"*A Two Glass of Wine Shift*": Dominant Discourses and the Social Organization of Nurses' Substance Use

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Abstract

We undertook an institutional ethnography utilizing the expert knowledge of nurses who have experienced substance-use problems to discover: (a) What are the discourses embedded in the talk among nurses in their everyday work worlds that socially organize their substance-use practices and (b) how do those discourses manage these activities? Data collection included interviews, researcher reflexivity, and texts that were critically analyzed with a focus on institutional features. Analysis revealed dominant moralistic and individuated discourses in nurses' workplace talk that socially organized their substance-use practices, subordinated and silenced experiences of work stress, and erased employers' roles in managing working conditions. Conclusions included that nurses used substances in ways that enabled them to remain silent and keep working. Nurses' education did not prepare them regarding nurses' substance-use problems or managing emotional labor. Nurses viewed alcohol as an acceptable and encouraged coping strategy for nurses to manage emotional distress.

Introduction

Nurses' problems with substance[1] use can pose serious risks to their health and well-being (Kunyk, Inness, Reisdorfer, Morris, & Chambers, 2016) and potentially compromise the provision of safe, competent nursing care to the public (Kunyk & Austin, 2011). Estimates of the prevalence of nurses' problems with substance use in Canada and the United States range from 6% to 20% (Dunn, 2005; Kunyk, 2015; Monroe & Pearson, 2009; Servodidio, 2011). New enrollees in substance-use monitoring programs for nurses in the United States and its territories in 2009 comprised 0.36% of the national nursing population (Monroe, Kenaga, Dietrich, Carter, & Cowan, 2013). We found it particularly concerning that many nurses with such problems are reluctant to obtain help and remain in practice (Bell, McDonough, Ellison, & Fitzhugh, 1999; Kunyk, 2015; Monroe et al., 2013). In one study in the Canadian province of Alberta, more than 90% of the nurses who self-identified as having problems with substance use were actively practicing and had not sought treatment (Kunyk, 2015).

Our concern with this serious issue arose from firsthand knowledge of both the everyday work lives and substance-use practices of nurses. Many of our nursing colleagues have lived with substance-use problems, either in secret or, if discovered, in disgrace. Tragically, some did not survive. This perspective was our entrée into a study of what, within the complex work worlds of nurses, might socially organize the conditions for them to have such problems and to be reluctant to seek help when they do.

Our next step was to review scholarly literature (Ross, Berry, Smye, & Goldner, 2018). Dominant concepts used to explain nurses' perspectives of substance-use problems, such as stigma (Darbro, 2005), negative attitudes (Howard & Chung, 2000), and the culture of the nursing profession (Darbro & Malliarakis, 2013; Solari-Twadell, 1988) permeated much of the existing research. Numerous

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conceptualizations of substance-use problems were also offered, such as problematic substance use (College of Registered Nurses of Nova Scotia, 2017), substance-use disorders (Monroe, Vandoren, & Smith, 2011), addiction, and substance abuse[2] (Monroe & Kenaga, 2010). Popular themes of contributory factors also pervaded: stress (Storr, Trinkoff, & Anthony, 1999; Trinkoff & Storr, 1998), nurses' access to drugs (Dittman, 2008; Kenna & Wood, 2004b), and nurses' attitudes toward substance use (Kenna & Lewis, 2008; Lillibridge, Cox, & Cross, 2002). However, a critical interrogation of how these very concepts and themes originated and were constructed was notably absent. We found ourselves puzzled about how these abstract concepts and themes connected to what we knew about nurses' actual work lives and substance-use practices, and believed that there was much more depth and texture to the story than was being told. Moreover, the nursing literature on the topic was dominated by quantitative research, with precious few qualitative studies that used the experiential knowledge of nurses who had substance-use problems as primary data.

We also felt a disjuncture[3] arising from what we saw as the decontextualization of the issue in the extant scholarly works. Nurses' problems with substance use have been principally framed in neoliberal terms of individual shortcomings (Kunyk, Milner, & Overend, 2016), whereas broader institutional and organizational conditions have neither been critiqued nor researched (Ross et al., 2018). This trend conflicted with what we knew experientially about the interconnections between nurses' substance-use practices and their workplaces. That individuated perspective also contradicted current public health–based approaches that consider the environment as the primary focus of inquiry into substance-use problems (Rhodes, 2002).

The disjunctures that we experienced, whereby our own experiential knowledge of nurses' problems with substance use and the conditions of their day-to-day work lives met with conflicting organizing discourses, became the problematic of our study. A problematic is a "puzzle" in the social world, in which disjunctures are explored with the aim of discovering how the lives of individuals involved are socially organized to occur as they do (D. E. Smith, 2005). We chose to address the shortcomings that we found in the existing literature and examine the disjunctures that we were feeling by using an institutional ethnography (IE) mode of inquiry to explore our problematic.

Numerous avenues of inquiry exist within a problematic, all arising from differing *standpoints*, or the particular knowledge and social locations of individuals situated in the problematic (D. E. Smith, 2005). We elected to align with a standpoint different from our own as the entry into the problematic and utilized the expert experiential knowledge of nurses who have experienced substance-use problems to research two questions:

Research Question 1: What are the discourses embedded in the talk among nurses in their everyday work worlds that socially organize their substance-use practices?
Research Question 2: How do those discourses manage these activities?

Research Approach

Institutional Ethnography

In the IE tradition, the process of inquiry is anchored in the everyday experiences and practices of people, rather than in abstracted notions such as concepts and themes. The IE researcher's main objective is to trace that local experience outward to discover how those experiences are managed, socially organized, and ultimately subordinated by broader ideological constructions of reality that are embedded within dominant discourses (Campbell & Gregor, 2002; D. E. Smith, 2005). In IE, discourses are seen as the words (in talk or texts) people take up in their day-to-day worlds that serve as maps, guiding them to the knowledge of "what they *should* be doing" (Clune, 2011, p. 41).[4] As with Foucault's discourse analysis, Smith's IE approach aims to expose social and power relationships within textual discourses; however, Smith's IE approach examines how these discourses are joined with social practices, particularly in institutions or work environments (Campbell & Gregor, 2002).

Language is the door through which a researcher can enter into and uncover the discursive organization that is hidden within everyday activities. The ways nurses talk, like all professional conversation, is laden with institutionalized parlance. D. E. Smith (1999) observed that an "intimate connection [exists] between learning an occupation and learning a language" (p. 144), in that, typical insiders' talk organizes the occupational group members' knowledge as it becomes adopted as taken-for-granted group norms. The talk is practiced, as these norms act as dominant discourses that inform and organize the group members' day-to-day activities. As the discourse is reproduced in nurses' talk, it acts as a generalizing[5] process that, in turn, coordinates and manages nurses' activities across other settings and times (D. E. Smith, 2005).

We uncovered how dominant discourses were reproduced within and across nursing work sites by ethnographically researching the ways the nurse participants talked in interviews about their substance use and everyday work lives, and their recounting of how other nurses talked about these matters. The historical importance of professional nursing's oral traditions has been recognized in foundational nursing work (Benner, Tanner, & Chesla, 2009). However, during our comprehensive literature review on nurses' substance problems (Ross et al., 2018), we found that the ways that nurses talk about their substance-use practices had remained unexplored. We believed that we could utilize this untapped resource to gain access into nurses' everyday work worlds

through the actual words spoken by nurses, the subtexts, the words they did not speak, the stories they told, how they talked as and among nurses about substance use, and how this talk was enacted in their everyday work lives.

Method

Participants

Inclusion criteria for the standpoint participants (referred to as participants in what follows) in our study required that they were registered nurses (RNs) or registered psychiatric nurses (RPNs), they were a current or past enrollee in the regulatory program in one Canadian province for nurses who were declared to have substance-use problems, and they worked in provision of direct patient care. We carried out recruitment via an advertisement posted in one of the provincial nursing organizations' e-newsletters. Participants included 11 RNs and one RPN. Nine of the participants had responded to the recruitment advertisement and three other nurses contacted us because they had heard about the study from nurse colleagues.

In IE, the number of participants is not prescribed; instead, importance is placed on participants representing a sufficiently diverse range of experiences and loci within the institution to illuminate the generalization of discourses across different times and places (DeVault & McCoy, 2006; Malachowski, Boydell, Sawchuk, & Kirsh, 2016). Our participants were employed in various types of clinical areas and in different units, hospitals, and regional health authorities throughout the province. Participants varied in age and length of time in nursing, had problems with different substances, and were of male and female gender identifications. Due to the extremely sensitive nature of the topic, we have not identified the specifics of any of these demographics in this article to protect participants' anonymity and confidentiality. We obtained all relevant research ethics board approvals and institutional consents prior to conducting the research. Participants provided informed, written consent to participate in the study. We strictly protected participants' confidentiality and anonymity, and all participants' names reported in this article are pseudonyms.

Data Collection

The written and spoken language practices of nurses obtained in participant interviews and Ross's (i.e., the lead author's) journal (described below) served as ethnographic data for the analysis. The lead author conducted all the interviews with participants, which took place either in person or via Skype (Microsoft, n.d.) in 2016 and 2017 as semistructured, audio-taped one-to-one interviews of 60 to 90 minutes in length. Most were single interviews, but the lead author contacted some participants for a second brief interview or collected subsequent information via an email if we required clarification or additional data. We provided participants with copies of their written interview transcripts and gave them an opportunity to provide comments, clarifications, or corrections as they saw fit.

Reflexivity involves making the research process itself a focus of inquiry (Carolan, 2003). As researchers' reflexivity is considered "a valid means of adding credibility to qualitative research" (Carolan, 2003, p. 10), we used the lead author's reflexive knowledge, in the form of a written journal (with entries prompted by interview experiences), as data in this study. We have included excerpts from the lead researcher's reflexive journal in our analysis, which are cited with the code LRJ in the findings. The lead author occupied a dual standpoint with respect to the participants. The lead author was also a practicing nurse (dually credentialed RN and RPN) with more than 36 years of experience. This provided the lead author with an insider's understanding of nurses' typical language and expressions, their conditions of work, the corporate and operational workings of health care institutions, and systems of nursing education. Unlike the participants, the lead author had not had any involvement with any nursing regulatory body because of substance-use problems.

Data Analysis

Traditionally, IE researchers analyze the language within institutional texts as data (Campbell, 1994; Diamond, 1992; Rankin & Campbell, 2006). Recently, D. E. Smith (2017) endorsed the notion of researchers undertaking "an ethnography of words as uttered" (p. 24) in her important work, *Talk as Practice*. As with the IE research of Watt (2017) concerning emotional work in the care of children with diabetes and G. W. Smith and Smith's (1998) study of school experiences of gay students, we have taken the approach of foregrounding talk in our analysis of social practices and relations.

Rigor in IE is achieved by "the corrigibility of the developing map of social relations" (DeVault & McCoy, 2006, p. 33), and is accomplished through a confirmable and accurate accounting of the actualities of peoples' lives, discovering how individuals' knowledges have been organized, how knowledge manages people's everyday activities, and how these knowledges and actions are coordinated with those of others. To achieve our research aims, we used indexing and mapping, analytic strategies typically employed in IE research (Rankin, 2017). The lead author carried out a preliminary review of the data from participants' interviews and the reflexive journal, using manual notations on the transcripts to index (a) how nurses talked (and did not talk) about substance use and (b) the participants' day-to-day work. In IE, work is broadly conceptualized as "what people do that requires some effort, that they mean to do, and that involves some acquired competence" (D. E. Smith, 1987, p. 165). This "generous" notion of work (D. E. Smith, 2005, p. 151) incorporates less visible types of labor, such as cognitive, emotional, and communication work, as well as visible physical activities. Locating work in ethnographic data is

fundamental to an IE analysis (D. E. Smith, 2005), as it guides the analyst's attention to the activities of the participants and the knowledge that informs these actions.

In the second and subsequent readings, these two indices were further subindexed with the goals of (a) uncovering and describing dominant discourses in the nurses' work lives and (b) mapping how these discourses entered into the nurses' day-to-day experiences (McCoy, 2006). In IE, mapping describes and traces people's activities (including talk) by "lay[ing] out a display of what is happening (the map), either in words or diagrams, that describes the features of the social practices" (Rankin, 2017, p. 5). In carrying out this analysis, we were watchful for tacit, taken-for-granted assumptions, and recurring events or use of words. These could uncover patterns that existed in local actors' (in this case, nurses') day-to-day work worlds that were socially organized to be repeated or generalized in other locations and times (Campbell & Gregor, 2002; D. E. Smith, 2005). We were also alert for disjunctures that occurred between nurse participants' experiential knowledge and ideological or conceptual ways of knowing imposed by dominant discourses. This directed our attention to where the participants' knowledge and experiences were subordinated to those discourses (D. E. Smith, 2005).

Findings

Our analysis of interview transcripts and the lead researcher's journal (LRJ) uncovered that our participant nurses' substance use and coping practices were socially organized by dominant discourses embedded in the ways nurses talked (or did not talk) in their everyday work lives. These included othering practices, meaning, practices of distancing through stereotyping into us and them categories (nonnurses and nurses with substance-use problems as others, and substance-use problems as other health issues); professional education practices; coping practices (coping with silence and using substances); and the work of managing disclosure (the paradox of obtaining help for and the work of concealing substance-use problems).

Othering Practices

Our data revealed underlying discursive categorizations in nurses' talk, whereby people with substance-use problems were viewed as others who were separate from nurses; nurses who had substance-use problems were seen as different from and lesser than nurses who do not; and nurses with substance-use problems were viewed as different from and less worthy of empathy and support than those with other types of health issues.

Othering practices toward nonnurses with substance-use problems. Participants reported that nurses typically spoke of their patients and those in the broader community who had problems with substance use in ways that were contemptuous and markedly lacking in empathy. As Paul articulated, people with substance-use problems were "just looked down upon [by nurses], not ever with any sympathy, but more of a weakness . . . that they're a lesser person because they're having to use." Participants told us that, in their day-to-day work, nurses typically spoke about people with substance-use problems in terms of moral or character deficiencies, social deviance, or low standing and used phrases such as "bad," "weak," "low-class," "skanky," "uneducated," "from skid row," "addicts," and "junkies." Participants identified that prior to and even during their active substance-use problems, they had themselves thought and spoken in this typical judgmental way about people with such problems. In contrast, nurses characteristically spoke of themselves as being "educated," "respectable," separate from, and elevated above these distinctly undesirable other people. Rachel recounted, "I believed, you know, I'm not like those other addicts. I'm not a junkie that shoots heroin on the street . . . I'm not the same as them."

Othering practices toward nurses with substance-use problems. This discourse coordinated nurses' activities by stipulating that they must be seen to be able to "handle" their substance use to retain their elevated moral, characterological, and social status. The participants recounted that they and their colleagues expected nurses to know better and definitely do better than to have such problems. Nurses who were discovered to have problems with substance use were othered as nurses, and viewed as incompetent, weak, immoral, and poor representations of the nursing profession. Participants reported that they had adopted and internalized this discourse as part of their nursing identity, and, subsequently, they experienced profound feelings of shame and embarrassment, and felt that they had failed as a nurse when they realized that they had a substance-use problem.

Othering practices toward substance-use problems. Participants recalled that nurses rarely spoke of people's problems with substance use as illnesses or health issues, although there seemed to be an expectation that they really should view them as such. When substance-use problems had been spoken of as health issues, it was clear to the nurses so affected, they were essentially considered as illegitimate illnesses. Helen and Paul illuminated how compassion was selectively practiced toward colleagues according to the type of health issue that they were dealing with. When asked whether she would have felt more supported by colleagues if she had said, for instance, that she was off work with a back injury instead of for treatment of substance-use problems, Helen explained, "I think I actually said that one of the times [laughs] actually I said that almost every single time."

Participants told us how nurses typically felt isolated and unsupported when they were "outed" as having a substance-use problem. Paul described how compassion from colleagues fell short during leave related to his problems with substance use:

Not one person sent me a get-well card. We're always putting money in for people who are off sick to buy them flowers or something, but I didn't get anything [when off work for treatment of substance-use problems] . . . It's all "it's an illness . . . except for how we're going to treat you."

As Paul recounted about his workplace, if a fellow nurse was known to have a physical health issue, support was extended both formally and informally. Many participants reported that, like Paul, if the nurse's health was affected by substance use, then he or she would most likely experience blame, condemnation, and/or exclusion.

According to our participants, their colleagues did not understand relapse as an expected part of the course of recovery from substance-use problems. Instead of a symptom of a health issue, relapse was spoken about as a characterological failure and even a betrayal of the profession. As Mark described, "When I went back to work after I'd relapsed . . . the head nurse told me that—to my face— 'you're not trusted here because you lied and you disappointed and betrayed your colleagues.'" Even nurses who had not relapsed worked in an atmosphere of deep mistrust, where it was assumed that they had or inevitably would do so. Pietra explained the attitude of suspicion present in the work setting in this way:

They wonder if you are going to relapse . . . There's a suspicion . . . and you can feel it because you're judged . . . I'm absolutely terrified there's going to be a discrepancy in the narcotic count . . . I've been called in three times.

Meanwhile, within this unsympathetic climate, the recovering nurses were also attempting to not relapse, to recover their health, and do the work of their regular nursing job.

Professional Education Practices

Several participants felt strongly that nurses lacked basic education about the reality that nurses can and do develop their own problems with substance use, and the warning signs of the same. According to Rachel,

You should learn about addiction in the health care field to really understand how prevalent it is because I think that that's missed . . . I think if somebody would have told me about it I might have been a little bit more wary or might have seen my own behaviors before the narcotics [became] troublesome.

When the topic had been spoken of in participants' formal education, the focus was placed on how to report miscreant nurses to institutional authorities, rather than understanding lived perspectives or learning about nurses' substance problems as health issues. As Molly explained, "There's no understanding of what it is like to have a disease and how to help . . . They [just] know how to report."

Participants expressed their beliefs that nurses, especially novices, were inadequately prepared in their basic nursing education to cope with the intense emotional work that they were required to undertake to manage the many stressors inherent in their jobs. Work stressors dominated the ways that participants talked about their substance use and work lives, particularly the distress that nurses felt from engaging with the suffering, traumas, and even deaths of their patients. Pietra shared her experiences of what, in retrospect, she viewed as a major gap in her nursing education:

I can look back on it now and say that I was not equipped emotionally to deal with what happens to people . . . We need to recognize that when we see those horrible events . . . we will need to work through those feelings and those thoughts about what's happened and the resources have to be available so we can be assisted through that . . . feeling helpless and hopeless, not knowing where to go to get the proper information of how to help [our patients] . . . There's nothing on this [in our nursing education] except how to make a bed and put a good corner on it and take vital signs, and you don't have that, you don't have that.

Nurses also reported having to cope with numerous other sources of workplace stress, including heavy workloads; imposed overtime; fatigue from shift work; musculoskeletal strain and injuries; verbal, sexual, and physical assault; and conflicts with coworkers, all of which were overlaid by unsupportive leadership. Bella articulated how she believed that a lack of any discussion in her nursing education about workers' rights and established standards for working conditions left her vulnerable and unequipped to safeguard her own health and well-being: "I just didn't know. I should have had a course about policies, and union, and that kind of stuff because I just didn't have any idea about . . . my rights in the workplace."

As importantly, however, several nurses in our study conveyed that the reverse was also true. Participants stated that learning about their fundamental workers' rights for safe working conditions and ways to advocate for these rights were crucial elements in their successful recovery from substance-use problems. They believed that this education empowered them to manage their workplace stressors in ways that better protected their emotional and physical health.

Coping Practices

Our analysis unveiled how nurses carried out the work of coping by practicing silence and/or substance use and how these practices were managed by discourses within the nurses' everyday talk about work stressors and substance use.

Coping by practicing silence. Our participants reported implicit and explicit messages in the way nurses talked, or did not talk, that organized the conditions for nurses to practice silence and to actively silence colleagues as they all endeavored to cope with some of the most difficult life circumstances and pressures embedded in their day-to-day work lives. Helen's remarks revealed taken-for-granted norms in nurses'

social relations that managed how participants talked or did not talk about work stressors:

> There were comments along the line that . . . "everyone finds this upsetting, you just have to deal with it" . . . you know, that's what the job's about . . . because if you started to raise anything that was at all loaded . . . people would be "yeah, that was really awful, now I gotta go to the bathroom or go do this or go do that or whatever," and it wasn't like people were mean about it. Just it was kind of like, "Okay, we have enough to deal with ourselves and we're done dealing with you too."

Another participant, Vicki, explained how nurses did not want to discuss such problems with other nurses, lest they be perceived as incompetent:

> [If a nurse is] not able to cope . . . they have a poor constitution . . . If you consistently were not able to cope, then you weren't cut out for this, and you'd probably be gossiped about [by other nurses].

Helen's and Vicki's comments revealed an assumption that it is crucial for nurses to silently cope with work stresses so as to not add to the burden of others, because all nurses are thought to be working on a razor's edge and struggling to cope with themselves. Colleagues' responses to an individual expressing distress, as well as the silencing of such expression, create an expectation that nurses are required to be strong, uncomplaining, and "just suck it up," as no one has the emotional, physical, or time resources to pick up another's "slack." Nurses consider peers who voice difficulty coping with work-related stress to be deficient, and talking about such feelings is often perceived as a sign of weakness or even evidence of unsuitability for the nursing profession.

Coping by practicing substance use. Nurses practiced substance use to cope with work demands in various combinations with talk and silence. Their selections of whether they practiced silence or talk along with their substance use depended on the discursive categorizations of the substances and stressors in question. For example, participants revealed that nurses did not place any premium on concealing or silence around their typical practices of liberally self-administering nonprescription over-the-counter medications and nonpharmaceutical substances that had either stimulant, calming, antidepressant, pain-relieving, sleep-inducing, muscle relaxing, and/or mild euphoric types of effects. They would openly use these to manage physical stressors, such as pain and sleep–wake cycle disturbances arising from shift work. This self-medication was often done with a wink and a nod, and with full knowledge and complicity of nurse colleagues. The lead researcher described how, as a nurse educator, she knew novice nurses to extensively use these types of substances to cope with work life: "The young nurses especially are self-medicating like mad. Energy drinks, diet pills, melatonin, St. John's Wort, Gravol, Benadryl to manage shift

work, take tons of ibuprofen and acetaminophen for pain, all this over-the-counter stuff" (LRJ). Rosie also illustrated how she knew other nurses to routinely use their professional scientific knowledge of these substances' effects to meet the physical demands of work. According to Rosie, "a lot of nurses had migraines and they weren't feeling well, so we gave them an injection of Gravol in the bathroom . . . to get you through your shift and that was okay."

Rosie also explained how it was not at all uncommon for nurses to pilfer nonprescription medications from their workplaces to enable them to work throughout their shift. Participants reported that nurses did not look upon the diversion of these drugs as stealing; however, they did understand that the practice is officially considered to be so. Nevertheless, we found that nurses' use of these nonprescription substances to cope with emotional distress was not spoken of.

Nurses typically remained silent if they used legitimately acquired prescription drugs, such as opioids, sedatives, anxiolytics, or antidepressants, for either physical or emotional reasons. This was because nurses reportedly categorically regarded use of these drugs as a sign of weakness and even evidence of being a "drug addict." In describing how nurses did not talk about their use of such medications, Molly recounted how she accidentally saw a nurse colleague's opioid prescription at work: "I know other nurses who were taking way higher doses of pain medication than me and they're still working . . . [I saw her opioid prescription in her open purse] and I thought, 'Holy shit that's a lot.'" Nevertheless, as Rosie described, nurses commonly, but quietly, used those drugs to cope with emotional distress on a day-to-day basis, so that they could carry out the requirements of their job:

> A lot of nurses are on Ativan [a prescription drug used to treat anxiety that has sedative effects] at night to sleep, to cope with the death and destruction that we see . . . [nurses] are more desperate and coping with your assignment and the sickness of people in the hospital and the death, it's horrible.

Many nurse participants also reported nurses frequently used these types of medications to manage physical pain, so that they could work, and that their pain often arose from the conditions of their work. However, stealing drugs in these categories from the workplace was absolutely not spoken of, and the nurses who were known to do so were categorically regarded as reprehensible. Judged worst of all were those who had taken drugs from their patients. As Pietra recalled,

> They cannot understand how you could possibly start filtering the medication from the hospital to your own personal supply . . . To use medications that you're entrusted to give to patients, because that's where mine went . . . is horrible.

Participants who had stolen these kinds of drugs from their workplaces also described how using them had actually enhanced their ability to carry out their work, by enabling them to better cope with physical and emotional work

stressors. These nurses were more tolerant with patients and coworkers because their emotions were numbed. They also were able to work harder and longer because they could forgo basic needs to eat and sleep, and they did not utilize their allotted sick leaves when unwell. As Rachel recounted,

> When I was using [opioids], it was quite easy because I could go for hours . . . I worked the next 21 days straight and I used [the drugs] every day . . . I actually ended up working more because at work is where I . . . got my drugs from, so I ended up being a bit of a workaholic and picking up as much overtime or extra shifts . . . It made me want to work more and it kept me at work more than at home.

Rachel described here how, although she was actively using drugs that she stole from work, she regularly and without complaint volunteered to work extra hours and more successive shifts than scheduled. Nurses who stole drugs from their workplaces shared their perceptions that their peers had viewed them as particularly hardworking and dedicated because of their willingness to work overtime. Unbeknownst to their colleagues, however, they were managing their work lives in specific ways to facilitate access to their supply of drugs.

We found that nurse participants spoke about nurses' practices of alcohol use altogether differently from other substances. As Helen explained, participants reported that nurses' use of alcohol outside of the workplace was widely spoken about and tacitly endorsed as a method to cope with emotional distress, particularly work stressors:

> I think to some degree having a drink after work or whatever, people were, yeah, "I'm going to go home and have a glass of wine . . . " . . . People did that to debrief or calm down and that was sort of chuckled about, but nobody talked about the fact that if someone kept drinking it would be an issue.

"Partying" or recreational binge-type heavy alcohol use was reported as common practice and talked about freely in a light, humorous fashion as a sanctioned way to "blow off steam." In fact, alcohol use was the only practice of substance use, or otherwise, that the participants said nurses talked about openly as ways to manage emotional distress arising from their work.

The lead researcher's reflections on her experiences in many nursing workplaces over several decades highlighted how nurses talked about alcohol use in a way that served as an accepted kind of shorthand signaling to other nurses that they were experiencing stress:

> You'd never say, "Oh, I just can't cope with that death, or the distraught relatives," or "I'm so stressed out by the workload I'm going to have a breakdown." No, you'd say, "This was a two-glass-of-wine shift!" and everyone would laugh and agree. (LRJ)

Not all manner of nurses' alcohol use was viewed favorably, however. Study participants described a taken-for-granted understanding that it was important to be able to handle their liquor. If the alcohol use was seen as problematic, or if a nurse was found to be drinking or intoxicated on the job, the nurse was disparaged in the same way as those who had problems with other substances. Regardless, participants reported that nurses who had problems with alcohol were looked upon far more sympathetically than those who had problems with other drugs.

The Work of Managing Disclosure

The paradox of obtaining help for substance-use problems. A curious contradiction was revealed in the nurse participants' talk. This was that, as noted prior, under specified conditions, the uses of some substances were implicitly and explicitly endorsed as suitable practices for nurses to utilize to manage their physical pain and emotional distress. However, nurses who were believed to have problems with substance use were judged as morally deficient and incompetent others. Here, we came to a disjuncture in the data analysis. We did not understand how, or whereby nurses were seen to have crossed that line—when did they become that "other" nurse? When the lead researcher posed this question to the nurses, they answered clearly—their categorization shifted when they asked for or evidently needed help. For instance, according to Mark, "I think when you get busted . . . when an individual gets caught . . . or asks for help. Once you're ID'd [identified], right?" As Mark articulated, it was at the juncture when nurses sought, or were visibly in need of assistance for problems with substance use that they had received clear messages both from their peers and their own internalized discourses that they had failed as a nurse.

The work of concealing substance-use problems. The participants were unambiguous in reporting that one of the primary reasons that nurses concealed their problems and were so distinctly disinclined to seek assistance was their fear of being harshly judged by their peers in this way if they admitted needing help. Nurses described how they feared being outed because the negative way that they and their colleagues had typically spoken about nurses and others with substance-use problems had set their expectations that they would be condemned. Consequently, nurses were typically guarded about their substance-use problems, and felt compelled to mask the true nature of their problems from colleagues by practicing silence and engaging in a great deal of difficult thought and emotional work to actively conceal their problems from their colleagues.

Many participants reported that when their problems did become known to colleagues, they needed to undertake a substantial amount of emotional and interpersonal work to navigate and cope with a work environment characterized by a relentless undercurrent of hostility, contempt, and suspicion. Even those nurse participants who ultimately did receive a positive reception from their peers when their

substance-use problems were disclosed reported that they had gone to great lengths to manage potential disclosure. Liza described her hesitation in this way: "I personally have never had anything but amazing support from all my colleagues . . . [but] I can guarantee you I wouldn't have told."

Discussion: Silent Angels—Moralistic and Individuated Discourses Managing Nurses' Substance Use

The historical nursing motto, "I see, and I am silent" (Villeneuve, 2017, p. 24) is now generally regarded as quaint and somewhat distasteful. Nevertheless, this imperative was clearly reflected in the present day, whereby nurses' experiences of work stresses are suppressed, reconstructed, and replaced with dictates of silent endurance and performance of duty. These current discursive representations of nurses readily bring to mind the historical Christian and Victorian, gendered, moralistic stereotypes of "good" women (and nurses) as temperate, uncomplaining, endlessly altruistic "angels" (Heise, 2002; Turkoski, 1995). Our data supported others' findings that vestiges of such virtue-based ideologies persist in current nursing discourse (Gordon & Nelson, 2006; Kunyk, Milner, & Overend, 2016). Our study also revealed how substance-use problems were discursively organized as character flaws that "good nurses" simply do not have. Those who did were categorized as others, quite separate from and of lesser social and moral stature than nurses themselves.

Uncovering how these moralistic discourses organized nurses' knowledge contributes much-needed depth to the broad and ill-defined conceptually based explanations in the literature on nurses' substance-use practices. Specifically, this knowledge adds important nuance to the widely used concept of stigma to describe nurses' negative judgments of other nurses who have substance-use or emotional or mental health problems and their own reluctance to seek help for the same (Kunyk, 2015; Kunyk, Innes, et al., 2016; Moll, Eakin, Franche, & Strike, 2013; Parrish, 2017).

Our findings also offer a challenge to the reductive conceptualization in the nursing literature explaining how nurses' substance-use problems arise from cavalier attitudes toward their self-administration of drugs (Kenna & Lewis, 2008; Lillibridge et al., 2002). These data highlight how nurses' substance use is linked to the premium placed on their mute accommodation of punishing working conditions (from shiftwork and overtime to death and violence). Rather than possessing faulty "overconfident attitudes," our participants reported that nurses purposefully leveraged their professional knowledge of substances to numb physical pain and emotional distress, so that they could meet the discursive imperative of silent stoicism and continue to work. In this way, nurses' substance-use practices often provided their employing institutions with compliant workers who subsidized the true cost of their work with their own health and well-being. These data also lent support to Turkoski's (1995)

notion that dominant ideologies of nurses' "professionalism" have historically managed their behavior in ways that deterred them from challenging their employers about poor working conditions. Another unexpected finding was the inadvertent institutional utility of nurses working more hours and shifts than scheduled to access the drugs they acquired from their workplaces and had become dependent on.

The individuated, moralistic discourses that were found in nurses' day-to-day talk are also generalized throughout the professional and scholarly texts that are intended to provide nurses with guidance about their substance-use and coping practices. The clear messages sent in these texts are that the responsibility for nurses' coping (or not) with work stressors is situated entirely with the individual nurse and that substance-use problems are evidence of their personal failure at this task. The role of the institution in the stressful working conditions that the nurses must somehow cope with appears to have been erased from this discursive construction.

For example, a professional resource document intended to assist nurses with maintaining their "fitness to practice" (College of Registered Nurses of British Columbia [CRNBC], 2008, p. 13) cryptically advises them to "set limits . . . [as a] workplace and professional self-care" (p. 13) strategy. In another text, health care providers are cautioned to not "forget to take care of themselves . . . say no when needed . . . don't over-identify with their patients . . . [and] plan regular breaks" (Parrish, 2017, p. 147). No direction is offered as to exactly how a nurse might actually go about doing so in their real-life working conditions. Advice to distance themselves from their patients seems irrelevant to the work contexts that our study participants described, in which they experience great distress from engaging with traumatized patients to provide them with competent nursing care. It seems equally unhelpful to instruct nurses to "take care of themselves" (Parrish, 2017, p. 147) when the realities of their work, both revealed in our findings and found in the literature (Shields & Wilkins, 2006), often involve punishing work environments with imposed overtime on understaffed units where they are unable to take breaks. It is also highly unlikely that they would feel safe to "say no" (Parrish, 2017, p. 147) or to "set limits" (p. 147) when they have been socialized into the professional norms uncovered here that dictated silent endurance of work stresses. Confusingly, this silencing discourse is echoed in that same document, where nurses are also advised to "avoid chronic complainers" (Parrish, 2017, p. 147) or to shun colleagues who do speak up. Nurses are also admonished in resource texts to "avoid self-destructive coping" (CRNBC, 2008, p. 11), in which problems with substance use are held up as exemplars of individual nurses' failure to do so.

Similarly individuated discourses align closely with current trends for workplace wellness programs in health care institutions. These programs redistribute the job of managing workplace stressors wholly back to the individual, typically by offering assistance in the form of "self-help tools and resources with lifestyle mentoring, or health coaching"

(Preston, 2012, p. 2). Initiatives to actually improve the nurses' working conditions or organizational culture are not part of this workplace wellness package.

One can also see individuated discourse generalized to the management of nurses at institutional policy levels. For example, professional programs to manage nurses who have been identified as having problems with substance use,[6] likewise, situate their focus solely on the individual nurse (Ross et al., 2018). These individuated perspectives are also articulated to broader discourses in the "new public management" (Rankin & Campbell, 2006, p. 14) administrative approaches that currently govern Canadian health care organizations. In that mode of institutional organization, nurses' work stressors that arise from corporate efficiency and cost-cutting imperatives "are glossed over as nurses' 'constraining beliefs'" (Rankin & Campbell, 2006, p. 158), thereby eliminating the institution from the problem, and framing the solution as "changing nurses' beliefs and behaviors" (p. 158).

These discourses are also consistent with those found in the scholarly nursing literature, in which a highly individuated (Ross et al., 2018), neoliberal (Kunyk, Milner, & Overend, 2016) perspective exists toward nurses' substance-use problems, which pays little heed to the institutional context of nurses' work lives. For instance, Burton (2014) concluded a common characteristic of nurses who had problems with substance use was that "they did not know how to effectively cope" (p. 157). Health care professionals are also counseled to "accept responsibility to modify a lifestyle burdened by stress, chronic overwork" (Storr, Trinkoff, & Hughes, 2000, p. 1463). Rarely do studies show that nurses are encountering situations that exceed a normal person's ability to cope or that employing institutions should bear some responsibility for such conditions (Lillibridge et al., 2002; Ross et al., 2018). Current public health-based approaches that view substance-use problems as inextricably connected to the conditions in peoples' environments (Rhodes, 2002) are inexplicably absent in the scholarly nursing literature (Ross et al., 2018). Notable exceptions are recommendations to address nurses' substance-use problems by mitigating their "traumatic" working conditions (Lillibridge et al., 2002, p. 226), improving their organizational support, and creating more positive work environments (Scholze, Martins, Galdino, & Renata, 2017).

Our participants reported their basic education did not prepare them with factual knowledge about nurses' substance-use problems, and that they merely learned, as Molly said, "how to report" other nurses' transgressions. These data were consistent with findings in the scholarly nursing literature that undergraduate nurses receive scant, if any, evidence-based knowledge on substance-use problems in general and nurses' in particular (Burton, 2014; Cares, Pace, Denious, & Crane, 2015), and that the education they did receive took a highly individuated perspective (Ross et al., 2018).

Our data also aligned with the content seen in professional texts (at the provincial and national levels) on nurses'

substance use (Canadian Nurses Association, 2009; CRNBC, 2017, n.d.) that targeted reporting of colleagues, but did not offer meaningful information about prevention of or possible contributors to nurses' problems with substance use. They instead addressed the issue by framing nurses as conduits of potential threats to patients—"nursing is demanding work, in which impairment could result in direct and significant risk of injury to patients" (CRNBC, n.d., p. 1)—and directed their focus toward urging nurses to police and report colleagues' impaired practice.

These educational deficits left our participants with no means of understanding or words to talk about their substance-use problems, other than the dominant individuated, morally centered, othering ways. Their only other alternative was silence. This crucial gap in nurses' basic education needs to be addressed. Furthermore, our study uncovered two socially sanctioned practices that nurses did use to manage the stresses in their work lives—silence and alcohol. Alcohol use was socially organized as both the verbal shorthand that nurses could use to voice their emotional distress arising from work and the authorized strategy to cope with it. This important new finding challenges the considerable weight afforded to the largely uncontested and taken-for-granted assumption in the literature (Ross et al., 2018) that nurses' ready access to prescription drugs is the prime contributor to their problems with substance use. Indeed, one study found that an astonishing "one in 20 of the nurses indicated that their substance use had limited their commitment to patient care" (Kenna & Wood, 2004a, p. 114), and that the (mostly women) nurses' overall alcohol use was disproportionately high, compared with typical gendered patterns of alcohol use and that of other health care groups. This predominant over focus on nurses' access to drugs has cloaked awareness of a possibly more serious situation, the largely unexamined role of alcohol in nurses' management of their work-life stressors.

Conclusion and Recommendations

Our study revealed how nurses' basic education and professional resources did not provide them with ways or words for understanding their substance-use problems, other than that of the dominant moralistic and individuated discourse. A lack of protective knowledge, coupled with a virtue-based professional identity offered them an illusion of immunity from substance-use problems. This created a perfect storm that left them vulnerable to insidious development of substance-use problems, without the awareness that this could happen to them, let alone be able to ask for help if it did. We also saw how nurses' gaining the knowledge and skills to self-advocate for their improved working conditions was connected with their recovery from substance-use problems.

Accordingly, we call for educational initiatives to both raise nurses' awareness of the moralistic, individuated discourses that they are a part of and provide them with

factually based undergraduate and ongoing education about nurses' substance-use problems. We also recommend capacity-building initiatives to equip nurses with the knowledge and skills to advocate for physically and psychologically safe workplaces. We wish to make clear that these recommendations are in themselves insufficient. To imply so would be perpetuating the stance that we challenge and continue to place the responsibility for the issue back on the individual nurses. Rather, we do so in keeping with the emancipatory intention of IE. This is to increase people's awareness of "the socially organized powers in which their/our lives are embedded and to which their/our activities contribute" (D. E. Smith, 1999, p. 8) and promote their empowerment with the knowledge enabling them to effect institutional change.

We assert that the role of the nurses' employing institutions in establishing the working conditions, wherein nurses develop substance and stress-related health problems, is conspicuously absent in the discourse and must be brought to the forefront of this issue. We uncovered dominant discourses in nursing regulation, management, and research that subordinated and silenced nurses' experiences of work stress. Nurses who deploy their knowledge of substances to silently manage these stressors are discursively organized as deviant individuals and held up as dangers to the public. We contend that a more critical perspective and empathetic approach must be taken toward nurses' substance-use problems and that organizational cultures and management approaches need to shift in ways that better support nurses.

Our data also added an important new finding—that alcohol use was the only coping strategy that nurses spoke of as being an acceptable, and even openly encouraged, way to manage emotional distress. We put forward that this as-yet underresearched finding of the role of alcohol in nurses' management of their work stressors merits more intense scholarly scrutiny.

Shining the light on these dominant discourses found in nurses' talk enables nurses to challenge, disrupt, and ultimately transform them in ways that better serve the interests of all involved—nurses and their families, health care organizations, as well as patients. It is our sincere hope that our discoveries contribute to that change.

Notes

1. In this article, the term substance is used to refer to *psychoactive substances*, which are those that "affect mental, psychological, behavioral functions; i.e., sensations of pain and pleasure, mood, consciousness, perceptions of reality, thinking ability, motivation, alertness" (Health Officers Council of British Columbia, 2011, p. 12). These include the categories of depressants (including alcohol, opioids, sedatives, hypnotics), stimulants, cannabis, psychedelics, and psychiatric medications (Health Officers Council of British Columbia, 2011).
2. We have chosen to avoid the use of such conceptualizations and instead use the following terms: substance-use problems, problems with substance use, or substance-use practices. Although we acknowledge that these could also be construed as social constructs, our intent is to be descriptive and not connote any category, concept, or alignment with any theoretical perspective.
3. In her work on the institutional ethnographic mode of inquiry, D. E. Smith (2005) asserted that individuals experience disjunctures when their own knowledge and experiences are being subordinated to dominant conceptual discourses.
4. In this study, we differentiate our use of the term discourse from how we use the terms talk and language. Here, talk refers to people's "words as uttered" (D. E. Smith, 2017, p. 23) in speech, and language denotes how people's words (in talk or written) coordinate their activities with those of others.
5. The approach to generalization in this study differs fundamentally from that of quantitative research, in which statistical findings are intended to be generalized to populations. We instead use the traditional IE meaning of the term, which denotes a process whereby local effects are socially organized to reoccur at other times and in other locations (D. E. Smith, 2005).
6. We have researched one such treatment program for nurses in a forthcoming work.

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