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Drug Addiction Stigma in the Context of Methadone Maintenance Therapy: An Investigation into Understudied Sources of Stigma

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Abstract

Experiences of stigma from others among people with a history of drug addiction are understudied in comparison to the strength of stigma associated with drug addiction. Work that has studied these experiences has primarily focused on stigma experienced from healthcare workers specifically even though stigma is often experienced from other sources as well. Because stigma has important implications for the mental health and recovery efforts of people in treatment, it is critical to better understand these experiences of stigma. Therefore, we characterize drug addiction stigma from multiple sources using qualitative methodology to advance understandings of how drug addiction stigma is experienced among methadone maintenance therapy patients and from whom. Results demonstrate that methadone maintenance therapy patients experience prejudice, stereotypes, and discrimination from friends and family, coworkers and employers, healthcare workers, and others. Discussion highlights similarities and differences in stigma experienced from these sources.

Keywords

Methadone; Stigma; Prejudice; Stereotypes; Discrimination; Drug Addiction

Stigma, or social devaluation and discrediting associated with a mark or attribute (Goffman 1963), represents a significant barrier to mental health. Recent meta-analyses demonstrate associations between experiences of stigma with increased rates of mental illness and psychological distress as well as decreased well-being (Mak et al. 2007; Pascoe and Richman 2009) among people living with a variety of devalued marks and attributes. Stigma associated with drug addiction and use is strong and often structurally reinforced by government policies that contribute to its widespread acceptability. For example, Tempalski and colleagues (2007) argue that the "war on drugs" within the United States contributes to the "socio-cultural stigmatization of drug users and view of drug use and users as 'criminals' and 'junkies'" (p. 1254). In contrast to the strength of stigma associated with drug addiction

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and use, research examining the experiences of stigma among people with a history of drug addiction is strikingly limited. Such research is critical to inform clinical practice and interventions with people with a history of drug addiction to improve their mental health outcomes as well as treatment retention and success. Therefore, in the current work we employ qualitative methods to characterize drug addiction stigma from multiple sources experienced by people with a history of drug addiction. We focus on the experiences of methadone maintenance therapy (MMT) patients because stigma associated with MMT is particularly strong (Des Jarlais et al. 1995; Smith 2010; Tempalski et al. 2007) and stigma has been identified as a barrier to MMT retention and success (Anstice et al. 2009; Brener & von Hippel 2008; Brener et al. 2007; 2010; von Hippel et al. 2008).

Drug Addiction Stigma: Prejudice, Stereotypes, and Discrimination

Stigma shapes the way that individuals who are not drug users feel toward, think about, and treat people with a known or assumed history of drug addiction. We adapt applications of theory to HIV stigma (Earnshaw and Chaudoir 2009) to drug addiction stigma within the current study, and differentiate between three ways in which people may react to others with a current or prior history of drug addiction. This allows us to develop a rich understanding of the ways in which drug addiction stigma is directed at MMT patients. Therefore, we focus on the stigma mechanisms of prejudice, stereotyping, and discrimination. Prejudice involves negative emotions and feelings held towards people who have been addicted to drugs. Prejudice towards injection drug users is associated with several personality traits (e.g., conservatism, religious fundamentalism), and higher perceptions of drug use as controllable (Brener & von Hippel, 2008). For example, healthcare workers who view drug use as ‘controllable’ were found to have greater prejudicial attitudes towards injection drug users (Brener et al. 2010).

Stereotypes involve group-based beliefs about people who have been addicted to drugs that are applied to specific people who have been addicted to drugs. Stereotypes about drug users are widely endorsed. Beyrer and colleagues (2010) have identified how stereotypes endorsed by healthcare providers and researchers act as critical barriers to undertaking research involving people with a history of drug addiction. These stereotypes include beliefs that people who have used drugs are non-compliant, are focused on getting high at the expense of using safe injection equipment, do not have strong communities, and are out-of-control and unwilling to change their risk behaviors. One study identified beliefs of drug users as violent, having weak characters, being unhygienic, having contagious diseases, and being dangerous to be the most strongly endorsed stereotypes among hospital nurses (Natan et al. 2009). Importantly, prejudice is associated with stereotypes such that healthcare workers who are more prejudiced are also more likely to endorse drug use stereotypes and therefore worry that injection drug use clients will misbehave in treatment settings (e.g., act violently; Brener et al. 2010).

Discrimination includes behavioral expressions of prejudice directed towards people with a history of drug addiction and can range from subtle (e.g., gossip) to extreme (e.g., job loss, social ostracism). Discrimination based on drug addiction may be widely acceptable, in part, because drug use itself is illegal (Ahern et al. 2007). Further, unlike discrimination based on other stigmas (e.g., race, gender, disability), discrimination towards drug users is not illegal per se. The Americans with Disabilities Act provides some protection from discrimination for people with formerly diagnosed substance use disorders, but does not protect current users or people with a history of drug addiction who were never diagnosed with a disorder. Despite the protection of the Americans with Disabilities Act, people with former substance use disorders report greater job loss than people with no history of substance use disorders

(Baldwin et al. 2010). In sum, discrimination towards current and former drug users is widespread, mostly legal, and socially acceptable.

Experiencing Drug Addiction Stigma from Multiple Sources

People with a history of drug addiction experience prejudice, stereotypes, and discrimination from others in important ways. Again drawing on theory applied to HIV stigma (Earnshaw and Chaudoir 2009), we focus on enacted stigma and anticipated stigma from others. Enacted stigma involves experiences of prejudice, stereotypes, and discrimination from others in the past; and anticipated stigma involves expectations of experiences of prejudice, stereotypes, and discrimination from others in the future.

Research has largely focused on stigma experienced from healthcare workers by people with a history of drug addiction (Anstice et al. 2009; Brener et al. 2007; 2010; Natan et al. 2009; von Hippel et al. 2008). Researchers studying drug addiction stigma may have focused on healthcare workers because stigma from healthcare workers acts as a powerful deterrent to healthcare retention among people living with a variety of stigmas (Earnshaw and Quinn 2011; Interian et al. 2010; Vanable et al. 2006) and therefore may threaten treatment retention among people with a history of drug addiction. However, people with a history of drug addiction also experience stigma from other sources, which may further undermine their mental health and MMT treatment and success. Ahren and colleagues (2007) identified family members as an important source of stigma among drug users: 75.2 % of their sample reported experiencing discrimination from family due to drug use. Stigma from family members may lessen the quality of people's interpersonal relationships and threaten their social support, both of which are important for mental health and treatment success (Gerra et al. 2003; Gyarmathy and Latkin 2008). Further, stigma from work colleagues is associated with heightened stress and decreased well-being among people with other devalued marks and attributes (Earnshaw et al. 2011). Workplace discrimination due to a history of drug addiction may also threaten employment status (Baldwin et al. 2010) and therefore income stability which is important for MMT retention (del Rio et al. 1997; Gerra et al. 2003). Taken together, experiencing and anticipating prejudice, stereotypes, and discrimination from family and friends, as well as coworkers and employers may undermine mental health and MMT success among patients in addition to stigma experienced from healthcare workers.

Current Study

Using qualitative methods (Beatty and Willis 2007; Bernard 2011), we report on the experience of drug addiction stigma from different sources among patients participating in MMT at an inner-city methadone treatment site in the Northeastern United States (New Haven, Connecticut). This study constitutes a secondary data analysis of qualitative data originally collected to assess participants' comprehension of a measure of HIV and drug addiction stigma. Cognitive interviewing, a qualitative technique, was employed as the most appropriate methodology to elicit participants' comprehension of survey items (Beatty and Willis 2007). While reviewing the content of the individual cognitive interviews, we observed that nearly all participants disclosed ways in which they continue to experience drug addiction stigma while in recovery. The current study aims to describe the sources from whom participants experienced stigma and the ways in which they experienced stigma. Therefore, sources of stigma that may undermine well-being and treatment success were evaluated (i.e., friends and family, coworkers and employers, healthcare workers, others) in relation to stigma participants reported experiencing (i.e., prejudice, stereotypes, and discrimination).

Methods

Participants

Individual cognitive interviews were conducted with 12 patients receiving MMT at an inner-city methadone treatment site. Participants were recruited from an ongoing HIV risk reduction randomized controlled trial at the methadone treatment site. The parent study did not address stigma associated with drug addiction or HIV in either the intervention or control arm. Participants were selected to be similar to the methadone treatment clinic's population in terms of gender (60 % men) and ethnicity (50 % Whites, 40 % African-Americans, 10 % Latinos/Latinas). Due to inclusion criteria of the parent study, all participants were assumed to be HIV-negative and have a history of opioid dependence, and were eligible for the current study regardless of treatment arm if they were 18 years of age or older, English speaking, and were willing to have their interview audio-taped for further transcription and analysis. Participants ranged in age from 22 to 52. Eight participants were male. Ten participants were White, and two were African-American. The study was capped at 12 participants because saturation of themes related to our original aim (i.e., to assess participants' comprehension of a measure of HIV and drug addiction stigma) had been reached. Within our analysis to meet our secondary aim (i.e., to describe the sources from whom participants experienced stigma and the ways in which they experienced stigma), we also found that saturation of themes had been reached.

Interview Protocol

Cognitive interviewing aims to identify the cognitive processes used in responding to survey items. These processes reflect the comprehension of the individual survey items, the retrieval of an individua's response(s) from memory, factors that may inhibit the response process (i.e., sufficient motivation to answer items accurately and social desirability concerns regarding sensitive topics), and the mapping of the individual's response to the available item's response options (Beatty and Willis 2007). As part of the cognitive interview, all participants completed a brief pilot measure assessing HIV stigma (e.g., items related to stereotypes, prejudice, and discrimination associated with HIV, experiences with HIV testing, and HIV prevention behaviors) and drug addiction stigma (e.g., items related to anticipated stigma, enacted stigma, and internalized stigma associated with drug addiction). Participants then were asked a series of brief general prompts by the interviewer.

The interview guide was *only* designed to elicit participant comprehension (e.g., "*Were there any questions you thought didn't make sense?*") and acceptability (e.g. *"Were there any questions you didn't like?"*) of HIV and drug addiction stigma items, not participants' experiences with drug addiction stigma per se. These procedures utilized a "think aloud" approach (Beatty and Willis 2007) whereby the participants are asked about their understanding or acceptance of the items, and allowed to openly respond about their thought process for answering the items in the measure. The interviewer was allowed to elicit clarification of participants' responses or follow-up specifics with participants if their statement(s) related to how they may have understood the item or to how their desired response to the item may or may not have mapped onto the available response options to that item (Beatty and Willis 2007). Therefore, all participant discourse analyzed in the current study regarding participants' experience with or anticipation of drug addiction stigma were spontaneously generated by participants as experiences they chose to discuss and/or share with the interviewer (Bernard 2011).

The study protocol ensured that all interviews and subsequent analyses of the current study were not conducted by members affiliated with the parent study. Participants were consented to participate in the current study after its procedure had been explained to them. Interviews

were conducted in a private room located at the methadone treatment site by a single interviewer, and were audio recorded with participants' permission. Interviews averaged 30 min in length, and participants were reimbursed for the time required to participate. All study procedures were approved by the University of Connecticut's institutional review board (IRB).

Analytic Approach

Audio-recorded interviews were transcribed verbatim and transcripts were independently checked for accuracy. Two doctoral level researchers independently reviewed each transcript for segments of participant discourse that specifically related to drug addiction stigma. The reviewers then discussed the segments they identified, resolving any discrepancies through discussion (Bernard 2011). A total of 58 independent text segments, or quotes, related to drug addiction stigma were identified across all twelve participants to be included in subsequent analysis. Text segments were then independently content coded by the two reviewers for manifestation(s) of drug addiction stigma reflected in the content of each quote (i.e., prejudice, stereotypes, discrimination) and the sources of stigma referenced by participants (i.e., family/friends, coworkers/employers, healthcare workers, others). The content codes were not mutually exclusive, meaning a single quote could be coded for more than one manifestation of stigma (e.g., prejudice and discrimination), as well as multiple stigma sources (e.g., friends/family and coworkers/employers). Inter-rater reliability between coders was assessed using Cohen's Kappa. Kappa was .980, $p<.001$ for the stigma manifestation described and .978, $p<.001$ for the source of stigma; indicating good reliability between coders (Landis and Koch 1977).

Results

Table 1 includes the quantitative results of the content coding: A count of drug addiction stigma content (i.e., prejudice, stereotypes, and discrimination) as it occurred by stigma source (i.e., family/friends, coworkers/employers, health care workers, and others). Participants discussed stigma the most in relation to friends/family and healthcare workers. They discussed stigma less in relation to coworkers/employers and others. Further, they discussed more experiences of stereotyping and discrimination, and fewer experiences of prejudice. Below, we summarize the content of the text segments. This summary is organized by source, and stigma content is detailed for each source. We provide examples from the participant discourse throughout this summary.

Family/Friends

Approximately 30 % of the coded statements reflected experienced or anticipated drug addiction stigma from family and/or friends. The most popularly noted source of stigma among family and friends were parents, although participants also referred to siblings, family members in general, and friends in general to a lesser degree. Family was identified as a particularly important source of stigma in the current sample. For example, one participant stressed that stigma from family members was damaging: "*They're like the big* [main] *people that you know, um, that hurt you*." Most statements reflected stereotypes and discrimination from family and friends. Fewer statements reflected prejudice. Participants who discussed how their family felt about them referred to a lack of caring or warmth.

Participants reported being stereotyped by family members. The most popular stereotype was that participants were viewed as 'untrustworthy' and may steal from family. For example, one participant stated:

> "Even though now that I'm clean, I'm in recovery, my mom and dad rarely even talk to me. Every time they see me, they have in the back of their mind, 'Is he

> clean?', 'Is he gonna steal from us again?', 'Is he a changed individual?'. It seems like my mother and father wouldn't give me the benefit of the doubt."

Some participants perceived that they had lost trust by stealing or otherwise hurting their family in the past when they were using drugs. Other participants reported that they had done nothing to lose their family's trust, but that their family viewed them as untrustworthy due to their drug addiction. One participant noted: "*They just didn't trust me in the house… like I never stole from them but they just knew about my drug use*." Therefore, these participants were deemed untrustworthy due to stereotypes surrounding drug use rather than their behavior while using drugs.

In addition to being stereotyped as untrustworthy, participants discussed family members' beliefs that drug users are 'irresponsible' or 'like to party'. This was especially frustrating to participants who viewed their drug addiction as a disease or addiction. For example, one participant stated: "*My father was like* [thought] *I was the scum you know, and it's nota disease, it's just you wanna party that's all it is, you just wanna party, you like getting high*." These participants felt that their family did not understand, or did not care to understand, their drug addiction. Further, many participants noted their family's beliefs that they would return to using drugs and negative behaviors that accompanied their prior drug addiction (e.g., stealing). For example, one participant wondered why his father did not believe that he could change even though his father believed that he, himself, was able to change from past actions of abusing his children:

> "So dad let me ask you a question: So you're a God-fearing man, you believe this, that, and the third, why don't you think God could change me? If he could change you, why can't he change me? Why do you feel like you're so better than [me]?"

Participants reported a variety of forms of discriminatory treatment from family members due to their drug addiction. Much of this treatment involved some degree of rejection. Some participants reported milder social distancing from family members, such as not picking up or returning phone calls from participants. Other participants reported more extreme rejection. For example, one participant reported family members disowning him because of his drug addiction: "*Cause family is, I would say they could be the biggest abusers* [of the people who discriminate] *cause* [people who have used drugs are told, for example] *'you're no son of mine', 'I disown you as my daughter.' "* As a result of being rejected by family, several participants noted that they no longer felt that they are a member of their family. At least one participant acknowledged that their family may have distanced themselves and treated them differently because they were trying to help them. The participant referred to this as 'tough love' stating:

> "And especially when they started with that tough love. I don't agree with it. I don't. You know just [when] people fall down be there to help them up, help them get up that's all. You know and family is you know most of them are all that tough love, tough love you know and that's not always the right way."

This participant thought that they needed more from their family when they were struggling with their drug addiction, rather than less.

There was variability in participants' reactions to their experiences of stigma from family and friends. Some participants reacted with anger, expressing feelings that they did not deserve the negative treatment. This anger led participants to avoid their family. For example, one participant stated: "*He* [participant's father] *disgusts me. They all do. They make me sick to my stomach. I don't go to any family functions*." Other participants claimed responsibility for their past actions while using drugs, and sought to repair their relationships with family. One participant said:

> "I know like I definitely pushed my family away a lot by using. Like a real lot. And now that I'm doing good - like they still don't trust me. You know what I mean like, I really don't talk to them, so like I still have to build that trust up. And it's going to take a long time. It's going to take a while."

Several of these participants expressed regret about their pasts, and struggled with how they could regain trust from family.

Coworkers/Employers

Approximately 20 % of statements reflected experienced or anticipated stigma within the workplace. The majority of these statements reflected stigma from employers, and a few reflected stigma from coworkers in general. Participants expressed concern that their employers would find out about their history of drug addiction, or participation in MMT, and would treat them with prejudice, stereotyping, and discrimination. They feared that their employers might discover their history of drug addiction through criminal background checks (e.g., arrests for drug use, or drug use related crimes such as stealing or prostitution) or by observing their appearance (e.g., seeing track marks on their arms). For example, one participant stated: "*They know I used to use drugs in the past, and my arm will show it.*" Similar to their discussion of stigma from family and friends, participants spoke more about stereotypes and discrimination within the workplace than about prejudice. The few participants who discussed prejudice noted that others in the workplace would 'look down on them' if they knew about their drug addiction. One participant said:

> "They look at you like you're a drug addict and then they look at you like they can treat you any way they want. You know what I mean. You're a drug addict. Well, you're lower than I am if you use drugs."

As exemplified in the above quote, some participants mentioned that prejudice would further shape their coworkers' and employers' thoughts and actions towards them.

Participants reported experiencing and anticipating several stereotypes from employers. Again, the most popular stereotype discussed was that participants were 'untrustworthy'. For example, two participants discussed their employers' concerns that they would steal money from cash registers. One participant noted that female employees with a history of drug addiction are often stereotyped by male employers as prostitutes. She stated:

> "It's like men employers… the managers are sleaze bags. Like, they try to get with you. You know they know you're a drug addict, they know you're in a program, you may not have money… So it's like they characterize you, you know 'cause you're a drug addict or you're a prostitute or whatever the case may be."

Another participant discussed stereotypes specifically associated with MMT. He feared that his employer would assume that he would fall asleep at work due to his medication.

Finally, participants expected that they would be discriminated against if their employers learned of their drug addiction history. Participants feared that they would not be hired once employers ran their criminal background checks and learned of their drug addiction. This fear was even felt by a participant with a college degree who otherwise felt that they would be strong candidate for positions in their field due to their education and previous work history. If they were currently working, participants feared that they would be fired. One participant noted that: " *I'm sure that if they did find out I might befired and that's what I get worried about.*" Participants were also treated differently than other employees without a history of drug addiction. One participant noted that waitresses with a history of drug addiction were not allowed to use the register at the restaurant where they worked.

Participants reacted to stigma in the workplace in several ways. Several expressed worry or anxiety about what would happen if their employer learned of their drug addiction. At least one participant noted that he actively tried to hide his methadone use from employers, stating: "*I'm on methadone and I'm trying to seek employment, I won't tell that my employer that I'm on meth* [methadone]." This participant attempted to avoid stigma by concealing his methadone treatment.

Healthcare Workers

About 30 % of statements involved anticipated or enacted stigma from healthcare workers. In contrast to their discussions of stigma from other sources, many participants were quick to point out interactions with healthcare workers that lacked stigma, or were characterized by warmth and understanding. In order to best represent the full spectrum of participants' interactions with healthcare workers, we include statements that reflect both the presence and absence of prejudice, stereotypes, and discrimination in this section. Approximately half of the statements focused on interactions with doctors whereas the remainder focused on interactions with nurses and healthcare workers in general.

Participants who discussed prejudice noted healthcare workers' lack of caring towards them. For example, one participant stated: " *I've ran into a lot of them* [healthcare workers] *that's not really concerned about my well-being*." One participant noted that some of the doctors that they have seen support MMT, whereas others do not. He reported experiencing greater prejudice from doctors who do not support it. Several participants pointed out that nurses are the least prejudiced towards them. For example, a participant stated that nurses: "*seem to be the ones that are the most caring and accepting and understanding to someone's problems*." Another participant noted that Emergency Room nurses may get frustrated with drug users, but that they don't harbor negative feelings towards them:

> "They do get frustrated with having to see the same people over and over and over again, or a young kid come in that's overdosed because, to them, they're trying to save lives and they're [the patients are] just doing something stupid and being selfish and stuff, like, you know, being reckless with their lives… and it's frustrating to them [the nurses], but they don't have a hate or an anger."

Similar to their experiences of stereotypes from family and employers, participants perceived that healthcare workers stereotyped them as 'untrustworthy'. Several participants reported that healthcare workers often thought that they were lying to obtain pain medication, or 'pill shopping'. For example, one participant stated:

> "Now it's like any time I ever need anything for pain for my muscles or even for anxiety and stuff like that, it's like I can just tell that they don't… either don't want to give it to me or they think I'm lying to get it because I'm not in pain."

As quoted previously, another participant thought that Emergency Room nurses saw drug users as 'being selfish' and 'reckless' even though they did not hold negative feelings towards users. Other participants thought that healthcare workers, especially nurses, were understanding. They thought that nurses were more likely than doctors to be empathetic and non-stereotyping, perhaps sharing past experiences with drugs or similar stigmatizing activities.

Many participants found it easy to identify discrimination from healthcare workers. They noticed that healthcare workers treated them differently before versus after they learned of their substance use history. The most popular form of discrimination involved withholding needed pain medication or treatment based on the stereotype that participants were pill shopping. Participants were even denied such treatment after major medical procedures:

> "I just had surgery and everything and it's [they were] like don't give the user any pain killers, don't give the user anything… that I can definitely tell that's like the flag goes up as soon as they hear I'm on methadone or I'm an ex-user. I definitely have been treated differently because of that."

In addition to being denied adequate pain treatment, participants discussed being treated rudely or coldly after healthcare workers learned of their methadone treatment. One participant recalled being treated differently by Emergency Room doctors after they told them about their methadone treatment:

> "I've gone to the emergency room…you know towards the end of the appointment I have just said on my own: 'Oh, I'm on methadone.' Because they [might] prescribe me something… and it wasn't even a bad med [medicine], like a narcotic or anything it was just like an antibiotic or whatever. And I would say 'oh I was on methadone,' so they would know, just in case it would clash bad and give me a bad reaction. And as soon as I would say that I was on methadone, they would switch up and treat me completely, completely different. Yeah it was crazy. And that's happened a few times. You know. Just like with an attitude and would kind of like brush me off. And before that they were like 'oh sweetie,' being really nice."

Participants reacted to experiences of stigma from healthcare workers in several different ways. Some were frustrated that healthcare workers did not care about them, and pointed out the irony of healthcare workers treating people with addictions, if viewed as a medical condition, with stigma: "*How could you be in a field where you know you have to help people and have that kind of attitude or demeanor toward someone that's sick?*" Participants who had not received adequate treatment for their pain felt that this was unfair or unjust. At least one participant was not concerned about stigma from healthcare workers because they could switch doctors if they were treated with prejudice, stereotyping, or discrimination.

Other Sources of Stigma

Approximately 20 % of statements reflected enacted or anticipated stigma from sources other than friends and family, coworkers and employers, and healthcare workers. Most of these statements referred to others in general, however several participants discussed stigma specifically from dating partners, fiancés, and government employees (i.e., representatives of the Department of Children and Families). Participants who discussed prejudice spoke about how others look down on them for their history of drug addiction. For example, one participant reflected on how other people feel differently towards them after they disclose their history of drug addiction: "*Once you start talking about your drug, you your experiences with drugs and alcohol, they tend to look down on you.*"

Participants experienced a variety of stereotypes from others. Several participants noted that others did not think that they could change, or that they would always be addicted to drugs, despite their engagement in MMT as a form of treatment for their addiction. For example, one participant said:

> "But now that I'm a changed individual, I'm trying, I'm workin' hard to keep myself clean, it seems like you guys [people in general] would give me the benefit of the doubt. You know, not always thinking about 'Damn, this, that, and the third' … or 'he used [drugs]' cuz, you know, if you're still thinking like that then, you know what, you're not even open minded to me changin. You don't even think I can change."

Participants found that others continued to apply stereotypes of drug users to them, even though they no longer were using drugs. One participant noted that women viewed him as 'wild'. Another participant reflected on how other people thought that they were

promiscuous, "*hittin* [sleeping with] …*everything that moved*," even though they were in a monogamous relationship with their partner. A new mother described how she was stereotyped by others as a poor parent, or at high risk of neglecting or abusing her child, because she was on methadone:

> "DCF was called just because I was on methadone. Methadone's a medication, so why should you call DCF because I'm taking a medication? I had no dirty urines my whole entire pregnancy, I was clean the whole entire time, I have no… I have a stable living house so why is DCF being called on me for taking a medication? That's the, that's the… I don't understand. It's like… that's the part that kills me. I just don't get it I guess."

As exemplified by this participant's quote, several participants felt that others did not understand the function or purpose of MMT. Participants described their use of methadone as treatment for an illness, whereas they perceived that others often viewed their use of methadone as continued drug abuse or addiction. For example, one participant noted that others view people enrolled in MMT as 'not clean' and simply receiving free drugs.

Participants discussed few experiences of discrimination from others in general. One participant noted that they were generally treated differently because of their history of drug addiction. The participant who perceived that he was stereotyped as 'wild' stated that women often refused to date him.

Participants' reactions to stigma from others in general were similar to their reactions to stigma from sources already discussed. Some chose to keep their history of drug addiction a secret to avoid stigma, while others felt frustrated or hurt by these experiences. One participant admitted anger in response to such stigma, stating: "*sometimes it makes you mad!*"

Discussion

The current study employed qualitative methods (Bernard 2011) to characterize drug addiction stigma from different sources experienced by patients receiving MMT at an inner-city methadone treatment site in the Northeastern U.S. Participants of the study described experiences of enacted and anticipated stigma from friends and family, coworkers and employers, healthcare workers, and others. Overall, they discussed more stigma in relation to family and friends, and healthcare workers, and less in relation to coworkers and employers, and others. Further, they discussed more experiences of stereotypes and discrimination than of prejudice.

There were several commonalities in the prejudice, stereotypes, and discrimination that participants experienced from these sources. First, although prejudice was the least discussed experience of stigma, participants who mentioned it consistently reported that others 'looked down' or 'thought less' of them because of their history of drug addiction. This is a manifestation of devaluation and discrediting characteristic of stigma (Goffman 1963). That is, methadone maintenance patients are perceived as 'less than' others because of their history of drug addiction or current engagement in MMT. Second, many participants reported being stereotyped as 'untrustworthy' by others. For example, participants reported that family and employers thought that they would steal from them, and that healthcare workers thought that they would lie to obtain pain medication for illicit use.

There were also some striking differences in the ways that participants experienced stigma from these sources. For example, although participants reported being stereotyped as untrustworthy by all sources, the discriminatory treatment that followed this stereotype

differed depending on the source. Participants reported receiving social rejection from family, being denied important responsibilities by employers (e.g., working the cash register), and receiving inadequate medical treatment from healthcare workers (e.g., withholding of needed pain medication) due to stereotypes of untrustworthiness. Therefore, the context of the participants' relationship with the source of stigma played an important role in determining the shape of discriminatory treatment based on this stereotype. Another difference was that participants' discussions of stigma from healthcare workers were more balanced than their discussion of stigma from family and friends, and coworkers and employers. That is, several participants seemed to make a point of defending healthcare workers by discussing supportive interactions whereas participants did not discuss supportive interactions with family and friends, or coworkers and employers.

Limitations and Future Directions

The small sample size represents a limitation of the current work. We captured the experiences of a small number of MMT patients. However, these patients discussed similar experiences with drug addiction stigma (e.g., mistrust from others), increasing confidence that their experiences generalize to other MMT patients. Future studies should seek to further explore these themes with larger sample sizes. Further, future studies should explore drug addiction stigma among more diverse samples of MMT patients in different social contexts. It is possible that other stigmas (e.g., racial/ethnic minority, poverty) shape the way in which MMT patients experience drug addiction stigma. Therefore, prejudice, stereotypes, and discrimination may be experienced differently across people of different races/ethnicities, gender, and other stigmas. For example, female participants in the current study spoke to ways in which drug addiction stigma was associated with stereotypes of them as prostitutes and such stereotypes were further endorsed by male participants in the current study. In contrast, male participants were not stereotyped as prostitutes suggesting that female participants' gender shapes their experience of drug addiction stereotypes in a unique way. Additionally, people may experience drug addiction stigma differently in different social contexts. Research should explore the extent to which patients experience drug addiction stigma in different areas (e.g., rural vs. urban areas) and its implications for impeding access to available treatment and support services.

An additional limitation of the current study is that we used cognitive interviewing, a methodology best suited for survey development. This was appropriate for our original study aim (i.e., to assess participants' comprehension of a measure of HIV and drug addiction stigma), and meant that participants' descriptions of experiences with drug addiction stigma were raised by the participants themselves rather than the interviewer. However, future research should employ other qualitative (e.g., focus groups) and quantitative (e.g., cross-sectional and longitudinal surveys) methodologies to further understandings of drug addiction stigma experienced by MMT patients.

Conclusions

Drug addiction stigma continues to impact the lives of people with a history of drug addiction, even after they have enrolled in MMT. In this way, the stigmatizing mark of drug addiction lingers after the behavior of drug use has ended. Although past work has focused on stigma from healthcare workers specifically, the current work suggests that prejudice, stereotypes, and discrimination also persist among friends and family, coworkers and employers, and others. Participants in the current study experienced distress as a result of experiences of stigma, including feelings of frustration, anger, and anxiety which likely threaten their emotional well-being and mental health. Importantly, drug use is a way that stigmatized people cope with the stress and negative emotions associated with discrimination (Pascoe and Richman 2009). For MMT patients, using drugs as a coping

strategy for stigma-related stress and negative emotions may have particularly negative consequences on recovery efforts and mental health. Given its prevalence, it is critical for clinicians to address drug addiction stigma from a variety of sources within methadone maintenance treatment settings to bolster the mental health and recover efforts of MMT patients.

References

Ahern J, Stuber J, Galea S. Stigma, discrimination and the health of illicit drug users. Drug and Alcohol Dependence. 2007; 88:188–196.10.1016/j.drugalcdep.2006.10.014 [PubMed: 17118578]

Anstice S, Strike CJ, Brands B. Supervised methadone consumption: client issues and stigma. Substance Use & Misuse. 2009; 44:794–808.10.1080/10826080802483936 [PubMed: 19444722]

Baldwin ML, Marcus SC, De Simone J. Job loss discrimination and former substance use disorders. Drug and Alcohol Dependence. 2010; 110:1–7.10.1016/j.drugalcdep.2010.01.018 [PubMed: 20347233]

Beatty PC, Willis GB. Research synthesis: the practice of cognitive interviewing. Public Opinion Quarterly. 2007; 71:287–311.10.1093/poq/nfm006

Bernard, HR. Research methods in anthropology: Qualitative and quantitative approaches. 5th. Plymouth: AltaMira; 2011.

Beyrer C, Malinowska-Sempruch K, Kamarulzaman A, Strathdee SA. 12 myths about HIV/AIDS and people who use drugs. The Lancet. 2010; 376:208–211.10.1016/S0140-6736(10)61005-7

Brener L, von Hippel W. Measuring attitudes toward injecting drug users and people with Hepatitis C. Substance Use & Misuse. 2008; 43:295–302.10.1080/10826080701202627 [PubMed: 18365932]

Brener L, von Hippel W, Kippax S. Prejudice among health care workers toward injecting drug users with hepatitis C: does greater contact lead to less prejudice? International Journal of Drug Policy. 2007; 18:381–387.10.1016/j.drugpo.2007.01.006 [PubMed: 17854726]

Brener L, Hippel WV, Kippax S, Preacher KJ. The role of physician and nurse attitudes in the health care of injecting drug users. Substance Use & Misuse. 2010; 45:1007–1018.10.3109/10826081003659543 [PubMed: 20441447]

del Rio M, Mino A, Perneger TV. Predictors of patient retention in a newly established methadone maintenance treatment programme. Addiction. 1997; 92(10):1353–1360. [PubMed: 9489052]

Des Jarlais DC, Paone D, Friedman SR, Peyser N, Newman RG. Regulating controversial programs for unpopular people: methadone maintenance and syringe exchange programs. American Journal of Public Health. 1995; 85(11):1577–1584. [PubMed: 7485676]

Earnshaw VA, Chaudoir SR. From conceptualizing to measuring HIV stigma: a review of HIV stigma mechanism measures. AIDS and Behavior. 2009; 13:1160–1177.10.1007/s10461-009-9593-3 [PubMed: 19636699]

Earnshaw VA, Quinn DM. The impact of stigma in healthcare on people living with chronic illnesses. Journal of Health Psychology. 201110.1177/1359105311414952

Earnshaw VA, Quinn DM, Park CL. Anticipated stigma and quality of life among people living with chronic illnesses. Chronic Illness. 201110.1177/1742395311429393

Gerra G, Ferri M, Polidori E, Santoro G, Zaimovic A, Sternieri E. Long-term methadone maintenance effectiveness: psychosocial and pharmacological variables. Journal of Substance Abuse Treatment. 2003; 25:1–8.10.1016/S0740-5472(03)00031-X [PubMed: 14512102]

Goffman, E. Stigma: Notes on the management of spoiled identity. New York: Simon & Schuster; 1963.

Gyarmathy VA, Latkin CA. Individual and social factors associated with participation in treatment programs for drug users. Substance Use & Misuse. 2008; 43:1865–1881.10.1080/10826080802293038 [PubMed: 19016169]

Interian A, Ang A, Gara MA, Link BG, Rodriguez MA, Vega WA. Stigma and depression treatment utilization among Latinos: utility of four stigma measures. Psychiatric Services. 2010; 61:373–379. [PubMed: 20360276]

Landis JR, Koch CG. The measurement of observer agreement for categorical data. Biometrics. 1977; 33(1):159–174. [PubMed: 843571]

Mak WW, Poon CY, Pun LY, Cheung SF. Meta-analysis of stigma and mental health. Social Science & Medicine. 2007; 65:245–261. [PubMed: 17462800]

Natan MB, Beyil V, Neta O. Nurses' perception of the quality of care they provide to hospitalized drug addicts: testing the Theory of Reasoned Action. International Journal of Nursing Practice. 2009; 15:566–573.10.1111/j.1440-172X.2009.01799.x [PubMed: 19958412]

Pascoe EA, Richman LS. Perceived discrimination and health: a meta-analytic review. Psychological Bulletin. 200910.1037/a0016059.supp

Smith CBR. Socio-spatial stigmatization and the contested space of addiction treatment: remapping strategies of opposition to the disorder of drugs. Social Science & Medicine. 2010; 70:859–866.10.1016/j.socscimed.2009.10.033 [PubMed: 19944509]

Tempalski B, Friedman R, Keem M, Cooper H, Friedman SR. NIMBY localism and national inequitable exclusion alliances: the case of syringe exchange programs in the United States. Geoforum. 2007; 38:1250–1263.10.1016/j.geoforum.2007.03.012 [PubMed: 18978931]

Vanable PA, Carey MP, Blair DC, Littlewood RA. Impact of HIV-related stigma on health behaviors and psychological adjustment among HIV-positive men and women. AIDS and Behavior. 2006; 10:473–482.10.1007/s10461-006-9099-1 [PubMed: 16604295]

von Hippel W, Brener L, von Hippel C. Implicit prejudice toward injecting drug users predicts intentions to change jobs among drug and alcohol nurses. Psychological Science. 2008; 19:7–11.10.1111/j.1467-9280.2008.02037.x [PubMed: 18181783]

Table 1
Frequency of drug use stigma content by stigma source

Stigma source	Prejudice	Stereotypes	Discrimination	Total
Family/friends	2	9	12	23 (31.1 %)
Coworkers/employers	3	5	6	14 (18.9 %)
Health care workers	7	6	8	21 (28.4 %)
Others	1	11	4	16 (21.6 %)
Total	13 (17.6 %)	31 (41.9 %)	30 (50.5 %)	74