The attached are Primary Source Documents of the Idaho Board of Nursing for:

COLLETTE LEEDS MAHONEY
N-19375

Idaho Board of Nursing – PO Box 83720 – Boise, Idaho 83720-0061 – (208) 334-3110
Collette Leeds
2211 Cornhusk Court
Boise, ID 83706

Dear Ms. Leeds:

Following their review of written materials and their meeting with you on February 18, 1999, the Board of Nursing members took action to issue you a limited license with conditions for two years, upon receipt of the $90.00 fee required under IDAPA 901.04a. The conditions of limited licensure are indicated on the attached Acknowledgement of Probationary Limited License and Monitoring Conditions form. You will need to affix your signature and return this form with the fee. A copy of the signed form will be returned to you with your limited license and forms to assist you in submitting your reports.

Motivation to assume responsibility for the submission of reports is an important aspect of recovery. Therefore, no reminders will be sent by the Board of Nursing to notify you in advance when reports are due. It is expected that reports will be submitted in a timely manner. Reports may be faxed (208/334-3262) to aid in their timely submission. All reports should be submitted no later than the 30th of the month in which they are due.

The probationary limited license may be withdrawn and shall be surrendered upon demand, without prior notice or hearing, in the event the Board of Nursing or its staff receives information or evidence that any of the conditions of the Probationary Limited License have been violated.

Please contact me if you have any questions concerning the Probationary Limited License or the conditions.

Sincerely,

SIMONNE deGLEE, MSN, RN
Associate Executive Director

SdG:ihc
September 2, 1998

Collette Leeds
2211 Corn Husk Ct
Boise, ID 83706

Dear Ms. Leeds:

Thank you for meeting with the Board of Nursing members during their August 26-28, 1998 meeting. The Board also appreciated the time and effort of your daughter and counselor in testifying on your behalf. The Board recognizes the progress you have made in recovery up to this time and would like to see evidence of continued recovery. As discussed in our telephone conversation of August 31, 1998, the Board has elected to deny your request for reinstatement at this time. The Board would like to receive documented evidence of a longer period of recovery. When you reapply for reinstatement, you must submit the same materials as were required previously in addition to evidence of continued recovery.

The Board members also expressed the need to see evidence that you comprehend the disease process of addiction, and need to be convinced that you are safe to practice as a nurse. A demonstration to the Board that you have researched the disease process, that you fully understand the issues of co-dependency, relapse, work-stress and how that might impact your nursing practice, might better convince the Board that you are ready for reinstatement of licensure.

The Board is charged with protecting the health, safety and welfare of the public through regulation of nursing practice. The Board must be assured that patients are not at risk under your care.

If you have any questions concerning this information, please contact me at the Board office (208/334-3110 ext. 21).

Sincerely,

SIMONNE deGLEE, MSN, RN
Associate Executive Director

SdG:lhc
THE DISEASE PROCESS OF ADDICTION:  
INCLUDING ISSUES OF CO-DEPENDENCY, RELAPSE AND STRESS.

By

Collette M. Leeds

Board of Nursing  
State of Idaho  
January 15, 1999
The purpose of this research paper is to address the disease process of addiction, including alcoholism. It includes the causes and contributing risk factors of genetics and environment and their effects.

This paper will also address the issues of codependency, relapse, stress, including work related stress, and ways in which they can affect nursing practice.

One of the earliest models of the disease concept of addiction that many experts and researchers have utilized throughout history is Jellineks model in 1940. This model describes addiction as a disease with supporting signs and symptoms.

Most definitions describe addiction as an uncontrollable, overwhelming process. Landry (1994) p.11 states “addiction can be described as a progressive, chronic, primary disease, that is characterized by compulsion, loss of control, continued drug use despite adverse consequences, and distortions in normal thinking, such as denial.”

Furthermore Landry (1994) also describes addiction as a disease, therefore (p.11) “a disease is a pathological condition accompanied by several characteristic symptoms and signs...diseases generally have a predictable prognosis”... “Disease also means an involuntary disability meaning that the state of the illness is not deliberately pursued.” One does not purposefully become chemically dependent. It is not a choice. Hence, the first step of Alcoholics Anonymous and other 12 step recovery programs; we admitted we were powerless over alcohol (drugs, etc.) and that our lives had become unmanageable. It is near impossible to begin the healing process without this vital step. If we dangerously think we still have some control over this disease we cannot fully surrender to a Higher Power, the program, or treatment and therefore healing.
Shewey (1997) gives another definition (p. 118) “Chemical dependency is a chronic, progressive, relapsing illness that is treatable. There is no complete cure and treatment is ongoing.” In other words, recovery is every day for the rest of my life. I will never be cured. There is only treatment. It is chronic. As we say in AA, we have a daily reprieve contingent upon our spiritual condition.

It was thought at one time that addiction was primarily a psychological disease and “perhaps the most important development in the field of addiction medicine has been the realization that addiction is a biopsychosocial disease. The nature versus nurture argument has been replaced by the awareness that addiction is the result of nature plus nurture. Indeed, addiction is the result of a complex interplay between numerous biological factors and several environmental factors,” (quoted in Landry p.12).

Addiction is cyclic in nature, that is, substance abuse causes problems in the individuals life which gives way to the addicted individual to perpetuate use. This compounds social, physical, emotional, and psychological problems which add to the continued use. Until the pattern and cycle are broken, by either death or recovery, the active disease of addiction continues.

I very much relate to Perkinson’s (1997) writing from a first person perspective of (p.117) “The promise of the disease-When we are lonely enough in this process, when we are isolated enough, when we are hurting enough, the illness comes along and offers us a smorgasbord of answers to our pain. Sex, money, power, influence, drugs, gambling, and alcohol are all there, and more, and we begin to feed from this cafeteria of sin. For awhile
things get better. All of these things relieve our pain for a little while. We find ourselves irresistibly drawn to this table of wrongs. We spend more time doing it. We eat, drink, stuff, cram, push, and shove. We find that more and more of our life centers around the use of these things. We get up on the table and stuff ourselves. We begin to lose our morals and values. We eat and consume, and vomit, and stuff ourselves even more. In time there is never enough. There is not enough sex. There is not enough money. There is not enough power. There is not enough booze. AA says one drink is too much and a thousand never enough. To conclude, in rehabilitation and in meetings, we learn that the using and drinking are merely symptoms of our disease.

More and more drugs, alcohol, control, and power became the solution to my problems. Thus they became my way of life until finally I landed in rehabilitation. There they introduced me to the program of Alcoholics Anonymous. In turn, 12 step recovery has become my solution to life, not only providing a solution to the problem of alcoholism and addiction. The program not only benefits me, but shows me how to contribute to society and have purpose toward and usefulness to society, thereby benefiting society as well.

The progression of the disease is complex and many of us speak of “crossing the line.” We could no longer live with or without drugs and alcohol. This left us with two choices—recovery or continued addiction.

Alcoholics Anonymous (1939) describes the progression in stages, beginning with stage one (p. 109) “His drinking may be constant or it may be heavy only on certain occasions. Perhaps he spends too much money for liquor. It may be slowing him up mentally and physically, but he does not see it. Sometimes he is a source of
embarrassment… He is positive he can handle his liquor, that it does him no harm… He would probably be insulted if he were called an alcoholic. The world is full of people like him. Some will moderate or stop altogether, and some will not. Of those who keep on, a good number will become true alcoholics after a while. Stage Two: … He is unable to stay on the water wagon even when he wants to. He often gets entirely out of hand when drinking. He admits this is true, but is positive that he will do better. He has begun to try… various means of moderating or staying dry. Maybe he is beginning to lose his friends. His business may suffer somewhat. He is worried at times, and is becoming aware that he cannot drink like other people. He sometimes drinks in the morning, and throughout the day to hold his nervousness in check. He is remorseful after serious drinking bouts… But when he gets over his spree, he begins to think once more how he can drink moderately next time. We think this person is in real danger. These are the earmarks of the real alcoholic. Perhaps he can still tend to business fairly well. He has by know means ruined everything. As we say among ourselves, he wants to want to stop.

Stage Three: ..Has gone much farther than number two. Though once like number two, he became worse. His friends have slipped away, his home is a near wreck and he cannot hold a position. Maybe the doctor has been called in, and the weary rounds of sanitarium has begun. He admits he cannot drink like other people, but does not see why. He clings to the notion that he will yet find a way to do so. He may have come to the point where he desperately wants to stop but cannot…. Stage four: ..He has been placed in one institution after another. He is violent, or appears definitely insane when drunk… Perhaps he has had delirium tremens. Doctors may shake their heads and advise…. To have him
committed. This picture may not be as dark as it looks. Many were just as far gone, yet they get well.”

As research continues in this field it is generally agreed upon that genetics and biology play a significant role as contributing risk factors. (Landry p. 150) states “...current research may reveal that some alcoholic people are deficient in specific neurochemicals. In addition, the study of genetics is helping to describe individuals at risk for developing alcoholism when exposed to alcohol,” and “research studies have confirmed that alcoholism tends to run in families in a pattern that is consistent with a genetically transmitted susceptibility.” Certainly genetics are only one risk factor as Blow and Hill (p.1511) state “substantial evidence supports the long held notion that alcoholism runs in families; however, while having a relative with alcoholism increases an individuals chances of developing alcoholism, it does not guarantee that outcome... it is a complex trait.”

Similarly, Landry (p. 151) writes “not every person with a family history of alcoholism will become alcoholic after drinking alcohol. There is a grave risk, but having genetic predisposition for alcoholism is not a guarantee of automatically becoming alcoholic.” Most importantly, “what is inherited is a predisposition for developing alcoholism.” And “people born without this genetic risk factor can be exposed to other risk factors that may also increase the probability of alcoholism. In other words, while important, hereditary is only one of several risk factors.”

Environment may play a significant role as well. For example, Mynatt (p.15) reports “findings indicate that the nurses come from chaotic families with alcohol and drug abuse, suffered victimization and developed low self esteem.”
Mynatt (1996) best gives an example of the progression from an environmental standpoint; (p. 19) "As the product of a chaotic family forms a new family, the family continues to be chaotic because developmental tasks were never accomplished. Further problems occur with the development of relationships with others and the self. Poor choices that include alcohol and drug use, abuse, and dependence, further erode self esteem. A chaotic life style results in more pain and suffering. Because problem solving, interpersonal, social, and coping skills are not adequately developed, one has difficulty handling stress and may go from one crisis to another, continuing the chaos. Thus one sees a continuing cycle with further erosion of self esteem, increased guilt, and depression, and further need to numb oneself from reality." The using becomes the answer to life. The individual caught in the cycle typically denies a problem.

Unfortunately, denial is a symptom, and part of the process as well. As with all chronic diseases Landry (p. 142) defines; "...denial is an unconscious, irrational defense mechanism in which the individual fails to perceive and acknowledge an important objective truth that is obvious and apparent to others. It is protection of the self from the unpleasant reality by an unconscious refusal to perceive it."

Furthermore Perkinson (p.115) states "the most characteristic of chemical dependency, is denial. Denial is a stubborn, angry refusal to see the truth. Here we refuse to see what is right before our eyes. We block out what is real until we really don't see it at all."

Another way we use defense mechanisms is through minimization. This is when we take reality and make it smaller. Other defense mechanisms chemically dependent persons
use are rationalization, intellectualization, and repression. They feed the monster that has manifested and become an inherent part of the disease.

The disease has early, middle, and late stages; In the early stage delusion is present and the person cannot see the problem. In the middle stage there is significant denial. The individual is beginning to have problems but justifies these by placing blame. In the late stage the individual cannot think clearly and therefore cannot relate use to problems such as financial and family problems.

Shewey (p.115) gives a “Definition of impaired Nursing Practice...Impaired nursing practice occurs when...the nurse is unable to meet the requirements of the code of ethics or standards of practice as a result of alcohol, drugs, or psychiatric illness that interferes with their cognitive interpersonal or psychomotor skills.” Thus the safety and well being of patients is the first priority when addressing issues of chemical dependency and how it relates to nursing practice. As Shewey (p. 115) states “the nurses primary responsibility is to the safe guard the resident. An impaired nurse cannot fully do this...care by a chemically dependent nurse may include lack of response to the residents (patients) changing condition or need for treatment, inaccurate assessment or documentation of the residents condition or response to treatment, unrelieved pain by the resident, giving the wrong medication or treatment...and physical or mental harm related to the nurses inability to accurately carry out the nursing responsibilities.”

Simply put, we became nurses so that we could help people. A nurse that is actively using drugs and/or alcohol, in the depths of the disease, opposes advocacy and may pose a serious threat to patients. Fortunately with treatment and in recovery, nurses can give very safe and effective care which is expounded upon later in this paper.
In AA we talk about living life on life’s terms. As alcoholics (addicts) we dealt with stress by using alcohol and drugs. We had to be given new ways to cope— a new set of tools, to function healthy. “Patients have been using chemicals to deal with the uncomfortable feelings caused by stress” and “chemically dependent patients need to do three things: (1) relax twice a day (2) maintain regular exercise (3) learn coping skills for dealing with stressors.” (Perkinson p. 98.)

In the program of Alcoholics Anonymous we are taught to relax by using prayer and meditation. We learn new coping skills by practicing the 12 steps of recovery in all of our affairs. This is highly effective. I have just recently completed the 12 steps for the first time. This does not mean I am done. As covered earlier, recovery is ongoing. But I am ready to sponsor other alcoholics and share my experience, strength, and hope.

Landry (p. 152) describes “The twelve- step programs are more than meetings. In fact, the core of the programs are the twelve-steps themselves. The twelve steps are suggestions for living a healthy life. They are recommendations for emotional, psychological, social and spiritual growth.” The process, which often takes many months or years, is growth oriented.

Certainly, a grave concern of stress is the possibility of relapse. One third of the people who enter treatment stay sober. One third of these people relapse four to five times and end up dying sober. Sadly, the last third become sober only to relapse, never to recover again. According to Perkinson the most crucial period is within the first 3 months of recovery. Typically a chemically dependent person will “begin to feel themselves under stress. Their new tools of recovery are not used, so the problems continue to escalate.
They reach a point where they think their only option is to drink or use drugs.”

(Perkinson p. 97).

As pointed out earlier, the 12 step recovery program is my solution to life so “patients who are working a daily program of recovery will not relapse. You can’t work the program and use at the same time. They are incompatible.” (Perkinson p. 97). Perkinson also supports taking a daily inventory. In AA we refer to the tenth, eleventh, and twelfth steps as maintenance steps; The tenth step instructs us to take an inventory at the end of each day along with prayer and meditation. Inventory involves taking honest stock of our day. Looking for patterns of misbehavior we are encouraged to tell another (supportive) human being and make amends as soon as possible. The eleventh step instructs prayer and meditation at the beginning of each day relying on a power greater than ourselves to help us throughout the day. The twelfth step tells us we are responsible for carrying the message and to help others.

The tenth step promises “by this time sanity will have returned. We will seldom be interested in liquor (or drugs). If tempted, we recoil from it as a hot flame. We react sanely and normally, and we find that this has happened automatically….we are not fighting it, neither are we avoiding temptation. We feel as though we have been placed in a position of neutrality: safe and protected.” (AA p. 85).

Relapse begins before the first use of a chemical. In AA we call this old behavior. It has also been referred to as relapse thinking. Landry (p.185) further explains “the relapse process often includes reactivation of denial as a prominent defense mechanism, a tendency toward isolation,… impaired judgment and decision making, poor coping with
periods of stress." This is why it is important having friends in recovery and going to meetings, in other words, fellowship of AA is so important.

Perkinson speaks directly to the recovering individual (p.277) “All relapse begins with warning signs that will signal for you that you are in trouble. If you do not recognize these signs you will decompensate and finally use chemicals.” All of the signs are a reaction to stress and they are a re-emergence of the disease... You will have some of them (symptoms) long before you actually use chemicals. For example “Apprehension about well being, defensiveness, tunnel vision, loneliness, loss of constructive planning, feeling nothing can be solved, and periods of confusion” are but a few symptoms of relapse thinking. A daily inventory checks this thinking and the behavior that goes along with it, so that we may take the appropriate action to deal with these insidious warning signs.

Smith and Hughes (p. 34) make a strong point in argument of the “understandable objection that the possibility of a relapse presents too much of a risk to patients. But numerous reports in the literature have documented that re-entry programs protect patients safety... the National Council of State Boards of Nursing has endorsed re-entry programs as a means of protecting patient safety.”

Smith and Hughes (p.33) give further stipulations for safety sake; “to reduce the risk of relapse” and ensure patient safety, such as “wasn’t permitted to carry narcotic keys or administer controlled substances for at least the first six months” after treatment, and “wasn’t allowed to work overtime, rotate shifts, or be pulled to other units to work” this will “provide a stable environment with consistent supervision and minimal disruption of aftercare.” Furthermore, “it affirms that chemical dependency is a treatable disease,
which makes it more likely that other chemically dependent employees will come forward and seek help."

Some experts and recovering persons agree and support relapse as part of recovery. Smith and Hughes (p. 34) support this; nurses “relapse once and learn from the experience to develop a stronger recovery program and support network.”

It has been my experience having talked with, interviewed and listened to individuals who have relapsed nurses included- that they quit ‘working’ a daily program of recovery and began to think of themselves as ‘cured.’ If we compare chemical dependency, a chronic illness, to another chronic illness such as diabetes (as I have recently been diagnosed with insulin-dependent type 1 diabetes), we will see similarities in treatment. For instance I monitor my blood glucose four times a day and take the necessary action i.e. insulin. I also must obtain education and have frequent visits with my doctor, among other things. This is to maintain tight control to prevent complications and even death. Similarly, I must have a daily program of recovery from the disease of addiction. The twelve steps, are my medicine. If I do not ‘take’ my medicine every day I will most likely die of the disease. I do not have control of the disease, or a cure, I only have treatment. As long as I am active in recovery everyday, I will not relapse.

Smith gives guidelines for reentry; (p.33) "The decision as to whether a nurse should return is best made by the nurse himself, the primary counselor or treatment team, and the nurses supervisor. It should be based on the nurses progress in recovery, cognitive and decision making skills, ability to handle stress (as evidenced by how the nurse has coped with treatment), and whether people are available to support the nurse at work and at home. Thoroughly assessing these factors in combination with a strong re-entry program,
helps ensure that the nurse can practice safely, and improves the prospects for successful recovery.” Re-entry benefits all who are involved.

CODEPENDENCY

Addiction starts with codependency. All addicted people have codependent traits, such as the need to control others and focusing and obsessing about others behavior. Some experts agree we could put the word ‘drug’ in the place of behavior of another person. The bottom line is we were looking outside of ourselves to ‘fix’ our problems. Although most of us claimed to have no problem (denial) and blamed others before coming to recovery. Codependency is an addiction as explained by Whitfield (1991) (p. 4)

“Codependence is the most common of all addictions: the addiction to looking elsewhere. We believe that something outside ourselves—that is outside of our true selves—can give us happiness and fulfillment. The elsewhere may be people, places, things, behaviors or experiences. Whatever it is, we may neglect our own selves for it,” and “Codependence is not only the most common addiction, it is the base out of which all of our addictions and compulsions emerge.”

Furthermore, Landry (p. 144) states “the hallmark feature of codependence is the ongoing and excessive trait of pleasing other people while depriving oneself. Although in certain circumstances this behavior may be noble and generous, in the codependent person it is an inflexible, enduring pattern that causes suffering, dysfunction, and impairment.”

On the flip side Larsen and Goldstien (1993) explain (p.1) “though often related, codependency and chemical dependency are not the same thing”, but go on to say, “a codependent relationship is a destructive one in which two people facilitate each others
dysfunctional habits. Codependency is caused by those very self defeating, learned behaviors, that diminish our capacity to initiate or participate in healthy, positive relationships. These dysfunctional behaviors are, in a way, 'behavior addictions' and can be just as powerful as any substance addiction."

The environmental risk factors of codependency are similar to chemical dependency (if not synonymous). For instance, persons raised in an environment where there was alcohol and drug abuse and/or other types of abuse—mental, physical or sexual, "that women with alcoholic parents often developed codependent exploitive relationships with men and they seek excessively dependent relationships because they are driven by the need to validate their self worth through their relationships" (Mynatt p. 14.)

According to Larsen and Goodstien (p. 4) "codependents have difficulty participating in healthy relationships precisely because they lack crucial characteristics" such as "adequate self-esteem and sensitivity, generally self-enhancing behavior patterns and the ability to establish a suitable level of commitment."

Therefore in the issues of chemical dependency and codependency, the family, as a whole, must be treated for any one treatment of a family member to be effective. In the big book of Alcoholics Anonymous, these issues are addressed in the chapters "To wives" and "The family afterwards."

I spent a great deal of time trying to 'fix' other people. I spent most of my time, energy, and thinking on issues related to addicted people, rather than satisfying my own needs. One reason I did this was so I wouldn't have to deal with what was really going on with me. I was depending and looking on outside things (relationships, drugs) to solve my problems. My main problems were low self esteem, feelings of inadequacy, fear of
abandonment, and the list goes on. My whole way of dealing with life was unhealthy. Therefore, the treatment for codependency mimics that of treatment for chemical dependency. Whitfield (1991) suggests group therapy, a 12 step program, individual counseling, education and then recommends conjoint family counseling if in advanced recovery or crisis, (so that one does not expect to fix any family member).

Larsen and Goodstien (p. 42) describe the effects of codependency within the workplace. They label a few ‘codependent personalities’; caretaker, perfectionist, people pleasers, and so on. “it is only overindulgence that creates problems. The nurturing habits of care-taking, the quality standards of perfectionists, the social skills of people pleasers…can be self-enhancing. They do not become a dysfunction until they are carried to extremes.” For instance, I can identify strongly as a codependent caretaker. I not only took care of the needs of others I defined those needs. (Larsen and Goodstien.)

In the workplace cooperation and teamwork are crucial to success. Not only was I a caretaker but a perfectionist at work as well as at home. So “perfectionists are absolutely intolerant of imperfection. Nothing is ever done fast enough or well enough or nothing is prepared in the proper quantity,” so “obviously they are not happy people or very easy to be around, so when it comes to teamwork the perfectionist is a real detriment.” (Larsen and Goodstien p. 42).

Just as with chemical dependency there may be relapse thinking in codependency. This also would constitute ‘old behavior’ in AA.

Nevertheless, I feel it is important to understand that my growth and recovery are processes—there is no destiny only continuation of recovery. As I said before, I have completed the 12 steps, ready to sponsor (currently beginning sponsorship) and carrying
the message and helping other recovering alcoholics (addicts). I am also in the process of being approved to chair AA meetings at the Ada County jail. In AA we consider service, unity and recovery (symbolized by the three-sided triangle a AA) vital to our continued sobriety. I am not cured, it is a continuum, but I hope that my experience, strength and hope will benefit and help other alcoholics (and addicts).
REFERENCES


