent of Sample
Baccalaureate in Nursing	6
Baccalaureate in Other Areas	1
Masters in Nursing	61
Masters in Other Areas	10
Doctorate in Nursing	7
Doctorate in Other Areas	15

Table 2

Rank of Nurse Educators by Percent of Sample (N=190)

Rank	Percent of Sample
Full Professor	7
Associate Professor	24
Assistant Professor	21
Instructor	41
Other	8

Table 3

Alcohol and Drug Use Information by Percent of Sample (N=190)

Use Information	Percent of Sample Responding "Yes"
<i>Alcohol:</i>	
Information received during nursing career	91
Nursing care specifically discussed	66
Information would be helpful	94
<i>Drug:</i>	
Information received during nursing career	82
Nursing care specifically discussed	49
Information would be helpful	97

Seventy-one percent of the sample did not feel that nursing curriculum currently provided adequate education in chemical dependency, although 13 percent of the sample did not answer this question. Ninety-four percent of the sample thought chemical dependency presented a problem for the nursing profession.

The relatively young age of the respondents and the fact that the majority received their highest degree within the last ten years probably serves to influence their attitudes toward chemical dependency. It is also interesting to note that 43 percent of our sample received their basic nursing education during the 1960s, which was generally prior to media coverage of drugs. This suggests that educators probably received chemical dependency education with their more advanced degrees.

Reliability of Substance Abuse Attitude Survey

In this study, the alpha coefficients for the five factors ranged from .56 to .71. Both treatment intervention and treatment optimism had alpha coefficients of .56. Chappel, Veach, and Krug (1985) reported alpha coefficients from their criterion group as .56 to .73, with treatment intervention and treatment optimism being .56 and .64, respectively. Cannon (1987) report alpha coefficients of .47 to .77, with scores of .47 on both treatment intervention and treatment optimism. Table 4 presents alpha coefficients for all three studies using the SAAS.

Table 4

Comparison of Alpha Coefficients of SAAS Scale and
Factors Present Study, Chappel et al., & Cannon

Scale and Factors	Present Study N = 190	Criterion Group N = 108	Cannon N = 384
Permissiveness	.60	.73	.71
Nonstereotype	.71	.76	.77
Treatment Intervention	.56	.56	.47
Treatment Optimism	.56	.64	.47
Nonmoralism	.63	.63	.63

When comparing the alpha coefficients for the Treatment Intervention and Treatment Optimism to Cannon (1987), and Chappel, Veach, and Krug (1985), these subscales had the lowest coefficients. Both scales had the fewest number of items (eight and five, respectively) which may in part account for the lower value. On the Nonmoralism subscale, the alpha reliability coefficient was .63, the same value as Chappel, Veach, and Krug (1985), suggesting a fair measure of reliability. On the Nonstereotype subscale, the alpha of .71, suggests good measures of reliability, although less than Chappel's .76. The Permissiveness subscale had an alpha of .60 as compared to

Chappel's .73. Looking at individual items in this subscale, we found that in our sample, the statement "Marijuana use among teenagers can be healthy experimentation" had a negative correlation. Deleting this item would raise the alpha coefficient to .69 which would indicate a significantly higher reliability. One reason for this item's negative correlation could be attributed to the change in the drug itself from the time when Chappel, Veach, and Krug (1985) were developing the scale in the late 1970s to present. Due to the increased sophistication of growing and harvesting the plant, the THC content has increased tremendously. A permissive person may have felt that marijuana used by a teenager at the time Chappel's instrument was developed was fairly harmless due to its low potency. The permissive person today is judging an entirely different product.

Research Questions/Hypotheses

Research Question 1

What are the attitudes of nurse educators in Oregon toward chemical dependency?

Mean scores for the five factors (Treatment Intervention, Treatment Optimism, Permissiveness, Nonstereotype, and Nonmoralism) are presented in Table 5. A high score on each of the subscales indicated that the attitude is held to a greater degree. Note that the mean and range scores on the Treatment Intervention and Treatment Optimism factors show that this sample tended to agree more often with items that were optimistic about

the treatment intervention and treatment outcome. They also tended to agree with items measuring nonstereotypical attitudes about chemical dependency. The nonmoralistic attitude mean score about chemical dependency suggested that the respondents agreed with more nonmoralistic statements than not. On the Permissiveness scale, the mean score suggested a more neutral position, while the actual range showed no respondents in the *strongly agree* (to permissive statements) category.

Table 5

Mean Scores, Range, and Standard Deviation on
Five Factors of SAAS (N=190)

Factors	Possible Range	Actual Range	Mean Score	S.D.
Permissiveness	9-45	9-34	20.27	4.38
Nonstereotype	10-50	23-50	36.19	4.58
Treatment Intervention	8-40	25-40	32.58	3.05
Treatment Optimism	5-25	14-25	19.76	2.40
Nonmoralism	10-50	12-46	34.30	4.91

Table 6 compares the scores in this sample with Chappel's and Cannon's. Attitude scores were converted into T-scores to compare with Chappel's criterion group. It is noted that the nurse educator sample was equal with Chappel's criterion group on

the Treatment Intervention factor. Chappel's criterion group included experienced clinicians in chemical dependency treatment who experienced satisfaction and had reported some success in treating substance abusing patients. The data reinforces the viewpoint that the majority of Oregon nurse educators (81 percent) feel optimistic toward chemical dependency treatment intervention statements as seen in Table 7. For example, 99 percent thought family involvement to be a very important part of the treatment of alcoholism and drug addiction, and 80 percent thought group therapy to be very important in the treatment of alcoholism and drug addiction. Since chemical dependency treatment interventions focus on group therapy and family dynamics, it appears that Oregon nurse educators endorse this treatment approach.

On the Treatment Optimism subscale, Oregon nurse educators compared equally with Cannon, but answered less optimistically than Chappel's criterion group. This difference could possibly be attributed to the content of this subscale, which has items which appear more treatment knowledge-based. As seen in Table 7, 80 percent of Oregon nurse educators agreed with treatment optimism items. An overwhelming majority of Oregon nurse educators (94-95 percent) felt drug addiction and alcoholism to be treatable illnesses which is consistent with Cannon's survey. Only 9 percent felt that an alcohol or drug dependent person who had relapsed several times probably could not be treated.

Table 6

Comparison SAAS Factor Scores for Oregon Nurse Educators, Chappel et al., & Cannon, Using T-Scores

Factor	Oregon Nurse Educators N=190	Cannon Oregon Nurses	Chappel, et al. Criterion Clinician N=108
Permissiveness			
Mean Score	20.27*	23.46	
T-Score	31	37	50.1
Nonstereotype			
Mean Score	36.19	34.77	
T-score	48	46	50.0
Treatment Intervention			
Mean Score	32.58	32.08	
T-score	50	47	50.0
Treatment Optimism			
Mean score	19.76	19.45	
T-score	46	43	50.1
Nonmoralism			
Mean score	34.30	29.85	
T-score	52	43	49.9

*Mean scores for permissiveness scale cannot be compared due to unequal number of items in scales between studies.

Table 7

Percent of Agreement and Disagreement in Subscales
of SAAS (N = 190)

Factor	Agree	Uncertain	Disagree
Treatment Intervention	81.31	13.16	5.53
Treatment Optimism	80.00	11.90	8.10
Nonstereotype	62.16	18.47	19.59
Nonmoralism	56.89	18.53	24.58
Permissiveness	17.60	16.38	66.02

On the Nonstereotype subscale, Oregon nurse educators responded similarly to Cannon's registered nurses, but answered more affirmatively to stereotypical statements about chemical dependency than Chappel's criterion group. For example, in the statement, "All heroin use leads to addiction," 39 percent of the sample answered affirmatively which suggested stereotypical attitudes about addiction. In another example, 58 percent of the sample thought that weekend users of drugs would progress to drug abuse. This is an example of the stereotypical response, and may partially explain the reason for the lower scores on the Nonstereotype subscale than Chappel's criterion group.

On the Nonmoralism subscale, our sample of nurse educators agreed with more positively worded items than Cannon's sample of

registered nurses, but less positively than Chappel's criterion group. It was in this subscale that we found our widest range, with one out of four nurse educators agreeing with moralistic statements about chemical dependency. For example, 23 percent felt that clergymen should not drink in public, and 38 percent felt that alcohol is so dangerous that it could destroy the youth of our country if it is not controlled by law. In comparison, it was heartening to note that 82 percent of Oregon nurse educators *disagreed* with the statement, "A nurse who has been addicted to narcotics should not be allowed to practice nursing again."

On the Permissiveness scale, only 17.6 percent of the educators responded affirmatively to permissive statements. However, in general, most educators agreed with nonpermissive statements such as, "Lifelong abstinence is a necessary goal in the treatment of alcoholism" (86 percent), and disagreed with permissive statements such as, "Personal use of drugs should be legal in the confines of one's own home" (79 percent).

The results of the Substance Abuse Attitude Survey suggested that Oregon nurse educators have similar attitudes to a random group of Oregon registered nurses toward chemical dependency.

Research Question 2

Is personal use of drugs and/or alcohol associated with the nurse educators' attitudes toward chemical dependency? The t-test results are shown in Table 8. Because only 6 percent of subjects answered yes to personal use questions #67, #68, #69, and #70,

only question #66, which asked respondents whether they had ever tried to cut down or control their use of alcohol and/or drugs, was used in the analysis. Twenty-six percent answered affirmatively to this question.

In Table 8, Group 1 represents the respondents who answered no to question #66; Group 2 represents those who answered yes. An alpha of .01 was selected for the analysis, based on the Bonferoni Correction principle. There were no significant differences between the five factors of SAAS and question #66 which asked, "Have you ever tried to cut down or to control usage of alcohol and/or drugs?"

Research Question 3

Is co-dependency associated with the attitudes of nurse educators toward chemical dependency?

Twenty-five percent of the sample found themselves frequently taking responsibility for other people's moods and behavior; 7 percent found themselves frequently putting aside their values to please others; 15 percent frequently avoided uncomfortable feelings by using drugs/alcohol, food, or sleep; 15 percent frequently felt most of their validation of self-worth came from outside sources; 2 percent believed they should be able to always solve their own problems without help from others; and 60 percent believed they should be able to frequently solve their own problems without help from others (Table 9).

Table 8

T-test Between Five Factors of SASS and the Cutting Down or
Controlling Usage, Question #66

Scale and Factors	Group 1	Group 2	Separate Variances
Permissiveness	N 120	N 42	T -1.91
	Mean 19.858	Mean 21.238	DF 84.25
	SD 4.534	SD 3.824	P 0.0590
Nonstereotype	N 127	N 43	T -1.70
	Mean 35.866	Mean 37.209	DF 75.91
	SD 4.657	SD 4.422	P 0.0935
Treatment Intervention	N 122	N 43	T -0.58
	Mean 32.664	Mean 32.977	DF 76.14
	SD 3.085	SD 2.972	P 0.5585
Treatment Optimism	N 123	N 44	T -0.05
	Mean 19.797	Mean 19.818	DF 68.42
	SD 2.333	SD 2.644	P 0.9622
Nonmoralism	N 120	N 43	T -0.01
	Mean 34.358	Mean 34.372	DF 64.40
	SD 4.520	SD 5.778	P 0.9888

The alpha for this scale was .4109. If item #65, "Do you believe that you should be able to solve your own problems without help from others", was deleted, the alpha would have been .584. Sixty percent answered in the frequency category on this question. The scale mean was 14.14, and the scale variance was 1.094. Correlations between the co-dependency scale and the SAAS are shown in Table 10. None of the correlations were significant using an alpha level criteria of .025 for a two-tail test.

Table 9

Co-dependency Items and Percent Responding to EachResponse Option

	N	Always %	Frequently %	* %	Rarely %	Never %
Responsible others						
moods/behavior	183	0	25	4	68	3
Values please						
others	183	0	7	5	72	16
Avoid Feelings	184	0	15	4	55	26
Validation						
Self-Worth	183	0	15	4	72	9
Solve Own Problems	179	2	60	3	32	2

*Answered between frequently and rarely.

Table 10

Correlation Matrix, Co-dependency Scale, and Five
Factors of SAAS (2-Tailed Values)

Scale and Factors	Correlations	P-value
Permissiveness	-0.1560	0.0434
Nonstereotype	-0.0203	0.7941
Treatment Intervention	-0.0838	0.2802
Treatment Optimism	-0.0925	0.2330
Nonmoralism	-0.0320	0.6802

In summary, in this study personal use of drugs and/or alcohol and co-dependency were not associated with the attitudes of nurse educators toward chemical dependency. There may be several reasons for this finding.

Our sample showed minimal signs of physical, social and/or occupational impairment due to the use of alcohol and/or drugs. The questions in this scale were adopted from a diagnostic tool measuring addiction and may not have been effective in measuring moderate use. The questions in our scale reflected middle/late stage addiction. Our results might have been different if we had asked about actual use of alcohol and/or drugs. The coefficient alpha for the co-dependency scale was low which could attenuate any correlations. In addition, the response options may have been

too limiting. For example, it might have been more useful to have an additional response option between frequently and rarely.

When asked the question, "Do you think chemical dependency presents a problem for the nursing profession," 94 percent answered yes. In a space given for comments, many of the sample expressed concern about the incidence of drug and alcohol use in nursing colleagues. Many felt that this was because nursing is a high stress profession and nurses have easy access to drugs. During the last several years the literature addressing chemical dependency in nursing has increased. Haack and Hughes (1989) explain that chemically dependent nurses do not fit the commonly held image of an alcoholic or drug addict, and co-workers can easily attribute signs and symptoms of a progressing addiction to stressful work or home environment. Chemically-dependent nurses do not receive help because peers and supervisors are either afraid to confront them or do not know how to help (Lachman, 1988).

Research Hypothesis 1

The attitudes of nurse educators who have received education in chemical dependency will be significantly different from those who have not received education in chemical dependency.

To answer this question, eight questions concerning formal education, continuing education, self education, and/or other education in alcoholism and drug abuse were asked.

Of 187 who responded to questions about education, 182 had had some type and amount of education; 5 reported no education; 142 reported some type and amount of education in alcoholism; 106 in formal education; 108 in continuing education; 142 in self-education; and 54 in other education (Table 11). Of these, the modal number of hours of formal and continuing education in alcoholism was 1 to 5. The modal number of hours of self education in alcoholism was 6 to 10 (Table 12).

One hundred forty-one reported some type and amount of education in drug abuse; 86 in formal education; 99 in continuing education; 141 in self-education, and 48 in other education (Table 11). Of these, the modal number of hours of formal and continuing education was 1 to 5. The modal number of hours of self education in drug abuse was 6 to 10 (Table 13).

It is interesting to note that practically all the nurse educators in the sample had some education in chemical dependency. The homogeneity of the sample precluded testing the relationship between education and attitudes. In retrospect, this homogeneity might have been predicted based on a tendency for nurse educators to have more education integral to their role of educator. As reflected in past research, more respondents reported education in alcoholism than drug abuse. The modal number of contact hours in education continues to be 1 to 5, even with this more highly educated sample. Finally, the most striking finding is that 76

Table 11

Type of Education in Alcoholism and Drug Abuse

Type	Alcoholism (N=187)	Drug Abuse (N=185)
Formal Education	106 (57%)	86 (46%)
Continuing Education	108 (58%)	99 (54%)
Self-Education	142 (76%)	141 (76%)
Other	54 (29%)	48 (26%)

Table 12

Amount of Education in Alcoholism by Number of Hours,
Percent, and Mode

Type	Number of Hours	Percent (N = 183*)	Modal Number of Hours
Formal Education	1-10	73 (40%)	1-5
	11+	29 (15%)	
Continuing Education	1-10	63 (35%)	1-5
	11+	41 (23%)	
Self	1-10	66 (37%)	6-10
	11+	69 (39%)	
Other	1-10	15 (8%)	less than 1
	11+	27 (21%)	

*N = 183 except for variables on which there were missing data.

Table 13

Amount of Education in Drug Abuse By Number of Hours,
Percent, and Mode

Type	Number of Hours	Percent (N = 183)	Modal Number of Hours
Formal Education	1-10	57 (32%)	1-5
	11+	26 (14%)	
Continuing Education	1-10	61 (34%)	1-5
	11+	36 (20%)	
Self	1-10	65 (36%)	6-10
	11+	70 (34%)	
Other	1-10	12 (8%)	less than 1
	11+	26 (18%)	

percent of nurse educators reported being self educated in chemical dependency. The category self education in both alcoholism and drug abuse clearly exceeded all other categories of education. In open-ended comments, many respondents reported experience with groups such as Adult Children of Alcoholics and Families of Alcoholics and Addicts. Some reported personal experience with family members and friends, and some described difficulties with impaired colleagues. This finding may in part support the idea that nurses may learn their caretaking role as children in chemically dependent dysfunctional families. More research is needed in this area.

Research Hypothesis 2

The attitudes of nurse educators who have work experience in chemical dependency will be significantly different from those who have not received education in chemical dependency.

In the sample, we found a significant relationship between the attitude scores on the Treatment Optimism subscale and work experience in chemical dependency ($F = 8.348, p < .0043$). No other subscales correlated significantly with work experience. Of the 190 nurse educators in the sample, only 14 percent answered affirmatively to having worked in the field of chemical dependency. The Treatment Optimism subscale contained five items, two of which were drug addiction and alcoholism being treatable illnesses. Other items concerned the treatment of a person who has relapsed several times, whether it is unpleasant to work with alcohol or drug-dependent patients, and whether one needed to hit *rock bottom* before being helped.

CHAPTER IV

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

This study was a partial replication of Cannon's (1987) study of nurses' attitudes. The purpose of the study was to explore nurse educators' attitudes toward chemical dependency. The relationship of education, work experience, co-dependency, and personal use of alcohol and/or drugs to attitudes were also examined.

Questionnaires were mailed to the target population $N = 250$. One hundred ninety were returned for a 75 percent response rate. The questionnaires included (a) the Substance Abuse Attitude Survey, a Likert-like instrument measuring attitudes in five subscales (Permissiveness, Nonstereotype, Nonmoralism, Treatment Intervention, and Treatment Optimism); (b) questions about work experience and education in chemical dependency; (c) questions about personal use of drugs and/or alcohol and co-dependency; and (d) demographic data about the subjects.

Three research questions and two hypotheses were generated. The first research question was: What are the attitudes of nurse educators toward chemical dependency? The results on the five subscales of the SAAS indicated that Oregon nurse educators were generally optimistic toward treatment of chemical dependence, responded positively to statements regarding treatment intervention, and tended to respond negatively to moralistic, stereotypical, and permissive statements.

The second and third research questions were: Is personal use of drugs and/or alcohol associated with nurse educators' attitudes, and is co-dependency associated with nurse educators' attitudes. Analysis showed no relationship between personal use or co-dependency and nurse educator attitudes.

The first research hypothesis was that nurse educators' attitudes would be significantly different as a result of education in chemical dependency. This hypothesis could not be tested because all but five of the participants had had some education in chemical dependency.

The second research hypothesis was that nurse educators' attitudes would be significantly different as a result of work experience in chemical dependency. A significant relationship was found between work experience in chemical dependency and the attitude subscale Treatment Optimism.

Conclusions and Nursing Implications

The results of this study suggest that the attitudes of nurse educators toward chemical dependency are generally positive, which supports the research done by Cannon (1987). From our study it does not seem that a negative attitudinal component has been identified as impeding curriculum development. Ninety-four percent of Oregon nurse educators feel chemical dependency is a problem and 71% do not think nursing curricula provide adequate education in chemical dependency. Why then is there little or no didactic or clinical curriculum in chemical dependency in Oregon?

Curricula change slowly, and priorities in health education may be given to those disease processes long recognized in the medical profession. Since chemical dependency is a relatively recent diagnosis, its exclusion in curriculum may be only a symptom of an over-burdened educational system. Economics could be a limiting factor; it is only recently that the federal government has taken an active interest and role in the nation's drug problem. A survey of nurse educators with specific questions about what components are lacking in chemical dependency nursing education, and what they feel needs to be taught would certainly give further direction in curriculum development.

The significant relationship found between work experience and optimism about treatment seems to substantiate the importance of including a clinical component in chemical dependency education for the nursing profession. Witnessing the process of recovery is always a powerful and influential experience.

It is interesting that *self study* appeared to be the most chosen method of education by this highly educated group. This finding may suggest greater personal involvement with issues of chemical dependency. For example, it would have been interesting to see how many of the sample had an alcoholic spouse, child, parent, or grandparent. Denial may be a strong factor in both addiction and co-dependency and one that is difficult to measure.

Our attempt to measure co-dependency and personal use of drugs and/or alcohol in relation to attitudes was not as

successful as we would have liked. It is apparent that more research is needed in developing and refining reliable instruments to measure these characteristics.

Chemical dependency is a significant problem for our health care system. The literature has documented both negative and positive attitudes toward chemical dependency. Nurse educators are in the position to change curricula and influence attitudes. Given the positive attitudes of Oregon nurse educators, the environment is ready for curriculum revisions that will teach future nurses how to identify, intervene, and treat the disease of chemical dependency.

References

- Adams, E. F. (1988). Drug dependency in hospital patients. *American Journal of Nursing*, 477-481.
- Ajzen, I., & Fishbein, M. (1975). *Belief, attitude, intention, and behavior: An introduction to theory and research*. Philippines: Addison-Wesley Publishing Co., Inc.
- Allport, C. (1935). Attitudes. In C. Murchinson (Ed.) *Handbook of social psychology*. Worcester: Clark University Press.
- American Psychiatric Association. (1987). *Diagnostic and statistical manual of mental disorders (rev. 3rd ed.)*. Washington, DC: Author.
- Beattie, M. (1987). *Codependent no more*. Minneapolis: Hazelden Foundation.
- Black, C. (1981). *It will never happen to me!* Denver: M.A.C.
- Cannon, B. L. (1987). *Attitudes of Registered Nurses Toward Substance Abuse and Impaired Nurses*. Unpublished master's thesis, Oregon Health Sciences University, School of Nursing, Portland, Oregon.
- Chappel, J. W., & Veach, T. L. (1987). Effects of a course on students' attitudes toward substance abuse and its treatment. *Journal of Medical Education*, 62, 394-400.
- Chappel, J. W., Veach, T. L., & Krug, R. S. (1985). The substance abuse attitude survey: An instrument for measuring attitudes. *Journal of Studies on Alcohol*, 46, 48-52.

- Chardorkoff, B. (1969). Alcoholism education in a psychiatric institute. 2. Student nurses: Relationship of personal characteristics, attitudes toward alcoholism and achievement. *Quarterly Journal of Studies on Alcohol*, 30, 657-664.
- Clement, S. (1986). The identification of alcohol-related problems by general practitioners. *British Journal of Addiction*, 81, 257-264.
- Council on Mental Health. (1972). Medical school education on abuse of alcohol and other psychoactive drugs. *Journal of American Medical Association*, 219, 1746-1749.
- Forneau, E. W. (1967). What student nurses think about alcoholic patients and alcoholism. *Nursing Outlook*, 15, 40-41.
- Gurel, M. (1976). Alcoholism training program: Its effect on trainees and faculty. *Nursing Research*, 25, 127-132.
- Haack, M., and Hughes, T. (1989). *Addiction in the nursing profession*. Springer Publishing Company.
- Harlow, P., & Goby, M. (1980). Changing nursing students' attitudes toward alcoholic patients: Examining effects of a clinical practicum. *Nursing Research*, 29, 59-60.
- Helzer, J. E., & Pryzbeck, T. R. (1987). The co-occurrence of alcoholism with other psychiatric disorders in the general population and its impact on treatment. *Journal of Studies on Alcohol*, 49(3), 219-224.

- Hoffman, A. L., & Heinemann. (1987). Substance abuse education in school of nursing: A national survey. *Journal of Nursing Education, 26*(7), 282-287.
- Kamerow, D. B., Pincus, H. A., & Macdonald, D. I. (1986). Alcohol abuse, other drug abuse, and mental disorders in medical practice. *Journal of American Medical Association, 255*(15), 2054-2057.
- Lachman, V. (1988). The chemically dependent nurse. *Holistic Nurse Practitioner, 2*(4), 34-44.
- McKelvy, M. J., Kane, J. S., & Kellison, K. (1987). Substance abuse and mental illness: Double trouble. *Journal of Psychosocial Nursing, 25*(1), 20-25.
- Menicucci, L. D., Wermuth, L., & Sorensen, J. (1988). Treatment providers' assessment of dual-prognosis patients: diagnosis, treatment, referral, and family involvement. *International Journal of Addiction, 23*(6), 617-622.
- Moodley-Kunnie, T. (1988). Attitudes and perceptions of health professionals toward substance use disorders and substance-dependent individuals. *The International Journal of the Addictions, 23*(5), 469-475.
- Safer, D. J. (1987). Substance abuse by young adult chronic patients. *Hospital and Community Psychiatry, 38*(5), 511-514.
- Schaefer, A. W. (1986). *Co-dependence misunderstood-mistreated*. New York: Harper & Row.

- Sowa, P. A., & Cutter, H. S. (1974). Attitudes of hospital staff toward alcoholics and drug addicts. *Quarterly Journal of Studies on Alcohol*, 35, 210-214.
- Spickard, A. (1986). Alcoholism: The missed diagnosis. *Southern Medical Journal*, 79(12), 1489-1492.
- Sullivan, E. J., & Hale, R. E. (1986). Nurses' beliefs about the etiology and treatment of alcohol abuse: A national study. *Journal of Studies on Alcohol*, 58(5), 456-460.
- Thome, B. (1988). Chemical dependency among nursing personnel. *The Nurses Digest*, 5(2).
- Tolor, A., & Tamerin, J. S. (1975). The attitudes toward alcoholism instrument: A measure of attitudes toward alcoholics and the nature and causes of alcoholism. *British Journal of Addiction*, 70, 223-231.
- Wechsler, H., & Rohman, M. (1982). Future caregivers' views on alcoholism treatment. *Journal of Studies on Alcohol*, 43, 939-955.
- Wegscheider-Kruse, S. (1985). *Choicemaking: For co-dependents, adult children and spirituality seekers*. Florida: Health Communications.
- Whitcup, S. M., & Miller, F. (1987). Unrecognized drug dependence in psychiatrically hospitalized elderly patients. *Journal of American Geriatric Society*, 35, 297-301.
- Zerwekh, J., & Michaels, B. (1989). Co-dependency, assessment and recovery. *Nursing Clinics of North America*, 24(1).

Appendix A

Cover Letter

Dear Colleague:

We would like you to participate in our study of nurse educators' attitudes toward chemical dependency. We are choosing nurse educators in Oregon because we believe that they are leaders in the profession and in a good position to influence nurse attitudes toward chemical dependency.

Will you please complete and return the questionnaire. You will not be identified in any way on the data record. Participation is voluntary. If you return the questionnaire, it will be considered your consent to participate in the study. Please do not put identifying information on any of the documents.

We really appreciate your participation in our study and will send a copy of the results to your school.

Sincerely,

Deb Berg
Libby Churchill
Nora Cross
Graduate Nursing Students
Mental Health Nursing
Oregon Health Sciences University

Appendix B

Follow-up Postcard

Hello,

Ten days ago, we sent you a questionnaire surveying nurse educators' attitudes about chemical dependency. If you haven't already filled it out and sent it back, please do. We need and appreciate your input!

Thanks for taking the time and energy to participate in our study.

Sincerely,

Deb Berg

Libby Churchill

Nora Cross

Appendix C

Questionnaire

QUESTIONNAIRE

The following questionnaire addresses attitudes regarding the problem of chemical dependency. There are no right or wrong answers, as we are only interested in your opinion. Please circle the letter on each scale which most closely agrees with your feelings about the statement. The term *drug* refers to drugs other than alcohol.*

A Strongly Agree	a Agree	u uncertain	d Disagree	D Strongly Disagree		
1.	Alcohol is an effective social relaxant.	A	a	u	d	D
2.	Marijuana should be legalized.	A	a	u	d	D
3.	Any drug can be safely used by a person who is mentally healthy.	A	a	u	d	D
4.	Almost anyone would turn to drugs if their problems were great enough.	A	a	u	d	D
5.	Alcohol is a food, not a drug.	A	a	u	d	D
6.	Physicians are an important source of drugs for most users.	A	a	u	d	D
7.	Marijuana use leads to mental illness.	A	a	u	d	D
8.	Heroin is so addicting that no one can really recover once he/she becomes an addict.	A	a	u	d	D
9.	Smoking leads to marijuana use, which in turn leads to other drug use.	A	a	u	d	D
10.	Clergymen should not drink in public.	A	a	u	d	D
11.	Alcoholism is associated with a weak will.	A	a	u	d	D
12.	All heroin use leads to addiction.	A	a	u	d	D

*Items #1, #3, #4, #5, and #6 were deleted from analysis.

- | | | | | | |
|---|---|---|---|---|---|
| 13. Daily use of one marijuana cigarette is not necessarily harmful. | A | a | u | d | D |
| 14. People who use marijuana usually do not respect authority. | A | a | u | d | D |
| 15. The laws governing the use of marijuana and heroin should be the same. | A | a | u | d | D |
| 16. Angry confrontation is necessary in the treatment of alcoholics or drug addicts. | A | a | u | d | D |
| 17. Using any illicit drug shortens one's life span. | A | a | u | d | D |
| 18. Weekend users of drugs will progress to drug abuse. | A | a | u | d | D |
| 19. Anybody who is clean shaven with short hair probably doesn't use illegal drugs. | A | a | u | d | D |
| 20. Family involvement is a very important part of the treatment of alcoholism or drug addiction. | A | a | u | d | D |
| 21. Alcohol is so dangerous that it could destroy the youth of our country if it isn't controlled by law. | A | a | u | d | D |
| 22. A nurse who has been addicted to narcotics should not be allowed to practice nursing again. | A | a | u | d | D |
| 23. Recreational drug use precedes drug abuse. | A | a | u | d | D |
| 24. Lifelong abstinence is a necessary goal in the treatment of alcoholism. | A | a | u | d | D |
| 25. Drug addiction is a treatable illness. | A | a | u | d | D |
| 26. Alcoholism is a treatable illness. | A | a | u | d | D |
| 27. Street pushers are the initial source of drugs for young people. | A | a | u | d | D |

42. The best treatment for an alcohol or drug dependent patient is referral to a good treatment program. A a u d D
43. Persons convicted of sale of illicit drugs should not be eligible for parole. A a u d D
44. Chronic alcoholics who refuse treatment should be legally committed to long-term treatment. A a u d D
45. An alcohol or drug dependent person cannot be helped until he/she has hit *rock bottom*. A a u d D
46. Once an alcohol or drug dependent patient is abstinent and off all medication, no further contact with a health care provider is necessary. A a u d D
47. Parents should teach their children how to use alcohol. A a u d D

DEMOGRAPHIC INFORMATION

Please fill in or check (✓) the appropriate response.

48. Please indicate your age: _____
49. What year did you receive your basic nursing degree? _____
50. What year did you receive your highest nursing degree? _____
51. What is your highest educational degree?
- ____ Associate degree
 - ____ Baccalaureate in Nursing
 - ____ Baccalaureate-other discipline
 - ____ Masters in Nursing
 - ____ Masters-other discipline
 - ____ Doctorate in Nursing
 - ____ Doctorate-other discipline
52. Please indicate your rank.
- ____ Full professor
 - ____ Associate professor
 - ____ Assistant professor
 - ____ Instructor
 - ____ Other _____
53. During your nursing career, have you received information or instruction about:
- | | | | |
|------------|----------|------------|----------|
| Alcoholism | ____ Yes | Drug Abuse | ____ Yes |
| | ____ No | | ____ No |
54. If yes, was nursing care specifically discussed for the following topics?
- | | | | |
|------------|----------|------------|----------|
| Alcoholism | ____ Yes | Drug Abuse | ____ Yes |
| | ____ No | | ____ No |

55. Do you think such instruction and information would help you in your nursing practice?

Alcoholism Yes Drug Abuse Yes
 No No

56. How have you acquired information about alcoholism (check any that are applicable [hours]).

<input type="checkbox"/> Formal Education	<input type="checkbox"/> 1-5	<input type="checkbox"/> 6-10	<input type="checkbox"/> 11-15	<input type="checkbox"/> 16-20	<input type="checkbox"/> 21+
<input type="checkbox"/> Continuing Education	<input type="checkbox"/> 1-5	<input type="checkbox"/> 6-10	<input type="checkbox"/> 11-15	<input type="checkbox"/> 16-20	<input type="checkbox"/> 21+
<input type="checkbox"/> Self Study	<input type="checkbox"/> 1-5	<input type="checkbox"/> 6-10	<input type="checkbox"/> 11-15	<input type="checkbox"/> 16-20	<input type="checkbox"/> 21+
<input type="checkbox"/> Other	<input type="checkbox"/> 1-5	<input type="checkbox"/> 6-10	<input type="checkbox"/> 11-15	<input type="checkbox"/> 16-20	<input type="checkbox"/> 21+
Specify _____					

57. How have you acquired information about drug abuse (check any that are applicable [hours]).

<input type="checkbox"/> Formal Education	<input type="checkbox"/> 1-5	<input type="checkbox"/> 6-10	<input type="checkbox"/> 11-15	<input type="checkbox"/> 16-20	<input type="checkbox"/> 21+
<input type="checkbox"/> Continuing Education	<input type="checkbox"/> 1-5	<input type="checkbox"/> 6-10	<input type="checkbox"/> 11-15	<input type="checkbox"/> 16-20	<input type="checkbox"/> 21+
<input type="checkbox"/> Self Study	<input type="checkbox"/> 1-5	<input type="checkbox"/> 6-10	<input type="checkbox"/> 11-15	<input type="checkbox"/> 16-20	<input type="checkbox"/> 21+
<input type="checkbox"/> Other	<input type="checkbox"/> 1-5	<input type="checkbox"/> 6-10	<input type="checkbox"/> 11-15	<input type="checkbox"/> 16-20	<input type="checkbox"/> 21+
Specify _____					

58. Do you think nursing curriculum currently provides adequate education in chemical dependency?

_____ yes _____ no

If not, what would you like to see changed or included?

We are interested in your work experience in the field of chemical dependency, including research, clinical practice, consultation, administration, and teaching.

59. Please check if you have ever worked in the field of chemical dependency.

_____ yes _____ no

If yes, how long? _____ months. In what capacity? _____

60. Do you think chemical dependency presents a problem for the nursing profession?

_____ yes _____ no

If yes, in what way do you see it as a problem? _____

The following questions may provoke mixed feelings due to their sensitive and personal nature. Please feel assured that your responses will remain confidential. Your participation is valued and integral to this study.

	Always	Frequently	Rarely	Never
61. Do you find yourself taking responsibility for other people's moods and behavior?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
62. Do you find yourself putting aside your values to please others?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
63. Do you avoid uncomfortable feelings by using drugs/alcohol, food, or sleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

64. Do you feel that most of the validation of your self-worth comes from outside sources?
65. Do you believe that you should be able to solve your own problems without help from others?
66. Have you ever tried to cut down or to control usage of alcohol and/or drugs?
_____ yes _____ no
67. Has alcohol and/or drug use negatively impacted your ability to perform duties at home, work, or school?
_____ yes _____ no
68. Are you less involved in social, occupational, or recreational activities as a result of alcohol and/or drug use?
_____ yes _____ no
69. Has continued use of drugs and/or alcohol created problems for you physically, psychologically, or socially?
_____ yes _____ no
70. With alcohol and/or drug usage, have you ever had "blank" periods when you could not remember what you did, where you were, what you said?
_____ yes _____ no

Thank you for your time and participation. The following space has been provided for any additional comments you might like to make.

Appendix D

Work Sheets for Scoring

Scoring Method for SAAS Questionnaire

Strongly Agree	= 5
Agree	= 4
Uncertain	= 3
Disagree	= 2
Strongly Disagree	= 1

High scores present more positive or moderate response.

R = scores reversed.

Permissiveness (9 items)

#2, #13, #24(R), #28, #33, #34(R), #38, #43(R), #47(R)

Treatment Intervention (8 items)

#20, #31, #35, #36, #39, #40, #42, #46(R)

Nonstereotype (10 items)

#7, #8, #9, #12, #14, #18, #19, #23, #29, #30

Treatment Optimism (5 items)

#25, #26, #32(R), #37(R), #45(R)

Nonmoralism (10 items)

#10(R), #11(R), #15(R), #16(R), #17(R), #21(R), #22(R), #27(R), #41(R),
#44(R)

Substance Abuse Attitudes T-Score Conversion Table

Raw Scores	T-Scores				
	Permiss	N Stypes	Tx Int	Tx Opt	N Mor
13	--	--	--	--	--
14	21	--	--	20	--
15	23	--	--	24	--
16	24	--	--	28	--
17	26	--	--	33	--
18	27	--	--	37	--
19	29	--	--	41	21
20	31	--	--	46	23
21	33	20	--	50	25
22	34	22	--	55	27
23	36	23	--	59	29
24	38	25	22	63	31
25	40	27	25	68	33
26	41	29	28	--	35
27	43	31	31	--	37
28	45	33	35	--	39
29	47	35	38	--	41
30	48	37	41	--	43
31	50	39	44	--	45
32	52	40	47	--	47
33	53	42	50	--	50
34	55	44	54	--	52
35	57	46	57	--	54
36	59	48	60	--	56
37	60	50	63	--	58
38	62	52	66	--	60
39	64	53	69	--	62
40	65	55	73	--	64
41	67	57	--	--	66
42	69	59	--	--	68
43	71	61	--	--	70
44	72	63	--	--	72
45	74	65	--	--	74
46	76	66	--	--	--
47	78	68	--	--	--
48	79	70	--	--	--
49	--	72	--	--	--
50	--	74	--	--	--
51	--	--	--	--	--
52	--	--	--	--	--
53	--	--	--	--	--
54	--	--	--	--	--

AN ABSTRACT OF THE
MASTER'S RESEARCH PROJECT

Deb Berg

Libby Churchill

Nora Cross

For the MASTER OF SCIENCE

Date of receiving this Degree: June 8, 1990

Title: THE ATTITUDES OF NURSE EDUCATORS IN OREGON TOWARD
CHEMICAL DEPENDENCY

Approved: _____

Carol Burckhardt, Ph.D., Associate Professor, Advisor

The purpose of this study was to obtain descriptive data regarding the attitudes of Oregon Nurse Educators toward Chemical Dependency. The relationship between attitudes and potentially influential variables were explored. These variables were: (a) personal use of drugs and/or alcohol, (b) characteristics of co-dependency, (c) work experience in chemical dependency, and (d) education in chemical dependency.

The sample consisted of 190 registered nurses employed in AD, BSN, MS, and/or Ph.D. nursing programs in Oregon. The sample was obtained from a list of all nursing programs supplied by the State Board of Nursing. The mean age of the nurses was 46 years. The average respondent received their degree in 1977; had obtained their master's in nursing; and were instructors in their academic institution.

Data were collected via a mailed questionnaire which included: (a) the Substance Abuse Attitude Survey (Chappel et al., 1985), (b) demographic information, (c) personal use scale, and (d) a co-dependency scale. The personal use scale and co-dependency scale was constructed by the investigators on the basis of literature review. All data gathering occurred during July, August, and September, 1989, and the response rate was 75 percent.

On the basis of the data obtained, it appeared that the majority of nurse educators in Oregon had positive attitudes toward chemical dependency. They tended to favor treatment intervention, were optimistic about treatment, felt drug addiction

and alcoholism to be treatable illnesses, and held nonstereotypical and nonpermissive views. It was on the nonmoralism subscale that we found our widest range, with one out of four nurse educators agreeing with moralistic statements about chemical dependency.

Analysis of the data to see if there was any correlation between personal use of drugs and/or alcohol and attitudes of nurse educators proved insignificant. Our scale measured diagnostic symptoms of addiction, not usage, our original intent. The scale measuring co-dependency was also unsuccessful and we found no significance between traits of co-dependency and the attitudes of nurse educators. Our population was homogenous and there was little variance in either set of data as noted above.

There was no statistical difference in attitudes of nurse educators who had education in chemical dependency, even though 182 out of 187 reported some type of education in chemical dependency. The modal number of formal and continuing education hours in alcoholism and drug abuse was 1 to 5. The modal number of hours of self education in alcoholism and drug abuse was 6 to 10. The homogeneity of our sample may have again interfered in testing the relationship between education and attitudes.

In our sample, we found a significant relationship between the attitude scores on the treatment optimism subscale and work experience in chemical dependency. No other subscale correlated significantly with work experience. Only 14 percent of our sample

acknowledges past work experience in the field of chemical dependency.

Lastly, 94 percent of Oregon nurse educators felt chemical dependency is a problem, and 71 percent of nurse educators did not think the nursing curriculum provides adequate education in chemical dependency. Ninety-four percent of our sample felt chemical dependency presents a problem for the nursing profession. Many felt that this was because nursing is a high stress profession and nurses have easy access to drugs.

In summary it can be concluded that nurse educators in Oregon have positive attitudes toward chemical dependency. The majority of our sample did not think the nursing curriculum provided adequate education in the field of chemical dependency, yet the overwhelming majority felt chemical dependency was a problem for nursing. There was a significant relationship found between work experience and optimism about treatment to substantiate the importance of including a clinical component in chemical dependency education for the nursing profession. The challenge of education about the disease of addiction faces nursing administrators and educators.