Protective Factors Against Relapse for Practicing Nurse Anesthetists in Recovery From Anesthetic Opiate Dependency

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Abstract
This qualitative inquiry explored factors that protect recovering anesthetic opioid-dependent nurse anesthetists from relapse after their return to anesthesia practice. Practicing nurse anesthetists in recovery from potent opioids were recruited through online advertising and individually interviewed over the telephone. The interview consisted of open-ended questions that aided description of personal experience of individual factors. Content analysis of the interviews revealed an overarching theme of a commitment to the recovery process, which provided the foundational protective element against relapse. Within this context, two major thematic factors emerged: personal factors and external factors. Personal factors came from within the individual and included such features as removing the obsession to use, self-realization, inner strength, and seeing the future. External factors were external to the individual and described as time away from practice, state regulatory agency involvement, and talking with significant others. Although the Twelve-Step process was not a factor per se, it was credited by all participants as the structure on which their recovery was built. This process provided mechanisms for developing the motivation and learning the tools necessary to maintain their sobriety.

Keywords: anesthesia providers, nurse anesthetist, opioid dependency, recovery, relapse

INTRODUCTION
Recovery from addiction to any drug is challenging at the very least. When the challenge of working with one’s drug of choice on a daily basis is added to the picture, the chances of relapse increase. Think of an alcoholic who chooses to work in a bar. This same phenomenon is experienced by anesthesia providers, both nurse anesthetists and anesthesiologists who become addicted to those opioids that are an integral part of almost every anesthetic. Access to these drugs is of such concern that controversy exists as to whether recovering opioid-dependent anesthesia providers should even return to the anesthesia profession (Berge, Seppala, & Lanier, 2008). This article takes a look at the phenomenon through the eyes of nurse anesthetists who have experienced opioid addiction and have been successful overcoming this challenge.

BACKGROUND
Nurse anesthetists share similar access to potent intravenous opioids as anesthesiologists. As there is less data regarding nurse anesthetists, much of the background for this study is provided by research on anesthesiologists. Historical evidence indicates relapse is twice as common among anesthesiologists with opioid dependence as in physicians with addiction problems in other specialties and that relapse rates are as high as 64% (Menk, Baumgarten, Kingsley, Culling, & Middaugh, 1990). Another study predicted that 5 of 25 opioid-dependent anesthesiologists will relapse within 5 years and 3 of 25 will die of drug-related issues (Alexander, Checkoway, Nagahama, & Domino, 2000). However, other evidence shows that rates for recovery among anesthesiologists are similar to physicians in recovery from other substances (Paris & Canavan, 1999; Skipper, Campbell, & DuPont, 2009). Although available evidence indicates that there can be successful reentry to the practice of anesthesia, little is known about what factors may facilitate successful recovery and return to anesthesia practice.
If return to the practice of anesthesia is the goal of an opioid-dependent recovering provider, demonstration of successful recovery is critical. “Successful recovery” used for this study was adapted from the Betty Ford Foundation Panel who defines recovery in terms of duration of sobriety (McLellan, 2010). Sobriety for 1–12 months indicates “early” sobriety, sobriety for 1–5 years indicates “sustained” sobriety, and sobriety for greater than 5 years indicates “stable” recovery.

Recovery is an individual process, influenced by a multitude of factors. One of the primary outcomes of successful recovery is abstinence from any addictive substances, especially for the nurse anesthetist who wants to return to the practice of anesthesia. Therefore, factors promoting recovery are protective against relapse. Several factors have been identified as having a positive influence on recovery and prevention of relapse for chemically dependent persons.

Among heroin users, research shows that family support, personal motivation, (Flynn, George, Broome, Simpson, & Brown, 2003), positive social environment, social life, and structured daily activities (Scherbaum & Specka, 2008) are factors associated with successful recovery. However, these studies use various definitions of success such as reduced heroin use and reduced criminal repercussions, which do not apply to healthcare providers.

Some findings indicate that recovery factors differ depending on the duration of sobriety. For example, helping others is part of the Narcotics Anonymous (NA) and Alcoholics Anonymous (AA) philosophy (AA World Services Inc., 2001a; NA World Services Inc., 2012); early in recovery, AA participants report more involvement in helping others with their immediate recovery needs, whereas those in stable recovery report more community-oriented help, such as community volunteer work (Zemore, 2007). Spirituality has also been identified as playing a protective role in recovery (Laudet & White, 2008; McLeod, 2011).

Unique to recovering anesthesia providers is the challenge of maintaining sobriety when return to practice means exposure to their drug of choice. The research of protective factors is limited, and there are likely a number of such factors at work in recovery from substance abuse and relapse prevention.

**METHODOLOGY**

The purpose of this qualitative research study was to explore and identify factors associated with return to work and successful recovery from opioid dependency among nurse anesthetists. Qualitative descriptive inquiry was used to identify and gain a deeper understanding of these factors, as this method provides a mechanism for understanding through the subjective experience as told in individual stories of recovery.

The sample was derived from the population of nurse anesthetists who had experienced anesthetic opioid dependency, undergone treatment, dealt with regulatory sanctions against their license that resulted in not practicing for at least 8 months, and successfully returned to the practice of anesthesiology (see Figure 1). After approval by the University of Alabama at Birmingham Institutional Review Board, participants were recruited through online advertising. An advertisement was placed on the Anesthetists in Recovery Web site, which is a national organization dedicated to the support of nurse anesthetists with substance abuse issues. Twenty-four potential participants contacted the investigator. Of those, 11 met all eligibility criteria; six returned completed consent forms. Data were collected through semistructured individual telephone interviews (see Figure 2).

**DATA ANALYSIS**

Content analysis was used to systematically and objectively categorize what the participants termed as factors helping to prevent relapse. This type of analysis can be applied to several varieties of communication such as media, written words, and in this case, verbal narrative (Neuendorf, 2002) and is a preferred technique for analyzing qualitative data (Sandelowski, 2000).

**RESULTS**

The demographic characteristics of participants are described in Table 1. The men all drank alcohol and experimented with various drugs during the 1960s and 1970s. One of the female participants described a similar history, whereas the other two rarely drank alcohol and did not abuse any substance until they were in their 40s. One began abusing after recovering from an injury. At that time, she injected herself intravenously with a nonsteroidal anti-inflammatory medication, ketorolac. She quickly progressed to injecting fentanyl and was caught about 6 months later. The other was dealing with family issues and frustrated with always being the “responsible one.” One day, “fentanyl looked like a solution.”

Fentanyl was the primary drug of abuse for five of the participants, although some used several opioids and anesthetic medications, depending on the availability. One participant used sufentanil exclusively. The average number of years of continuous sobriety for the participants was 10.7 years (range = 8–16.4 years). Two participants described having a coexisting mental disorder (i.e., major depression or bipolar disorder). These two participants also experienced at least one relapse early in their recovery and were treated with naltrexone at some point in their recovery.

The average time of opioid use before the participants entered recovery was 2.1 years (range = 6 months–5 years). In the case of the participant who concealed abuse for 5 years, the participant who concealed abuse for 5 years,

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**Figure 1. Eligibility criteria.**

<table>
<thead>
<tr>
<th>Criteria</th>
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<tbody>
<tr>
<td>1. Has been dependent on a potent anesthetic opioid</td>
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<tr>
<td>2. Has been treated for opioid dependency</td>
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<tr>
<td>3. Has had license sanctioned because of dependency</td>
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<tr>
<td>4. Was away from the practice of anesthesia for a minimum of 8 months</td>
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<tr>
<td>5. Is actively practicing as a nurse anesthetist with no narcotic restrictions on their license</td>
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<td>6. Has been abstinent for at least 5 consecutive years</td>
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**Table 1.** Demographic characteristics of participants.

<table>
<thead>
<tr>
<th>Participant</th>
<th>Sex</th>
<th>Age (years)</th>
<th>Years of Opioid Use</th>
<th>Years of Sobriety</th>
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<tbody>
<tr>
<td>P1</td>
<td>M</td>
<td>25</td>
<td>4</td>
<td>10 years</td>
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<td>P2</td>
<td>M</td>
<td>30</td>
<td>3</td>
<td>12 years</td>
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<tr>
<td>P3</td>
<td>F</td>
<td>28</td>
<td>5</td>
<td>8 years</td>
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<td>P5</td>
<td>M</td>
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<td>7</td>
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<td>M</td>
<td>40</td>
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<td>F</td>
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<tr>
<td>P10</td>
<td>M</td>
<td>33</td>
<td>7</td>
<td>8 years</td>
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</tbody>
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buccal administration of sufentanil was used. This method is very similar to sublingual administration, in that the liquid medication is placed directly in the buccal area of the mouth and absorbed very quickly. This type of administration enabled the participant to covertly use while in the operating room, avoiding the need for frequent breaks. Five of the participants were caught at work, whereas one admitted use and sought help. The results revealed an overarching topic that a complete commitment to the recovery process was necessary to prevent relapse. Within this major topic, participants indicated several factors that protected them from relapse and provided them the motivation to remain clean and sober (see Figure 3). These factors were ultimately grouped into two major themes: personal factors and external factors. Personal factors were those in which the participant described something from within, whereas external factors were described as factors found outside the control of the participant.

Although not coded per se, the Twelve-Step process, either through AA or NA, was credited by all as providing the foundation on which recovery was built. Participants found, learned, and developed their individual personal and external factors through the process of recovery. This was termed “working” their recovery steps, and all participants felt they could not have been successful without this work. An example of not working through the steps was given by one participant who, although she had not been caught at the time, she knew she had a problem and therefore attended AA meetings with a family member. During this time, however, she also lied about her sobriety at the meetings. She had quit drinking alcohol and taking other drugs but continued using sufentanil every 3–4 hours on a daily basis. When finally caught at work for diversion, she “got honest” with her AA group and “dove” into AA and remains active and sober today. For the two participants who told of their relapses, early recovery attempts were not associated with a Twelve-Step Program, and as described by one who did not use opioids for over 1 year, “hungrily, angrily, lonely, and tired, (I) started again.” After his relapse, he credited his successful recovery to his “total surrender” to the Twelve-Step process. It was “the only thing that worked.”

**Personal Factors**

Personal factors came from within a participant, although often were discovered or learned through the Twelve-Step process or counseling. These factors provided the structure that kept the participant on the path of recovery, protecting the participant from relapse, especially when dealing with stress or faced with a trigger situation. Factors identified included (a) removing the obsession with the drug(s) of choice, (b) self-realization, (c) seeing the future, and (d) inner strength.

**Removing the Obsession.** One of the participants said that, through AA/NA, “the obsession (to use) can go away.” This is extremely difficult to learn if not in a Twelve-Step Program, as recounted one of the participants:

> The first 18 months of my sobriety… I wasn’t in AA. I was just doing group therapy and on a little Zoloft, and it was just that obsession, it was so overwhelming. Even after 18 months of being dry, I couldn’t figure out how to live without using [how not to obsess over the drug].

Although he had not relapsed, it was not until he became fully involved in AA that the obsession subsided. None of the participants could completely explain how AA/NA removed

<table>
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<th>TABLE 1 Description of Sample</th>
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<tr>
<td>Age, years</td>
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<tr>
<td>62</td>
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Figure 2. Interview questions.
the obsession. However, they all credited AA/NA for relieving it. Someone summed it up by saying, “I really can’t put a finger on how the obsession goes away. It just does…. I really have to credit my Twelve Step Program.” Someone else felt, by staying close to his program, “the obsession is not there anymore.” Another revealed that, by working his Twelve-Step Program, “the obsession just got lifted on its own through [his] realization that, you know, this [using] isn’t good for me.”

For some, recognizing and treating underlying mental illness removed the need, or obsession, to self-medicate; controlling underlying illness was crucial for successful recovery. This sentiment was conveyed by one participant who said, “Now, I’m not saying I’m any different from any other addict out there, but with me I have to be on medication [for depression] and as long as I take the medication like they say and I do the things they say, and I go to work,
I don’t feel the need to [self] medicate myself. I am very fortunate…”

One participant learned to not act on his first thought or impulse, especially when these thoughts/impulses were about drugs: “Maybe I need to go with my third or fourth thought on something before I act…. I think that is how my obsession went away.” Another felt, once she got caught and the choice [to use] was taken away from her, the obsession was lifted and has never returned.

Self-Realization. Participants portrayed self-realization as a deep understanding of where they were before recovery and who they are currently. Five expressed how happy they were to be sober and working. For the most part, participants felt they had “the best job ever” and they “loved their career.” Keeping this realization forefront in their thoughts was key to maintaining their recovery, not only while at work but also outside the workplace as well. Statements such as “It’s absolutely essential to remember who I am and where I come from, because in a heartbeat, I could go right back there [abusing drugs]” was a common thread when discussing questions about preventing relapse. One person said about not relapsing, “…Because every time I go to a meeting I see somebody come through that door and the desperation and hopelessness that I see in their eyes and, when they share, I don’t want to be that person ever again.”

Realization also came from a humbling sense that addiction is a leveling disease; it affects all races, ages, and social classes. This awareness helped put things in perspective and prevented the egocentric thoughts of being able to handle everything if he or she began using again. The participants described a humility that kept their arrogance in check; they recognized they were no better or worse than anyone else. Participants understood and accepted themselves. This understanding and acceptance removed their fear of not meeting everyone’s (including their own) expectations. For example, it became all right to say “no” to working extra time and to realizing that everyone makes mistakes.

This humility was, for some, translated into helping others in similar situations. Giving of themselves fortified this self-realization. One half of the participants sponsored others or worked in their community helping other addicts in some way. Those who did give of themselves not only expressed a desire to prevent anyone else from going through what they did not want to be.

Seeing the Future. Another protective personal factor was the ability to use the trigger management technique described by several participants as “playing out the scenario.” This technique was characterized on some level by every participant. It involves having a clear understanding of where one is, where one was, and where one wants to be. When confronted with a trigger or cue to use, one is encouraged to think about the consequences if the impulse is acted on. As described by one participant:

I’m not going to deny that sometimes when I open up an ampule of fentanyl now, I don’t think about, “Oh, I remember this, I’d like to do this, but [if I do,] this is going to happen [getting caught], and this is going to happen [losing a job], and this is going to happen [ending back in rehab], and I don’t want that to happen.”

Another participant described that she “romanced” drug use in her mind but was able to recall her intervention, rehabilitation, and job loss. This recollection enabled her to step back from the situation and take a different path.

When confronted with triggers, one participant realized what he did not want to feel:

…I don’t want to feel that way anymore. I don’t want to feel guilty. I don’t want to feel like I’ve hurt somebody…whether it’s me, patients, or my kids. I don’t want to get up in the morning dreading going to work for fear of what I might do. I don’t want to feel like every time somebody looks at me funny I have to worry because they might want me to test today. I don’t want to feel that way.

Inner Strength. Inner strength comprises all factors related to an internal sense that one is confident he or she has the ability to avoid relapse and is closely integrated with the final step of the Twelve-Step process termed “spirituality” (AA World Series Inc., 2001b). According to the Twelve-Step process, this final step is the culmination of total surrender to a higher being and involves the integration of all other steps into a strength similar to what is termed by AA as “spiritual fitness.” For some, this inner strength, or fitness, was described as an internal honesty, which, if not maintained, would result in relapse. Spirituality cannot be visualized by others, as it is the personal gut level sense of, “I have the tools and I am okay. Because of this, I go into any environment and handle the situation.” One person was told, “You are the only one that is going to know whether or not you are spiritually fit because you are the only one that knows what is going on in the inside.” As noted by another participant, “Being honest with myself keeps me sober.” Similar statements were common throughout all interviews. Another person explained how God provided her with this inner strength. She described a “God-shaped hole” in her soul that was filled with God. She took a daily check on her spiritual maintenance; if she deemed herself spiritually fit, she then could go anywhere and do anything without being afraid of drugs or anything else.

External Factors
Aspects of one’s external environment were those factors out of one’s control. These factors were also credited with supporting their recovery. Such factors included (a) getting a chance, (b) time, (c) state regulatory agency involvement, (d) work environment, and (e) talking with others. Getting a Chance. Every participant expressed that their success was dependent on, at least partially, someone willing to take a chance on them by allowing them to work. Either the hospital administration or an individual provided participants the opportunity to work in anesthesia again. Three of the six participants were not fired or forced to resign from their job
because of their dependence. Their jobs were modified to accommodate contracts with their State Monitoring Agency; they were able to function as a nurse, performing preoperative assessments or monitoring patient care in the post-anesthesia care units. Neither of these responsibilities required direct patient care or administration of any medications. These three participants were also able to transition back to the operating room once permitted by their State contract.

Others struggled finding someone caring enough, or desperate enough because of staffing issues, who was willing to “take a chance” on them. One person credits his ability to find a job to the fact that, after looking in several places for a job, he found one in which the Chairman of the Department of Anesthesiology had a father who was an alcoholic and active in AA.

One woman felt her chance was the number one reason she was successful in returning to work. When her contract allowed her to return to practice, she was initially turned down by her previous anesthesia group. She had to come to terms with the fact that returning to practice might not be an option. However, there was another anesthesiologist in the same system, but worked for a different anesthesia group, who offered her a job telling her, “Everyone deserves a second chance.” She feels that, without this opportunity, she would not have been able to return.

**Time.** Several participants expressed how time away from contact with anesthesia drugs helped them to overcome the addiction. One participant, who was away from the practice of anesthesia for 3 years, felt this time frame helped reduce the obsession to use. He worked on his recovery program during that time, in order that, when he went back, he was armed with other tools to handle triggers. One, who began abusing after she was 45 years old, worked in a preoperative clinic for 8 months during her initial recovery. She was invited by one of the anesthesiologists to work for nurse anesthetists taking vacations, and this was her reentry into anesthesia practice. For her, this time frame helped her avoid relapse.

The participants in this study had been in recovery for several years, and they all iterated that the strength of feelings associated with triggers had decreased over time. Most described a sense of amusement or interest when presented with a trigger today. One participant noted: “...but I got through it, after the first year or two year cycle [dealing with triggers]. But I have to tell you, that we got a new doc six months ago, you know. And, and he decided he liked Dilaudid [i.e., hydromorphone, used to treat surgical pain for patients], you know. He had Dilaudid in his little boxes now and my first thought was, “Huh, I never did this before,” but now I don’t even notice it [Dilaudid]. It’s just kind of interesting how that works out... I just chuckled.”

Another laughed when telling how he realized he had not used a restroom in the operating suite for years. This was not a conscious choice; he had just avoided them since his recovery, and he did not discover this fact until he was talking with others about triggers. This avoidance was an unconscious desire to prevent a trigger situation.

**State Regulatory Agency Involvement.** Agreements and contracts mandated by state regulatory agencies were most influential factors during the first few years of recovery. Everyone’s contracts varied, but all six participants were mandated to attend AA and/or other meetings, report to their agency routinely through paperwork or face-to-face meetings, and undergo random urine drug screens for a specified period. Early in the recovery process, these contracts were protective, if for no other reason than fear. “The Board of Nursing will sober you up,” one person described. Although these contracts “didn’t come close to an actual Twelve-Step Program [in preventing relapse],” if remaining a nurse anesthetist was the goal, “crossing your Ts and dotting your Is” was a big factor. “They were definitely the fear factor.” (If interested in comparing state programs for chemical dependency, see http://webapps.aana.com/Peer/directory.asp?State=KS.)

Accepting the contract and recognizing the need to “jump through the hoops” played a role in successful completion of the contract but also fostered internal motivation on the part of the person to stay sober. One participant has sponsored several young women in her Board of Nursing Diversion Program and has witnessed their anger and defiance directed at doing what is required of them (i.e., complying with their contract). Her response to their defiance was, “Oh my God, you know, do you want your life back? Then shut up and do what they say!”

Fear was not the only protective factor provided by these agencies, however. It was also recognized in early recovery that trusting one’s own ability to control his or her life had not been successful to this point; therefore, it was helpful to rely on something or someone who knew more. It was recognized that regulatory agencies provided a mechanism for success, even if the process was not completely understood. One person completed her State Peer Assistant Group agreement after 2 years, just as her Board of Nursing increased the agreement time for Advance Practice Nurses to 3 years. She figured this was done to increase the chance of success in recovery, so although she was not required by the state to attend meetings and so forth, she was “suspicious” that her third year was going to be difficult. Taking the lead from her State Board of Nursing, she made very few changes to her program during that year and acted as if she still had an agreement.

**Work Environment.** Whether the staff and operating room team knew about the participant’s history varied. No one hid the fact that he or she was in recovery, but in many instances, the information was given on a need-to-know basis. However, for some, putting their history out on the table helped them. This was definitely accepted if they already knew “they’re going to be difficult. Taking the lead from her State Board of Nursing, she made very few changes to her program during that year and acted as if she still had an agreement.

Talking With Others. Talking with others helped some when they were faced with a trigger situation. Even recently, one...
woman described going to the restroom immediately after getting her patient settled in the postcare unit and realized she had some leftover Demerol (a commonly used opioid to treat pain after surgery) in her pocket. Being in the restroom, when she realized this was a trigger for her and her way of dealing with it was to immediately leave the restroom, find a close coworker and tell her the story; just talking about the trigger made it subside. Others, especially early on, would call someone such as their AA/NA sponsor when something along these lines happened. They realized they were not thinking rationally and needed to listen to someone who knew better. Another person was working in a preoperative clinic performing assessments when she was told the anesthesia group she had worked for would not allow her to return to their practice. She was devastated, and her way of dealing with the situation was to attend an AA meeting during lunch that day and share her disappointment. Doing this helped her accept the choice made by her employer.

DISCUSSION
It is clear that returning to the operating room after recovery from opiate dependency is challenging. The results of this study provide a snapshot of some of the factors that protect recovering nurse anesthetists from relapse when they return to practice. It is also clear that relapse prevention cannot be attributed to one particular factor; rather, the successful return to anesthesia practice requires a deep commitment to the entire recovery process, encompassing a desire to change, plus the tools to make and maintain that change. Protective factors described in this study provided the motivation and tools necessary to maintain that commitment.

The Twelve-Step process provided the structure through which these changes were made. Almost all participants articulated that continued involvement in a Twelve-Step program was crucial in their recovery. It was evident that successful recovery was more than attending meetings, however. It meant painstakingly working through the Twelve Steps continually. Someone stated, “AA is the steps, not the meetings.” This involved embracing their addiction and their desire to change and realizing it could not be done alone.

Self-realization is a personal inventory of where one is, and it provides the motivation to stay there. The self-realization of not wanting to hurt others anymore, keeping his or her job, wanting the best for their children, and not wanting to feel guilty are just some of the motivational influences described by participants. This personal factor provided motivation for accepting the recovery process and the willingness to work the Twelve Steps. Self-realization was manifested as an awareness of where the individual came from and the strong commitment to never return to that place. Removing the obsession was another of the most common protective personal factors described in this study. Eliminating the desire to use allowed participants to work on the Twelve Steps and make the necessary changes so the obsession did not return.

The need for trigger management was described by all participants. As showed by imaging the addicted brain, the presence of a trigger can stimulate a craving (Volkow et al., 2008). If not armed with the proper tools and inner strength to control this desire, the ability to just say “no” is gone. Figuring out how to deal with these situations is crucial with any recovery program but is especially important when one will be facing these triggers on a daily basis. The Twelve-Step approach and counseling include teaching a variety of strategies to deal with triggers.

Spirituality is often considered a major influencing factor in sobriety (Laudet & White, 2008). Although it was noted in this study, spirituality was more integrated into the factor of “inner strength” than standing out on its own. Some talked about surrendering to a higher being and trusting that higher being to guide them; although more often than not, spirituality was subtly described when they talked about looking inward and feeling a sense of fitness brought about by conquering the Twelve Steps and, if necessary, treating their underlying mental disorders.

External factors were those factors over which the participant had less control. Of these, having someone take a chance on them was particularly important. This factor was described by most of the participants, and although one participant credited this factor as the most influential factor, getting a chance did not appear to be protective as much as a means by which they were able to get a foot back in the door and prove themselves. The other external factors seemed more protective early on in their recovery, when participants were still figuring out the recovery process. Participants had little control of factors such as the conditions set forth by their state contract, including how much time was spent away from practice. For some, this time was longer because of difficulties finding someone to take a chance on them. Whether the participant agreed with their contract did not matter; all participants accepted and complied with their stipulations. None described their interaction with their regulatory agency as adversarial; in fact, the importance of diplomatic compliance by participants was stressed. Whether this interaction was thought of as protective varied among the participants, although random urine drug screening was definitely a deterrent to using.

Talking with others was a factor that was especially protective when first returning to work, although some described recent circumstances in which talking with others helped them through a trigger situation. The participants recognized the importance of bouncing thoughts off others for confirmation of appropriate thinking or for a redirection of inappropriate thoughts.

This study illustrates the strength of the commitment that must be made to prevent relapse, and it was the hope of the participants that others in similar situations find something that could help prevent relapse. The results from this study also help inform those who do not have chemical dependency. Because of the focused nature of the selection of the participants, findings from this study are not generalizable to past practicing nurse anesthetists who are in recovery from opioid dependency. The voice of those who were not successful in returning to work could provide another facet of the problem, although accessing that population would be
very difficult. As well, propofol abuse is on the rise, presumably because of the lack of regulation, (Early & Finver, 2013) and is another area needing research.

REFERENCES


