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Abstract

Processes of professional socialization influence types of substances used, patterns of use, and estimation of normalization. This project explores psychoactive substance use among professionals and students in professional programs in Canada, rationales for use, strategies to manage use and potential consequences, and factors within professional education and culture that influence decisions about use. The intent of this study is to uncover social processes through which professional contexts influence substance use. The researchers sought to explore how professionals and professional students described their own decision-making about substance use and their perceptions of professional influences. The mixed methods pilot study involved ecological momentary assessment (EMA), using an app designed for the study, and qualitative interviews. Participants completed a brief survey on the app each time they used a substance during a 4-week period, reporting what substance was used, how much, where, who with, and anticipated or delayed effects. Thirty-four participants were involved in the EMA component, 20 of whom engaged in interviews. The findings suggest a certain amount of substance use is expected, accepted, and even promoted in professional fields. Thematic analysis revealed novel understandings about (i) deliberate decisions, (ii) disclosure and use, (iii) stigmatized substance use, (iv) normative substance use, and (v) the professional context. This study demonstrates potential advantages of undertaking research to explore substance use, as distinct from substance abuse, problematic use, dependence, or addiction. Conceptualizing substance use more broadly can help to identify factors that both encourage use (e.g., performance demands, social norms)

and constrain use (e.g., responsibility, role modeling). This can expand approaches to address substance use that look beyond the individual to social and institutional contexts, acknowledging that responsibility is a collective process.

Keywords

workplace, surveys, professional socialization, professionals, students, ecological momentary assessment

Introduction

This article explores psychoactive substance use among professionals and students in professional programs in Canada, rationales for use, strategies to manage use and potential consequences, and factors within professional education and culture thatmay influence decisions about use. Psychoactive substances encompass licit substances (e.g., caffeine, alcohol, over-the-counter medication), prescribed medication (e.g., oxycodone, benzodiazepines), illicit substances (e.g., marijuana, cocaine, MDMA), and healing plants (e.g., peyote). Professions are groups granted the power to provide expertise and services in specified areas (Gorman & Sandefur, 2011). Through extensive education, students learn not only the content expertise and skills of their profession but also the informal ways of being that are typical in that profession. This may include learning particular ways of relating to substances. While there appear to be unique patterns of substance use within professions (Kiepek & Baron, 2017), relatively little is known about the processes through which professional contexts influence substance use (Monroe & Kenaga, 2011). This article examines some of the social processes that influence professionals' use of substances.

Background

The professions are fields of work that are relatively autonomous, and enjoy high levels of social status and esteem. They use accredited formal educational programs to transmit the knowledge and skills of the field. They base their practice on a body of knowledge which can be demarcated as fairly exclusive, yet has practical application to social, health and other problems. Professions claim jurisdiction over particular aspects of human experience by being able to classify, consider and respond to a problem. The exclusivity of their knowledge base gives professional expertise, judgments, and claims particular power. The professions are often marked by a kind of service

orientation, a sense of vocation or calling, doing work that holds social value (Gorman & Sandefur, 2011).

Professions typically involve processes of licensure, codes of ethics and standards of practice, along with professional associations and regulatory bodies which govern educational curricula and address practice violations (Weinberg, 2010). The professions are self-governing, regulating members and controlling the affairs of their own professional body. Depending on the success of a profession's jurisdictional claims, they may exert monopoly powers, eliminating, controlling or subordinating related or competing occupations. There is typically also a sense of community as members forge long-term commitments to the profession (Gorman & Sandefur, 2011).

A lengthy and exclusive education period serves not only to convey knowledge and skills, but also to socialize new members into a professional culture. The extensive training provides a means of occupational closure, barring entry to those deemed unfit, and helping to raise the prestige of the profession (Gorman & Sandefur, 2011). The process of developing a professional identity is a particularly intense form of secondary socialization known as professional socialization (E.g., Beagan, 2001; MacLeod, 2011; Seron, Silbey, Cech, & Rubineau, 2016). It can entail formal and informal learning of new ways of thinking and speaking, new forms of self-presentation and appearance, and new relationships to others, including other workers and those who avail themselves of professional services. Students may learn new ways of managing or expressing emotions, new ways of integrating personal and work lives. They learn the 'cultural capital' of the profession, the 'rules of the game' or ways of being and acting to move smoothly within a new social context (Bourdieu, 1984). In short, professional socialization is "the practice of making familiar to members the communally approved

meanings, norms, and practices… Small talk, as much as formal lectures, helps to develop a sensibility for knowing how to act like a professional" (Seron et al., 2016, p. 181).

Substance use in the professions

Patterns and prevalence of substance use are unique in the professions, and vary by profession as well as by type of practice (e.g., private/public), gender, and career stage (Joos, Glazemakers, & Dom, 2013; Kenna & Wood, 2004; Diane Kunyk, 2015; Leignel, Schuster, Hoertel, Poulain, & Limosin, 2014; Li, Baker, Qiang, Grabowski, & McCarthy, 2005; McNiel et al., 2011; Moisan et al., 2014; Shah, Bazargan-Hejazi, Lindstrom, & Wolf, 2009; Shore, 2001; Volger, McLendon, Fuller, & Herring, 2014; Winwood, Winefield, & Lushington, 2003). For example, physicians and pharmacists report higher illicit use of opiates, anxiolytics, and sedative-hypnotics than the general population (Kenna & Wood, 2004) and cocaine use among a sample of lawyers was higher than the general population (Benjamin, Darling, & Sales, 1990). Among medical students, use of cognitive enhancement pharmaceuticals is common (Emanuel et al., 2013) and a systematic study reported that 16% of them use methylphenidate (Finger, Silva, & Falavigna, 2013). Patterns vary by gender and type of practice. For instance, in social drinking, female lawyers working in criminal litigation reported higher consumption than those in other fields (Shore, 2001), while dentists in private practice demonstrated higher prevalence of problematic drinking (13%) than those in public practice (5.5%).

Performance and experience expectations are shaped by everyday context, including professional contexts, in turn influencing patterns of substance use (Brooks, Chalder, & Gerada, 2011; D. Kunyk & Austin, 2012; Merlo, Cummings, & Cottler, 2012; Shore, 2001). Processes of professional socialization influence types of substances used, patterns of use, and estimation of acceptability. For instance, professionals who work night shift may intermittently rely on

substances to aid with sleep and/or facilitate alertness (Shy, Portelli, & Nelson, 2011) and recommend similar substances to colleagues. This study sought to explore how professionals and professional students described their own decision-making about substance use, and their perceptions of professional influences.

Methods

We conducted a mixed methods pilot study on professionals and students enrolled in professional programs, which involved ecological momentary assessment (EMA) and qualitative interviews. EMA utilizes electronic Android or iOS devices and specially designed software as a means to collect real-time data in situated contexts. Participants were asked to complete a brief survey on an App each time they used a substance over a four week period. In addition, they could opt to participate in a 30-60 minute interview (in person or by skype) at one, two or three time points (just before, during, and just after the four weeks). Analysis of the pilot study findings pertaining to the EMA data are reported in a separate article (Authors, under review; Kiepek, Harris, & Beagan, submitted manuscript). Briefly, the App included 34 prompted substances (e.g., anti-depressants, cocaine, steroids, Ritalin) and an option of "Other." Participants recorded the substance(s) they used, the social context and general location of this use, perceived immediate and longer-term effects on performance and the quality of the experience. Ethics approval was obtained from Dalhousie University Social Sciences & Humanities Research Ethics Board (REB #: 2015-3671). This article draws only on the qualitative interview data.

Inclusion criteria

Participants were English-speaking, residing in Canada, 19-years or older, and used at least one psychoactive substance. Participants were eligible for this study if they were professionals or

post-secondary students in a professional program, and their substance use met one or more of the following patterns: i) approximately daily use of a non-prescribed psychoactive substance; ii) non-prescribed use of one or more psychoactive substances approximately weekly, though the type of substance used may vary (e.g., one substance one week, and a different substance the next week) and *some* of the substances may be prescribed, or iii) infrequent (less than weekly) but heavy use (e.g., substantial use over a discrete period in a month; binge use) of a psychoactive substance. Participants needed to have access to a mobile device and WiFi in order to use the EMA instrument.

Table: Participant characteristics (N=20)

Participant Code	Profession	Status	Gender
A	Allied Health	Student and professional	Female
B	Social Work	Student	Female
C	Allied Health	Student	Male
D	Social Work	Student	Female
E	Nursing	Student	Female
F	Social Work	Student	Female
G	Social Work	Student and professional	Male
H	Allied Health	Student	Male
I	Allied Health	Student	Male
J	Allied Health	Student	Male
K	Nursing	Student	Female
L	Social Work	Student	Female
M	Social Work	Student and professional	Male
N	Nursing	Student	Female
O	Social Work	Student	Female
P	Nursing	Professional	Female
Q	Nursing	Professional	Female
R	Social Work	Student	Female
S	Nursing	Student	Female
T	Allied Health	Student	Female

"Allied Health" includes occupational therapy, physical therapy, speech language pathology, pharmacy, and psychology.

Recruitment

Recruitment involved emailing research coordinators at twenty Canadian universities to request they forward the advertisement to students and alumni. Universities were purposively selected to include multiple provinces and regions (e.g., Atlantic region) and those offering a comprehensive range of professional programs, such as law, engineering, business, veterinary science, pharmacy, dentistry, nursing, social work, speech language pathology, audiology, occupational therapy, physical therapy, medicine, and psychology. There was no compensation for participation. All eligible volunteers were accepted during the recruitment period for EMA data collection. At the time of consenting to EMA participation, people were asked whether they agreed to be contacted for an interview, either in person or by phone.

Thirty-four participants, from six Canadian provinces, were involved in the EMA component; twenty of these (14 women; 6 men) engaged in interviews (see Table). Higher representation of participants in the health professions might be indicative of which Schools forwarded the advertisement to their students. The researchers had received responses from some professional Schools (e.g., law), who were uncertain about involving students in a study of this nature. Seven of the twenty participants were from Nova Scotia, seven from Ontario, three from British Columbia, two from Alberta, and one from Manitoba. Participants ranged in age from 18 to 50 years old, with 90% being 21 to 35 years-old. Participants were invited to participate in three interview; one prior to using the App, which included orientation to the EMA data collection process, one at Week 2 to gather information about using the App and any reflections that emerged from questions asked during the first interview, and once during Week 4 to gather further information about the data collection process and ask additional questions about topics that emerged as a result of data collected by researchers up to that point in the study. Six people

engaged in all three interviews, 11 participated in two interviews, and three engaged in one interview each. A majority of the participants were students, ranging from first-year of studies to final month of studies, with varied exposure to clinical placements. For many students, the data collection period occurred over the end-of-term examination period. Three participants were working as professionals while also engaged in continuing education and two participants were working professionals. This offered a range of perspectives that could contribute to understandings of professional socialisation.

Insert Table here

Data collection and analysis

Qualitative semi-structured interviews took place by phone (n=39) or at a private location selected mutually by the interviewer and participant (n=4). They were 30 to 60 min long, and the interview guide included open-ended questions to explore participants' perspectives on their use of substances, the impact of this use on their daily activities, and the cultural positioning of substance use within professional contexts (social and institutional). All interviews were conducted by the lead researcher and with consent were audio-recorded. Recordings were transcribed verbatim and checked against the audio. The quality of one audio file of a participant who solely used caffeine was compromised, impeding complete transcription. Preliminary analysis was undertaken while the interview process was underway.

Transcripts were analyzed according to constructivist grounded theory methodology (Charmaz, 2011), using coding, mapping code hierarchies and memoing. Thematic analysis was led by the first author, supported by two research assistants, all of whom engaged in coding and met regularly to refine themes. Member checking was conducted with the second author. Constant comparison entailed both immersion in individual accounts and systematic examination

across participants (Charmaz, 2011). Concept mapping (Rosas & Kane, 2012) was used to clarify interpretations of the relationships between substance use, its effect on performance and the experience of activities, and aspects of professional role and identity.

Substance use among professionals

During the interviews, participants were asked about their current use of substances. Almost everyone said they use caffeine, three-quarters of the group drank alcohol, and just over a third used cannabis, mental health medications (antidepressants, anxiolytics, and antipsychotics) and/or pain medications. One or two people reported using cigarettes, sleeping pills, melatonin, MDMA, LSD, cocaine, and/or hallucinogens. Thematic analysis revealed novel understandings of i) deliberate decisions, ii) disclosure and use, iii) stigmatized substance use, iv) acceptance of substance use, and v) the professional context.

Deliberate decisions

Interviewees reported engaging in considerable deliberation when making decisions about substance use. Substances tended to be selected to attain a desired outcome and used in ways to minimize undesired effects. Below we discuss benefits, intentionality, the mitigation of undesired consequences, and the tailoring of use.

Benefits

Substance use was understood as beneficial for relieving pain, enhancing sleep, providing energy, and engaging in daily activities. As one participant said of caffeine, “I'm a better caregiver to patients when I’m not irritable or grouchy. I’ve got energy, I’ve got motivation” (P, female, nursing, professional). Some people found substance use reduced anxiety, thus helping them to cope with professional demands. For example, one person used beta blockers to get through public presentations: “You come across as really composed. So people think that I’m

very composed and calm, but it's interesting that they think that when I'm actually not. I'm actually terrified of it" (G, male, social work, professional and student). In contrast, sometimes substances were used to push further, accomplish more; as one person described the appeal of Adderall to "See if I can push beyond my kind of natural capacity… constantly trying to keep up with deadlines, trying to take on so many things" (A, female, allied health, student and professional).

While some substances were seen as a means to improve performance, others were described as rewards for completing tasks: "That was the idea last night too… We all deserve to go out and have a drink… It's a little bit of self-care potentially. Getting through the monotony of classwork" (C, male, allied health, student). This was particularly true for alcohol, which some saw as an incentive for work performed, or "a nice little treat" (T, female, allied health, student). As one participant explained, "If I'm writing a paper or something, it's kinda like, incentive. If you get this done, you get a nice big glass of wine once you get to your references" (S, female, nursing, student). One person explained that such rewards can be part of a daily routine for women in their profession: "Especially the women who are working with kids right now, they have the 3 W's. They go for work, they go for a walk and they have wine, and then it's a glass every night before bed" (T).

While other activities might help with energy, sleep, or reducing anxiety, psychoactive substances have the advantage of working more immediately to achieve desired outcomes. For some professionals, substance use may be a perceived benefit to enhance insight into the perspectives of clients or patients who use substances. A participated noted, "In [my profession] we're told to not be judgmental… And I guess trying things will help me, in my practice. … It just leads you to understand" (S).

Intentionality

Participants almost exclusively described using substances intentionally to achieve desired outcomes. They selected or avoided specific substances, or timed their use to be least disruptive and most advantageous. For example, someone who could not study while high only smoked marijuana before bed. Another participant used hallucinogens (e.g., psilocybin, LSD) in a similar way, recognising the expected effects of the substances:

> I don't try and do normal, functional, activities when I use them. I try and carve out a day or space for them specifically. I like to get into nature and it really helps me with just a better sense of self-understanding…. carving out an intentional space in time to explore creativity and almost in a sense spirituality. (R, female, social work, student)

One participant used different strains of marijuana depending on desired effects on performance; one strain for leisure, one for relaxation, and yet another for performing menial tasks.

Prescription medications were sometimes seen as pragmatic tools for achieving intended outcomes. For example, one participant was using an antidepressant as a temporary measure during a time of unusually high pressure and stress, saying, "I'm hoping eventually to go back to using all my other coping strategies and my other resources" (F, female, social work student) when stresses lessened. Similarly, one person chose to use a prescription medication to achieve the same effects attained with marijuana, simply because legality made it more practical:

> I would much rather travel internationally with a prescribed medication that's in a little bottle that shows that it was prescribed to me. I obviously can't travel internationally with illegal substances… I cannot imagine myself going out and

> smoking a joint outside the building at work as part of a therapeutic, like part of my own medicine therapy. (A)

Mitigating negative consequences

Substance use decisions were largely dependent on time, place, people, and obligations. This theme was most consistent across participants. For example, someone might use a substance to enhance the experience of partying, "Given the right circumstances, and everything was safe and I didn't have a house with children and I was out and the kids were safe and away" (K, female, nursing, student). Another person outlined some of the factors influencing whether she used cocaine:

> A couple weeks ago a friend was doing lines [of cocaine]. It was like, 'you want some of this?' And I was like, 'oh I can't, I have like, [a sport] in the morning,' like 'it's fine.' And so I said 'no' then because I had responsibilities. So then this time at our neighbour's house, it was like 'well I have no responsibilities, so may as well.' (S)

Similarly, a participant described off-label use of clonazepam "for the fun [of it]" or to relax when feeling stressed: "I don't do it out partying, or out with a crowd of people. I'm at home, safe, in my own house. Everything's taken care of. It's just to chill" (K). There is clearly an assessment here of potential effects, and deliberation about desired and undesired effects.

People assessed consequences beyond the immediate pharmacological effect, such as longer term effects on sleep, energy, clarity, emotional state and ability to perform. For example, a participant who engaged in binge drinking stated, "I would never drink on a work night and get hungover. It just wouldn't happen" (G). Someone else chose not to smoke marijuana the day before work because it disrupted sleep, and subsequently, work performance:

> Caring for people, you should be on your A game…. I don't think I'd be on my A game because I don't sleep very well after, if I have a couple [of joints]? I don't sleep at all. I'm tossing and turning all night. (P)

Sleep was a major concern for many participants, affecting choices to avoid certain substances at certain times or to use certain substances to facilitate sleep. Three of the participants reported using melatonin, including one person who worked shift work:

> That's why I take it, when I do. It's 'cause I know I need to fall asleep, because I need to be up at 5:30. And I don't find it affects me the next day. … [Other medications] make you groggy but I don't find this makes me groggy at all. (N, female, nursing, student)

Several participants used over-the-counter or prescribed sleeping medication, balancing the need for sleep to optimize work/school performance against the "evils" of substance use: "I wanted to choose something like what I consider is a lesser of evils… I chose sleeping pills" (D, female, nursing, student).

Some participants avoided certain substances, due to previous experience or perceptions of potential effects. For example, one person reflected that "smoking cigarettes slows me down, smoking marijuana leaves my head feeling a bit fogged for like a day or so afterwards, alcohol too, just kind of slows me down" (A). The participant went on to say, "if I don't use substances I'm more likely to wake up early in the morning, have a clear mind and be ready to get to work" (A). Some were avoiding quite significant effects, such as one person who became suicidal when mixing alcohol with anti-depressants: "It gets very extreme very quickly, and I'll just feel very low for the next while, like next few days" (L, female, social work, student). Finally, some avoided particular substances, even scrutinizing the ingredients of cold medications to avoid triggering previous addictive use patterns.

Tailoring use

With the highly intentional assessment of potential benefits and consequences, timing, commitments, context and people, participants unsurprisingly reported tailoring their use of substances, making changes when deemed necessary. One participant had used alcohol to induce sleep, but did not like the idea of *needing* to have a drink: "That did not seem, like, healthy" (D). Another participant reduced use of caffeine-filled energy drinks after some deliberation with others, saying, "It isn't good for my heart, it's pretty risky. So I just cut it back to only two drinks" (G). In both instances, perceptions of health held particular influence.

Disclosure and use

As illustrated below, substance use was rarely discussed in professional settings, and when it was, "problematic" use was clearly delineated from recreational use, abuse, misuse, and addiction. Participants discussed how, when, and why they might discuss their substance use with others.

Discussing substance use in professional settings

Most participants reported that substance use rarely or never explicitly arose in professional settings or in professional education. It was discussed almost exclusively in relation to the substance-related problems of clients: "I can't really think of a time that we've discussed like substance use among ourselves. Or as [professionals] or as a profession" (D). Students reported that discussions in class perpetuated stigmatising discourses relating to substance use. As one explained, "It's seen as maybe a drug abuse problem. It's seen as a negative thing. … so it's kind of only talked about when it's a problem" (N).

Substance use by professionals was only raised in reference to professional regulation and the potential for loss of license to practice. Students suggested this conveyed a stance of

individual autonomy and risk: "[Professors] don't talk about illegal substances, … what you do in your off time is your time. But they're also like, 'remember that everyone's always watching you'" (S). One person noted inherent tensions among competing professional standards that influence disclosure, including professional regulations that hinder open disclosure, professional philosophies that encourage disclosure by others, and professional practice approaches that recommend against self-disclosure in therapeutic contexts.

Delineating problematic use

Some participants appeared to derive comfort from the notion that problematic and non-problematic substance use differ qualitatively, with only a small percentage of the population demonstrating problematic use. As one participant explained:

> There's a very large population of people who use substances casually and it doesn't really impact their life. There's another group, about ten percent of the population, that use substances in a sort of maladaptive way either to cope with stress or to handle emotions that they're not able to deal with themselves. So I think it would depend on the context and the behaviors that went with it. If I noticed someone who was emotionally volatile, their moods were really different from day to day, or if they were experiencing withdrawal symptoms, like if I noticed them shaking the day after a big day of drinking or sweating a lot. Those things would be a clue to me that this person was in a place where they, their addiction or substance use, is impacting them negatively. (M, male, social work, student and professional)

Another participant endorsed the notion that only ten percent of the population develop problematic use, and when asked about the other 90 percent replied, “Nobody just talks about them” (K).

In contrast, some participants challenged the distinction between licit and illicit substance use, suggesting it may be artificial: “I’d already been questioning the difference between, say caffeine use by professionals and illicit substances. I guess this project just helps me reiterate that in my mind everyday. It’s like ‘oh ok. I’m a substance user too’” (C, male, allied health, student). This participant further noted the potential for social status to define acceptability, noting, “There was a joke… like let’s ban caffeine. Let’s ban a substance that the professional class uses, and then let’s see what they have to say about pot” (C).

Sharing personal experiences with others

Though participants tended to refrain from disclosing substance use to others in professional contexts, disclosures were sometimes made when they felt safe and trusting of colleagues. For instance, if another person disclosed use of the same substance, this might generate an increased sense of safety and understanding. One student had discussed anti-depressant use with other students who used similar medications: “Usually the discussion opens with someone sharing something. And it's like, ‘oh yeah me too.’” As this participant said, “[It’s] not like I just come in and go ‘Oh I feel awful today, I’m sure glad I took my Prozac’” (P). Conversely, one participant reported using self-disclosure to create a sense of safety for a professional colleague who was encountering difficulties at work: “It was a way to let him know that he wasn’t alone” (G). The same participant wondered if some types of work places facilitated the development of trusting relationships, such as contexts that required relying on colleagues during crises.

Epistemologies of practice in the profession may also affect the degree of openness to discussing substance use. Some professions were perceived as less conservative, more open to challenging repressive norms. As one person said, in their profession "It's assumed that we all have this political stance that people should have control over their own bodies. It shouldn't be politically policed, etcetera. So I find that it's more commonly discussed" (F). One participant noted that personal experience can influence a decision to enter a particular profession, making people more likely to use self-disclosure strategically in professional contexts, to connect with clients or effect change.

Generally, however, participants indicated that substance use was highly stigmatized in their professions. Several people thought professionals should be able to discuss substance use more openly, without risk of repercussion. One person observed, "I feel like that issue is under-addressed, it's kind of a dirty secret for professionals. It makes it difficult for us to seek help if we should ever need it" (G). One person who used medical marijuana noted the benefits of being given the opportunity to discuss use openly:

> Getting my marijuana prescription … has provided me with someone to talk to who had a better understanding, a better knowledge … someone that's a little bit more objective to talk to about the effects. And how it could work for me or against me or whatever. And I guess that's what reducing stigma is all about, is just slowly getting a few people coming out, and then more people coming out and all of a sudden it's okay to talk about it. (R)

Another person used self-disclosure deliberately as a way to reduce stigma, saying, "I think it's a shame that sometimes we assume that professionals don't struggle, so I've become pretty open with that, and kind of breaking down that stigma." The participant went on to point out inherent

contradictions: “I don’t really think it’s fair if we’re encouraging other people to use those treatments but then we think it’s not acceptable if we are.” (L)

Some participants thought silencing around substance use was connected to a broader reluctance in the professions to talk about vulnerabilities, saying professionals tend to “really celebrate successes and to be totally quiet about our failures and our struggles” (A). Some suggested that open discussion about prescribed and non-prescribed substance use in professional education programs would begin to create attitudinal change. Students who had disclosed use of substances usually associated with mental health concerns found it helped them to connect with others with similar diagnoses or medication regimens, providing a sense of belonging and community. Some also found such disclosures allowed them to feel more genuinely themselves in professional contexts.

Stigmatized substance use in the professions

Participants noted that there was considerable stigma attached to the use of certain substances, perhaps especially intensely in the professions. As one participant suggested, people “who do drugs” are considered “not trustworthy” (S). Others noted that the type of substance used and the mode of delivery all affected the degree of stigma. More generally, the heavy use of substances was seen as potentially undermining professionalism:

> If I were to show someone my credentials, they’d be like ‘Wow. You’re really successful.’ Then I’d be like, ‘and I smoke a lot of weed.’ I don’t know if they would be like, ‘oh wow like, that completely turns us off of you now.’ (S)

When participants were asked what they would think if they knew a professional who was providing a service to them was using substances, some thought it would negatively affect their perceptions. As one person stated, “If it was a street drug, or an illegal substance, it would

probably discredit them. I would be a little bit less [… trusting] of them I guess" (L). Another participant also thought use of illegal substances would taint their perception of a professional, saying, "I really don't want it to influence my perception of other people, but unconsciously I think that it does" (B, female, social work, student).

One participant pondered this question for several weeks between interviews, and revealed uncertainty about how to evaluate other professionals:

> It gets really complicated right? … how do you decide what a mild, and not, abuse is. Because I don't know a lot about drug use, heavier drug use. So, how could any use at all affect their performance? And is that a risk I'm willing to take? And I think, another thing was, kind of this image that society and public school has kind of bred into me? That people who use drugs? Someone who uses drugs, you know, they're kinda gross, they're kinda sketchy [dishonest or disreputable], they're people you kinda wanna keep a little bit of distance from? And I think that's kinda feeding into it as well. Because when I think of drug use immediate[ly] – I don't think of people who are highly educated or professionals. I think of people who have really really serious drug problems, and are homeless, or things like that. And I know that's probably not the case, but that's just, the opinion's been bred into me, over 20-odd years. [chuckles] (T)

These comments suggest the power of social discourses about substance use that override even first-hand experience and observation that substance use is not confined to "sketchy" people and can in fact co-exist with professional status.

The stigma associated with use of prescribed, or therapeutic, substances was highly entangled with stigma about mental illness. Some participants suggested diagnoses of mental

illness are automatically considered evidence of "weakness" (A), and seen as undesirable in the professions. Not surprisingly, then, people described limiting such disclosures, as noted above. One person stated, "You don't know the can of worms that you're opening… for the most part people just don't understand" (G). One participant suggested that knowledge of mental illness "qualifies" professional identity, such that you are no longer simply a physician or teacher, but rather become "the bipolar physician" or "the depressed teacher." This participant stated:

> Nobody at work knows about my psychiatric history. I tend to keep that fairly private. I think there's still a lot of stigma around psychiatric illness. Despite a lot of recent efforts to educate people I think there's still a stigma that exists and it's gonna take time for that to dissipate. I also don't want to be judged on the quality of my work with my psychiatric diagnosis as sort of a precursor… I don't want people to sort of look at the work that I do through [that] lens. (M)

The stigma attached to mental illness may also be internalized by professionals who themselves have diagnoses. One person described trying alcohol, marijuana and tobacco to control symptoms before turning to a prescribed anti-depressant: "I remembered that I had this SSRI and that this was the kind of thing it was prescribed to me for in the first place" (A). This participant told no one at work about the diagnosis or substance use, saying, "I don't know, it's a real problem to me… but I, I don't, I just can't." Some participants observed that while physical health concerns are validated in professional workplaces, mental illness concerns often are not, except – perhaps – in mental health settings.

Risk of judgement

While use of many types of substances may be subject to stigma, in a professional context this seems particularly tied to a risk of being judged as "unprofessional", and as incompetent and

unsuited to a professional role. For example, one person who used medical marijuana thought disclosure would "jeopardize" self-presentation: "The reason I wouldn't [disclose] would be because of potentially having someone think of me as less competent in some way, or other negative connotations with recreational drug use, like lazier, or not as motivated, or something like that" (R). Similarly, a student who chose not to disclose heavy drinking said, "I just think that it would impact how professional they think I am" (E, female, nursing, student). This person went on to say professionals are "trained to be … super responsible and stuff" so that heavy drinking "just doesn't seem like something that a clinician should be doing" (E).

Use of illicit substances was resoundingly associated with personal concern about negative judgement by others, despite the fact that several participants suggested many professionals do use illicit substances. Nonetheless, people feared negative judgement: "I'm kind of closeted about smoking weed. I don't talk about it with my break room friends even. I don't really talk about it with people, at all… I don't want to be judged." (Q, female, nursing, professional) Yet the same concern about negative judgement extended to use of prescribed medications, particularly those associated with mental health concerns. Even painkillers and sleep aides were perceived as revealing ("undesirable") weakness in those who are expected to have the capacity to perform all activities without relying on external resources:

> Like we are supposed to do things ourselves, and it would seem inadequate, in a way, if we are using things other than, you know that aren't necessarily socially sanctioned. So, where like caffeine is seen as okay, it's not seen as appropriate to smoke to calm your nerves, or drink to calm your nerves, or whatever. (A)

Again, the negative judgements seemed internalized, as some participants suggested that knowing other professionals had used substances in the past would make those individuals seem

more “normal” (K) and better able to relate to others. However, if substance use was current and might be accepted to some extent, the person might nevertheless be viewed as less credible. One participant explained they would “still respect their authority a bit. But not take them as seriously” (S).

Acceptance of substance use in the professions

While use of some types of substances was subject to stigmatization, the use of other substances was not only acceptable but even expected and encouraged. As noted above, professions and professional education programs are sites of often intense secondary socialization, where new entrants learn to adopt a professional identity. Not surprisingly, then, peers, mentors, professors, and colleagues provide implicit cues about what is acceptable, and what is not, in relation to substance use.

Many participants spoke about tacit influences, such as an emphasis on healthy lifestyles among health professionals, discouraging the use of many substances. Using those substances poses a risk of being cast as a cultural outsider. As one person said of tobacco: “There was no smoking culture whatsoever, so I didn't smoke. In a health profession, tobacco use is generally seen as inappropriate or a negative thing. So, I guess not smoking is consistent with that kind of professional environment” (A).

In contrast, some substances seem to be implicitly endorsed or even promoted in professional contexts. For example, one student reported that a professor had encouraged their class to use alcohol: “Our … professor would encourage us to go out, encourage us to have a drink of alcohol. Just to relax, and go out there and meet people” (H, male, allied health, professional). In some professional programs, it appears the use of particular substances is normal and expected, as suggested in the following quotation:

> Talking about drinking is a fairly open subject. Professors will joke about having a few beers or wine and things like that. And then also caffeine is definitely something that's always talked about. Those two I would say are the most socially accepted. (L).

Participants noted the messages conveyed through the ways professional colleagues talked about different substances, such as normalising heavy use of caffeine and *moderate* use of alcohol, while speaking less positively or even falling silent about heavy drinking or smoking marijuana.

Caffeine use was the substance-related activity most commonly reported in school and work settings. One person noted, "Everybody jokes about, 'alright nobody's functioning yet, nobody's had their coffee'" (C). Another person said, "there's always the IV caffeine drip jokes" (S) to indicate a need for caffeine throughout the day. It was noted by one participant that caffeine served to help people feel connected:

> There's almost a culture surrounding coffee in the sense of, everyone, professors and students, all make the joke, 'Oh I need that morning coffee. I haven't had my coffee.' There's a sort of inclusion? Or sort of, 'Oh we all know what we're talking about with coffee,' we all need it. (D)

Consuming caffeine also affords inclusion in work-related social activities. One student stated that during breaks, "We'll go down as a crowd and just load up on more coffee… Collectively, we will kind of go and get our drugs on" (O, female, social work, student).

Some participants noted the social acceptance of caffeine through its routine provision during meetings, workshops, conferences, and other professional events: "If you think of caffeine as a substance, it's endorsed, it's promoted, it's been provided for us, by the people who are running the workshop. They are actively encouraging us to use this substance" (A). Some of

the participants spoke about caffeine use as a "badge of honor," indicating that the person is working intensively and requires a supplement. As one participant explained:

> It's almost like a badge of honor. To just be, 'Yeah I'm a coffee addict.' … constantly on the go and have all this stuff going on, and people like to talk about it all the time… Coffee addiction sometimes has a bit of that humble brag [aspect], like I'm just so on the go, and I'm so involved, that I have to have constant stimulants in my life in order just to get through the day. (C)

This was reiterated by another participant who asserted that caffeine becomes a symbol for how busy, and therefore how important, people are, along with the need for drinking alcohol to relax. Beyond caffeine reflecting a hardworking lifestyle, it can also be used to signify socioeconomic status through the quality and cost of coffee consumed.

If the use of some substances in professional settings can be a means for social inclusion, so too the choice not to use certain substances can lead to a sense of difference or exclusion. Participants described some uncomfortable experiences in social settings when they decided not to use alcohol or caffeine. Caffeine use was so common that "people who don't drink coffee are considered weird … People who choose decaffeinated coffee, they'll give you a weird look, like 'are you secretly a robot?'" (F). Similarly, those who choose not to drink alcohol are viewed with some suspicion: "People often kind of wonder like 'well why don't you drink?'" (D). In the view of participants, not drinking alcohol is interpreted as being due to religion, or because someone is a recovering alcoholic, or is using contraindicated medications. Regardless, it seems to demand an explanation or justification. Some thought the choice not to use publically condoned substances was read as critique of others' use: "I'm probably more likely to hide my

lack of use of substances… I don't wanna make people feel like I'm judging them for it. Because if you enjoy it … please go ahead. I just don't find it personally helpful" (C).

Professional context

There appeared to be tensions surrounding substance use specifically connected to the context of the professions. In particular, work-related stress and demands, as well as limited time, encourage the use of some substances, even as notions of professional image, identity, competence, and responsibility inhibit the use of others – or at least restrict their use to particular conditions. Many participants spoke about their patterns of substance use changing, but they did not always know which changes were due to immersion in a profession and which were due to age and change over time. Several students noted they drank less alcohol (frequency and quantity) while in professional programs, but they were also simply older. They connected this with increased and incompatible responsibilities, but also with adopting a more professional identity. Substance use they deemed excessive was described as both immature and unprofessional.

At the same time, some substance use was understood as an expected response to the high levels of stress and multiple demands of professions and professional programs. Participants identified several other ways in which they coped with stress, such as social time, physical exercise, meditation, and yoga, as well as planning and organization, but noted these all took time that was in short supply. Substance use could be a faster way to "cope": "It can be difficult to juggle all of it… Everybody has their own way of dealing with, and for a lot of people it does involve some kind of substance" (D). Use of some substances was understood as both a way to get it all done, and a way to unwind after periods of intense work. Some participants also saw using substances such as marijuana, antidepressants, benzodiazepines, and melatonin as a way to

address sleep disruptions caused by shift work. Yet some patterns of substance use were seen as incongruent with professionalism.

Being professional

In terms of substance use, 'being a professional' appeared linked to appearing professional, meeting work obligations and expectations, performing optimally, and modelling desired behavior. One participant pointed out a tendency to switch from beer to wine seemed linked to professional image. Drinking heavily and any use of illegal substances were seen as particularly incongruent with professional image: "You're a lot less likely to, the night before, go out and get totally wasted because the next day you have to be there and you have to look the part" (L). In the interviews, it was sometimes clear the concern was about "looking the part" while at other times it was clearly about optimal performance. For example, one participant said about smoking marijuana, "The fact that you know you have something in your system that's illegal, unprofessional, you would worry about it if anything were to happen. Would they want you to do a drug test?" (P). In other instances, people spoke of having a professional responsibility to perform to the best of their ability, and engaging diligently in self-regulation in order to provide optimal care to others. When substance use was related to the professional area of practice, people also suggested they had a responsibility to model preferred behavior: "I'm working with a lot of clients in and around addictions and if I'm preaching to them about living a life of recovery and then going out after my meeting with them and smoking, it's a little bit hypocritical" (M).

Private versus public use

Private versus public was somewhat contested territory regarding substance use. Participants overwhelming asserted that what a professional does on their own time is their decision, provided it does not impact their work performance: "Alcohol consumption, again, something

that I consider is personal" (G). One participant drove home the personal nature of choices around substance use by comparing it to personal hygiene: "I just wouldn't see it as relevant to disclose… It's not like I'm not gonna say how much time I spend showering either" (R).

Yet at the same time professionals learn that they are always a professional, regardless of context, which suggests always measuring up to particular conduct:

> We've been warned in classes that we have to be careful of how we present ourselves in public. Especially when we're graduated and working in the field, you never know who you're gonna run into and you wanna carry yourself as a professional, wherever you go. (L)

Essentially, all public settings become spaces where professionals are susceptible to be evaluated and judged regarding their substance use. Accordingly, some people tailor their use for private or public: "I openly drink coffee, people see me drink coffee, but … I'm much more selective about who gets to see me smoke marijuana or cigarettes" (A).

Illicit substance use, such as smoking marijuana, was more likely to be confined to one's home or among a known group. Some would indulge among friends, or at a party, knowing that is a semi-private setting, yet others questioned whether even that was sufficiently "private":

> I mean if they are doing it in their own personal life, yeah I guess that would be completely fine. But I think there would be a very fine line of when you're in the home versus out of the home …. I feel like as a professional it would be done more privately and not with a bunch of friends who may know someone who may know someone. (F)

The risk, of course, with use of illicit substances is potential loss of license; as one person said, "It's not something you talk about because it's illegal" (P). Another participant noted there is always potential for bleeding of personal life into professional life:

> If you're a professional, I can't speak for everyone, but you're probably less likely to be involved in having street drugs because with that is a lot of consequences… Who knows if the person who's selling you those drugs at some point is going to be your client and/or if you become in trouble with the law. Like that's really a good way of getting rid of your license or your registration. (L)

Acceptable and unacceptable use

Similarly, when participants were asked to consider how they would view *other* professionals using substances there were tensions between public and private, with a general view that as long as work performance is unaffected it is a private matter. Yet some questioned whether people using certain types of substances can accurately gauge work impairment. And others suggested that even though the substance use may not affect performance it would affect their perception of professionalism.

Generally, participants thought substance use by professionals during personal time was acceptable, provided it did not impact their professional role: "Whatever you're doing on your own time is your own business" (P). As one participant explained:

> While working in a hospital in [name of town] it was brought to my attention that, on the side, a couple of doctors did do coke occasionally and at first it totally blew my mind because of their profession. But then after working with these people for a couple of weeks I knew they were very, very good at what they do. So if looking at my doctor, my dentist …. I would accept them, if someone said, 'oh it's a

> problem,' I'd probably be concerned. But if it was occasional, recreational use I'd be like okay everyone has their vices and, as long as you keep them separate, it wouldn't bother me so much. (T)

There seemed to be consensus that professionals should not be under the influence of a non-prescribed substance at work. One participant asserted:

> I think I'd be pretty disappointed. Especially if they were actually on the clock... and then they care for people. I think that that's fairly irresponsible… Because I don't think you're in your right mind to make judgement calls, and here you are caring for people and you're high. (P)

Others questioned, though, whether the person using certain types of substance would necessarily be able to assess whether it was affecting performance:

> I don't know whether it's possible, if you're using illicit substances like cocaine or heroin, things that are highly addictive … I don't completely trust that control that they might report they have. Where you hold all these people's lives in your hands. I feel uncomfortable about people in professions, maybe, using those types of, substances. (O)

There was nothing approaching consensus among participants regarding whether use of some substances was simply unprofessional, regardless of effects on work. Some people thought there was widespread underestimating of the number of professionals using illicit substances such as cocaine, because such use is assumed to be incongruent with professional competence: "Lots of people use it and still lead relatively normal lives. There's people who have very successful jobs and careers that use cocaine recreationally" (M). In contrast, some participants

thought that use of particular substances simply undermines professionalism, and potentially competence:

> If I was in a decision between using that lawyer who uses cocaine and that lawyer who doesn't, I probably would go for the lawyer who doesn't.... Maybe it's because, in my own experience, I know that substance use can creep into your professional life. I see the lasting effects of substance use. Especially if it's not carefully regulated, it can really creep into your professional life. (A)

Conclusion

The findings suggest a certain amount of substance use is expected, accepted, and condoned in professional fields. At the same time, participants report a marked lack of open discussion about substance use in professional settings. This disconnect between how substances are used and how this use is discussed (or not) has implications for how substance use is framed and, subsequently, the appropriateness of responses.

Participants readily recognised alcohol, caffeine, tobacco, and pharmaceutical substances as drugs. There tended to be a view that everyone is, in essence, a "substance user". Substances used were more likely to be licit and associated with performance enhancement for school, work, and social connection. At the same time, even prior to engagement in the study, participants appeared to continually reflect on their own decisions to use any substance, including caffeine and prescribed medications. Participants described clear intentionality regarding substance use, weighing costs and benefits, adjusting use by time, contexts, obligations, and anticipated outcomes. Interestingly, there were few reports of cognitive enhancement substances, despite the relatively high prevalence of prescribed and non-prescribed use among university populations internationally. Similar to the findings by Finger, et al. (2013), a Canadian study reported that 15

percent of medical students used non-prescribed cognitive enhancers (Kudlow, Treurnicht Naylor, Xie, & McIntyre, 2013). The few participants in our study who reported trying cognitive enhancers (e.g., Adderall) found they had no discernable effect, though they knew of others who found their use to be beneficial.

Patterns of use and acceptability change over time. As one progresses from student to professional, substance use may become more refined. Higher quality, more expensive substances become more attractive than the lower quality substances associated with undergraduate studies or non-professional roles. Being perceived as *needing* certain types of substances, such as caffeine and alcohol to work harder during the day and unwind at night, may become a "badge of honor" among professionals. In other words, substances that serve as performance enhancement have a higher status. Not using these publically condoned substances may signal incomplete or "failed" professional socialization, marking someone as an outsider in their profession.

Use of illicit substances was viewed as somewhat immature, and thus unprofessional. As students progress through professional programs and into the workplace, the acceptability of experimental use diminishes. This was, of course, inevitably conflated with age and maturity. Use of illicit substances tended to occur in private and was only discussed with a small network of trusted people. The potential consequences for professional role were seen as significant, whether or not substance use was impacting job performance. Use of illicit substances could risk professional employment by attracting attention from regulatory and legal bodies.

Prescribed substances, particularly mental health medications, also tended to remain private, disclosed only to trusted persons. While prescription medications are legal, and use is monitored by health professionals, there is considerable stigma associated with mental illness

(Arboleda-Florez, 2003; Spurgeon, 2008). Instead of being perceived as a performance enhancement strategy, they are seen as a response to a personal deficit or imperfection. Participants indicated that reliance on prescribed substances might be perceived by others as an indication of weakness or inadequacy, thus undermining perceived professional competence. Goffman (1963) defines stigma as "an attribute that links a person to an undesirable stereotype, leading other people to reduce the bearer from a whole and usual person to a tainted, discounted one" (p. 11). Substance use has historically been viewed as a moral failing (Valverde, 1998) and mental illness as an impairment (Anderson, Jeon, Blenner, Wiener, & Hope, 2015). These entrenched beliefs can lead to attributions of "spoiled identity" (Goffman, 1963) for substance users. Standards of professional conduct include a responsibility to uphold a respectable image and maintain appropriate conduct in one's personal life (Macdonald, 1989).

Other research has noted that, although the stigmatization of mental illness may be disapproved of by professionals who experience it, they may nevertheless internalize societal messages regarding deviant identity (Peterson, 2017). While some indicated they deliberately disclose use to challenge stigma, it needs to be noted that they do so at some risk; they may well be seen as less competent by professors and colleagues, considering the doubts participants raised about acceptable substance use by professionals. Risks associated with disclosure of personal substance use can therefore result in stigmatization based on personal failure, but can also put one at risk of penalization by professional regulatory bodies for professional misconduct. Non-disclosure also comes with risks if it becomes known that the person uses substances, as current research suggests that people who withhold personal information, whether flattering (e.g., donating blood) or unflattering (e.g., substance use), are judged more severely than those who openly disclose such activities (John, Barasz, & Norton, 2016).

Strong messages about problematic substance use were conveyed through formal and informal professional socialization. When use of particular kinds of substances is addressed almost exclusively in relation to problematic use by clients, or regulatory violations by professionals, there is a clear construction of "us" versus "them". In other words, (good) professionals are constructed as people who do not use those substances – or at most use them in moderation. Participants described little acknowledgement that substances by others may be used in controlled manners, either by professionals or clients, or that substance use is shaped by contextual factors.

The emphasis by several participants on problematic versus non-problematic use is particularly interesting. Professionals may well find comfort in the notion that the problematic users (the 10% who are "other") are an identifiable, separate group. Professionals – especially health professionals –often hold the power to decide on which side of the line someone falls. Part of professional socialization is learning to make expert judgements and learning to wield this definitional power with care. Some participants noted that these lines are rather arbitrary, when the use of a substance such as caffeine is touted as a badge of honor and the use of marijuana is considered taboo.

Implications

This study demonstrates the importance among professionals of suspending automatic assumptions that the *use* of a substance implies the risk of *abuse*. While participants acknowledge this suspension in relation to their own use, there are nevertheless implicit and explicit contradictions when evaluating the use by others, whether clients or patients, professionals or students. Participants spoke about difference between their espoused theories (e.g., that people may use illicit substances in non-problematic ways) and theories in action (e.g.,

judging someone who uses an illicit substance as untrustworthy). Future research might draw on critical discourse analysis to examine conflicting accounts of non-problematic and problematic use of substances, in relation to the type of substance and the person using it (e.g., self versus other) (Kiepek, 2016).

The importance of developing more nuanced understandings of substance use can contribute to policies, responses, and theory. The legal status, availability, and desirability of substances varies internationally and regionally. In some countries, there is a current shift toward decriminalization and legalization of some substances and pharmaceutical medications are rapidly entering international markets. It may be timely for professional schools and regulatory bodies to re-evaluate codes of conduct in light of these current political and social developments.

At an individual level, the stigma associated with illicit substance use, prescribed mental health substances, and certain patterns of licit substance use (e.g., heavy drinking) renders some conversations taboo, and as "unprofessional." This may leave students and professionals with few options should they wish to continue using substances or if questions or concerns about their substance use arise. They are also restricted from asking detailed questions about the implications of substance use at a regulatory level, which may impede seeking help if needed.

At a systems level, conceptualizing substance use more broadly helps to identify factors that both encourage use (e.g., performance demands, social norms) and constrain use (e.g., responsibility, role modelling). This may support the development of complementary strategies to support and enhance professional performance. Given that some patterns of substance use can risk loss of license, analysis of professional contextual demands can contribute to novel approaches that shift from the development of individual-focussed capacities (e.g., stress management, emotional regulation) to social, institutional, and cultural-level interventions.

Individual approaches assume a deficit in a person's knowledge, skills, or competence, or in their ability to make decisions regarding the use of performance-enhancing substances. Addressing the professional conditions of stress, heightened performance expectations, sleep disruptions, time demands, and so on may alter the relationship between substance use and professional identity.

Theoretically, by exploring substances collectively and focusing on the perceived effects, the blurred boundaries between concepts of therapeutic, enhancement, and recreational use are increasingly evident. For instance, a person may use a medication prescribed by a physician to enhance sleep or a substance like cocaine to enhance clarity of thought. Similarly, using a prescribed beta blocker to reduce anxiety when giving professional presentations blurs the line between therapeutic use and enhancement. These findings complicate deficit-based interpretations of this use as "self-medicating" (Tronnier, 2015) and highlight a desire to enhance performance and experience. This study has examined some of the ways in which participants deliberately chose to use certain substances in professional contexts and some of the parameters they employed to regulate this use. Future research might examine *how* these parameters are learned (e.g., through personal experience, social modelling) in professional settings. The use of substances in professional settings is relatively under-explored but the findings of this study demonstrate rich opportunities for further investigation.

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