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GUEST EDITORIAL: SERIES ON HEALTH EQUITY LANGUAGE

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The power of the language we use: Stigmatization of individuals and fellow nurses with substance use issues

1 | BACKGROUND

The power of language has grown in importance as we consider the impact and influence of words on our perceptions of reality. The inherent power in our word choices, whether implicit or overtly biased, has implications in how we see our world and how we treat others. We are referring to the Sapir–Whorf hypothesis, and while a discussion about the controversies it ignites is for another time, the basic premise is that when we use language, we both reflect reality and create reality. Words are powerful forces, and at times, they exert power over others. When we consider individuals who are struggling with alcohol use disorder (AUD) and substance use disorder (SUD), the language we use has consequences for us and them. Specifically, as Sapir (1929) writes:

> Language is a guide to "social reality".... Human beings do not live in the objective world alone, nor alone in the world of social activity as ordinarily understood, but are very much at the mercy of the particular language which has become the medium of expression for their society (pp. 209–210).

In the "linguistic relativity principle," Whorf (1956, p. 221) describes how our language directs us to certain observations, which in turn, creates different perceptions about those in society, including stigmatizing views. Nurses' stigmatization of certain individuals who use health services is a phenomenon that reaches beyond AUD and SUD diagnoses (Copeland, 2022). When a group is stigmatized, it is about power relations. For nurses, stigmas are formed in the socialization process and social interactions with individuals that fail to fall within behavioral norms, which then produces discriminatory vocabularies and labeling (Copeland, 2022). As we continue our editorial series on learning the language of health equity, this paper seeks to advance our understanding of evidence-based and person-centered ways to use appropriate language when engaging with nurses or individuals who have challenges with substance use.

2 | LANGUAGE, STIGMA, AND SUD

Within the context of SUD, the language we use, our discourses, our observations of the world around us, construct how we perceive and react to the world and those individuals in it. Thus, depending on our language usage, we may not only reflect stigma toward those with SUD, but create stigma, reinforce it, and contribute to its sustainment. The recent National Institute on Drug Abuse (NIDA) initiative, "Words Matter, Preferred Language for Talking about Addiction" (June 23, 2021), supports how we can create a new reality by adopting a new vernacular.

Table 1 is one of several provided by NIDA (2021). Each table provides concrete language usage for SUD and offers suggestions to reduce stigma and the discrimination it can cause. For example, "impaired nurse," are words that create mental images of individuals who have lost control of their lives and bodies and are unable to function, thus, influencing our observations and interactions. In 2011, the National Council of State Boards of Nursing denounced the use of the term, "impaired nurse" as it implied the individual was functioning poorly or incompetently when in reality, the "nurse with a SUD can be high-functioning and high-achieving" (p. 3). It should be noted that the preference for use of terms related to SUD is an individual one. In a similar way that personal pronouns are used to indicate gender identities (e.g., they/them/their; she/her/hers; he/him/his) (Soled et al., 2022). Individuals in recovery may prefer the term "addict" because it is a term that they identify with, whereas others may not. Some individuals may identify with the term "alcoholic" and use it with sponsors and in testimonials, indicating that they have accepted their disease and its effect on their lives while some may not. The use of these terms for SUD may also be context specific. For example, some individuals may use terms like "alcoholic" or "addict" in certain settings such as recovery groups and prefer "person with SUD" in clinical or other healthcare settings. Other individuals may use terminology that focuses on their recovery work such as "person in recovery" or "sober person." Therefore, like how personal pronouns indicating gender identities are respected, we can ask permission to use terms that individuals with AUD and SUD may want us to use. Requesting clarification indicates respect, a willingness to learn, humility, and provides a sense of psychological safety to the person. For nurses and other healthcare providers, it is part of providing person-centered care.

3 | NURSES WITH AUD AND SUD

Often the best example of a place where we can change our use of language is in reference to ourselves and the nursing profession, which we define broadly as including registered nurses (RNs), and

TABLE 1 Terms used talking about yourself or others with substance use disorder (NIDA, 2021)

Instead of…	Use….	Because…
Addict	Person with substance use disorder (Hadland et al., 2018)	• Person-first language. • The change shows that a person "has" a problem rather than "is" the problem. • The terms avoid eliciting negative associations, punitive attitudes, and individual blame.
User	Person with OUD or person with opioid addiction (when substance in use is opioids)	
Substance or drug abuser	Patient	
Junkie	Person in active use; use the person's name, and then say, "is in active use."	
Alcoholic	Person with alcohol use disorder	
Drunk	Person who misuses alcohol/engages in unhealthy/hazardous alcohol use	
Former addict	Person in recovery or long-term recovery	
Reformed addict	Person who previously used drugs	

advance practice RNs (e.g., nurse practitioners, certified registered nurse anesthetists, and clinical nurse specialists). Further, licensed practical nurses, certified nursing assistants, and registered midwives are critical in providing care, therefore, it behooves all groups of formal caregivers to adopt principles of using more equitable language. If we can use less stigmatizing language in reference to the members of our professions, then we are more likely to be able to do so for the people we care for in healthcare settings. Through understanding the challenges faced by members of our own profession, we can also better understand the experiences of individuals who have and/or continue to face similar challenges.

Like all individuals with AUD and SUD, and to a greater extent, nurses who struggle with these conditions are particularly vulnerable to stigmatization. For the 20th consecutive year, the Gallup Poll reported that the public rated nurses highest for honesty and ethics (Saad, 2022). Nursing has been consistently ranked as the most trusted profession, therefore, the high standard of respect bestowed by the American public toward nurses makes any "deviation" from the trusted image stigmatizing. When nurses stumble, fall, and fail, nursing colleagues tend to show less mercy than would be shown toward other individuals outside the profession. This is not a new trend and was described 35 years ago by Curtin (1987), when she coined the phrase "throw-away nurses," a disdainful term, and one she challenged. Curtin (1987), in her thought piece, cited an example of a nurse who had been a role model for her and who was found to have been diverting medications. Curtain made a point of describing her devastation on behalf of this nurse, who then lost her license, her professional position, and her "freedom" (p. 7). It is extremely disappointing that so much of what Curtin wrote over three decades ago still has relevance and applicability to nurses in recovery today. Despite her humanistic and progressive recommendations to offer nurses immediate treatment, continued employment, and implementing parameters of return to work that supported recovery (i.e., working the day shift, evidence of continued sobriety, etc.), even today we are still trying to consistently provide this support for those in our profession with AUD and SUD.

For those nurses who are reported to the state boards of nursing and face disciplinary action related to substance use, the public scrutiny is dehumanizing and shaming. It objectifies people who are fighting a chronic yet treatable disease; a disease that is rooted in biochemical, social, psychological, and spiritual aspects of an individual's life. Taped recordings of boards of nursing meetings, public files of hearings that may include recurrence of substance use, and other open records leave a trail of visual and written discourse about nurses with SUD. Past and current psychological trauma are often underlying themes emerging from the discourse of nurses' experience. These documents and recordings create a discriminatory reality for nurses that discounts the context of AUD and SUD as chronic and treatable diseases. The low enrollments to alternative-to-discipline (ATD) programs may be due to the shame, guilt, humiliation, and self-stigmatization from nurses themselves, impacted by a culture of shame from the nursing profession. It seems as if there are three contexts against nurses who struggle with substances and alcohol: individual/professional/regulatory, organizational, and societal.

4 | ATD PROGRAMS

Today's nurses who enter SUD treatment and recovery still face many barriers, perhaps the most salient being the regulatory aspect of their status within the nursing profession. State boards of nursing are charged with protecting public safety and ensuring the state nurse practice acts are upheld. Nurses who appear before the state boards of nursing are frequently there because of alcohol and substance use, with some nurses facing criminal charges. ATD programs offer a humanistic approach by allowing nurses to come forward and report their dependency, with some protections in

preserving their nursing licenses. Most states have ATD programs, which include contracts for SUD recovery monitoring agreements and other stipulations. For many nurses, ATDs provide an alternative to boards of nursing disciplinary actions. Yet, stigma and discrimination, or being unaware of these programs prevent many nurses from using ATDs. In canvasing 15 states making up 66% of nurse licensees, Clark (2021), found surprisingly low numbers of new enrollees in ATD programs. For example, in 2020 only 112 California nurses out of 457,604 licensees had enrolled in the ATD program. Clark (2021) found that across the states surveyed, "annual enrollment is astonishingly low" (n.p.). More current findings indicated this is far below the 6.6% of nurses with SUDs (Trinkoff et al., 2022).

For those nurses who are on a path of recovery, there may be many barriers to work reentry. Internalized shame related to being a member of a stigmatized group may prevent nurses from returning to nursing work. Externally, financial stressors, the slow pace of boards of nursing decision-making related to status of the nursing license, and difficulty finding employment are also barriers to work reentry for nurses after SUD treatment (Matthias-Anderson & Yurkovich, 2016). Potential employers, especially in large healthcare systems, may eliminate recovering nurses from consideration for employment due to concern for patient safety or fear of litigation. The ease by which prospective employers can access public information about past or current action against the license of a nurse in recovery for SUD makes it easy for employers to eliminate the nurse immediately from consideration. This only increases shame and stigma while decreasing hope for the nurse wishing to return to work.

The use of discriminatory hiring practices for nurses in recovery may violate the Americans with Disabilities Act (ADA), although the application of the law is not without challenges. According to the United States Commission on Civil Rights (2000), an employer is legally compelled to not discriminate against a person with a history of addiction who is currently participating in a rehabilitation program or who has completed a rehabilitation program provided they are currently substance-free. Accommodations for safe work environments for nurses in recovery should be treated with the same serious consideration as accommodations for an individual with other disabilities. The continued use of language and probing questions regarding mental health and substance use history on licensure and job applications is a legally nebulous territory that likely requires employer guidance and training to ensure compliance with ADA standards.

When a nurse being monitored by an ATD program does return to work, operationally this results in additional paperwork for the organization that is employing the nurse. There may be limits on the nursing license and practice restrictions. ATD program involvement may include monitoring requirements, such as daily check-ins and random specimen collections. While such accountability is part of the ATD programs, and some would argue the recovery process itself, supervisors and healthcare systems need to use non-stigmatizing language in their interactions and be willing to work with individuals who are reentering the workforce.

During conversations with nurses in recovery, we often hear statements such as "I never thought it would happen to me" and "Nursing is all I've ever wanted to do." The love of the work of a nurse brings them back into the organization and supports engagement in the work of recovery. Further, they perceive themselves to be much better nurses while in recovery (Matthias-Anderson & Yurkovich, 2016). Often, ATD monitoring during the tough early recovery period keeps them accountable (Matthias-Anderson & Yurkovich, 2016). Enrollment in ATDs is often during a vulnerable time for nurses with SUD, and the language and behaviors of peers and employers shape the reality of recovery for them.

Protection of public health and safety is often cited as the rationale for restrictions around return to work and the long list of regulatory procedures regarding substance use mandatory reporting. The primary function of state regulatory bodies is the protection of public health; the question is whether stigmatizing language, discrimination, and punitive measures for nurses with SUD offer better protection for the public versus an environment focused on well-being, self-discovery, and continuous support through recovery. The vast underuse of ATD programs and minimal utilization of traditional SUD recovery pathways in nursing means that most nurses with AUD and SUD are not receiving help to begin or continue recovery, placing them and the populations they serve at much greater risk than a process that provides monitoring and support.

5 | CONTRASTING LANGUAGE, STIGMATIZING CONSEQUENCES

Language around substance use in the nursing profession appears in at least two contradictory spheres. In one sphere nurses may consume substances to cope with the rigors of the professions, as well as being exposed to and having access to pharmacological agents. For example, the normalization of substances is commonplace as a way of managing stress, such as alcohol after a particularly difficult shift, or managing the rigors of bedside nursing with caffeine or energy drinks during long work hours (Ross et al., 2018; Trinkoff et al., 2022). As a part of their professional orientation, nurses are responsible for dispensing a variety of pharmacologic agents designed to mediate the body's functions in a desirable way. In the limited studies completed thus far regarding nurse attitudes toward substance use, the use of legal substances by the individual nurse appears to be well accepted up to the point of an SUD diagnosis (Kunyk et al., 2016; Ross et al., 2018). As a mental exercise regarding the acceptability of casual overuse of substances, the authors recommend thinking about how difficult it might be for a nurse in recovery to attend any outside-of-work social activities with colleagues, such as an after-work happy hour or a "Margarita breakfast."

In the other sphere, nurses with SUD who are "caught" and confronted by employers are often discussed in terms that create a sense that they are "others," distinctly different from "us" (Ross et al., 2018). The transition from casual overuse of substances to full blown

addiction is not always apparent to the individual nurse. Further, their support system, coworkers, and often the recognition of a need for intervention occurs only after a sudden event. This may take the form of a driving under the influence (DUI) charge, a suspicion of working while under the influence, or a diversion of substances from the workplace. While the process of developing a SUD can be insidious, the transition from nurse to "addict" or "alcoholic" is more likely to be sudden, isolating, and stigmatizing.

This stark contrast in language is unscientific at best, considering the nature of SUD, which exists along a continuum based on risk to the individual and to society (United States Department of Health and Human Services, 2016). An individual with SUD does not wake up one day with a full-blown problem; rather, SUD develops over time, through continued substance misuse that creates chemical changes in the brain (United States Department of Health and Human Services, 2016). The point at which a nurse changes from a colleague who had "one too many at happy hour" to a nurse with a SUD is often based not on the status of a nurse's substance use but rather the status of legal action in their lives, such as whether or not they were pulled over for a DUI infraction on the way home.

The line of demarcation between acceptable substance use and the moment at which a nurse is deemed an "addict" or "alcoholic" can have devastating consequences. For a nurse newly diagnosed with or even simply suspected of SUD, they often must leave their place of employment, surrender, or forfeit their nursing license and means of income, and lose their social relationships. Retrospective studies of nurses who died by suicide show a relationship between substance use investigations at work and the decision to move forward with a suicide plan (Barnes et al., 2022; Davidson et al., 2021). While impossible to isolate a single variable, stigmatizing language and processes are almost certainly a part of the complex process that results in death by suicide for at least some nurses.

Curtin (1987) ends her discussion of stigma and nurses' substance use by asking if we can afford to "throw away" nurses given that an estimated 18% of nurses in the United States screen positive for substance use problems (Trinkoff et al., 2022). This remains an important question given the crisis of the nursing shortage today, but it is not just about the shortage. We also know that COVID-19 increased US nurses' use of substances, particularly alcohol (American Nurses Association Enterprise, 2020a, 2020b; Foli et al., 2021). Study after study in the nursing literature documents the psychological harm done by the working conditions faced by nurses during the COVID-19 pandemic. Yet there are psychological traumas encountered daily by nurses, and some of these traumas put nurses at risk for developing substance use problems (Foli, 2022).

6 | IMPLICATIONS FOR RESEARCHERS

Given the many challenges individuals with SUD experience, researchers in substance use should receive training in and apply updated and equitable language to reduce stigma. The use of informed and non-stigmatizing language will facilitate trust, so individuals feel safe and free from judgment. In addition, theoretical models may offer a way to organize data collection and analysis. The Socioecological Model (SEM) (Bronfenbrenner, 1994) and *Intersectionality* (Crenshaw, 1990), are useful frameworks to deepen our understanding of substance use among nurses and different populations. The advantage of using the SEM (Bronfenbrenner, 1994) is that it elucidates how individuals, interpersonal, institutional community-level, and wider societal factors impact behaviors of individuals who have challenges with substance use. Further, *Intersectionality* (Crenshaw, 1990) as a framework may be useful to understand how intersecting identities of nurses and individuals locate them in more disadvantaged positions for substance use. More specific to nurses, the middle-range theory of nurses' psychological trauma situates substance use as a potential outcome of ongoing and past traumatic experiences (Foli, 2022; Foli et al., 2020, 2021). Finally, additional research is needed to examine potential disparities for equitably accessing and/or receiving substance use treatment that includes individual, professional, and organizational barriers and facilitators.

7 | CONCLUSIONS

Words, language, and discourse create our reality and as nurses we can choose to use them differently to create a more caring and therapeutic reality. A new ontological self is needed for all individuals in nursing that reflects thoughtful, equitable, and person-centered conduct; such conduct will dismantle pillars that too often support the stigmatization of colleagues and patients. The reality is that at times nurses, like most people, use language to describe others that sometimes cause harm, and this is particularly true with highly stigmatized groups such as people with AUD and SUD. In nursing, these patterns of behavior are harmful not only to our patients, but also to our fellow nurses who may themselves struggle with alcohol and substance use. To shift away from obligation and toward greater respect and dignity, nurses must disentangle their identity as a nurse from patient nonnormative behaviors and conditions. All people who struggle with alcohol and substance use deserve to be treated with kindness, respect, an informed mind and mindful discourse, and provided with resources to support healing and recovery. Our nursing colleagues deserve this too, including accountability without judgment, employment without suspicion, transparency without shame. This must be our charge. This should be our reality.

AUTHOR CONTRIBUTIONS

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CONFLICT OF INTEREST

The authors declare no conflict of interest.

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