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## Intra-group Stigma: Examining Peer Relationships Among Women in Recovery for Addictions

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### Abstract

This grounded theory study explores how women with histories of addiction perceive stigma while in treatment. In-depth interviews were conducted with 30 women participating in a residential drug treatment center. Previous research has found that support from peers during recovery can be critical to managing illnesses. In fact, researchers have postulated that peers can be a more effective form of support than even family. This study extends existing literature indicating that peer support systems can be supportive, however they can also be perceived as negative support that impose stigmas. Findings reveal that women perceive stigmas due to how various types of drug use violate societal expectations and conflict with notions of deservingness. Specifically, the “hard users” (i.e., women who use heroin or crack cocaine) perceive stigmas regarding how their drug use violates norms of womanhood. Moreover, the “soft users” (i.e., those who use alcohol or marijuana) perceive stigmas that their drug use is considered undeserving of support. This paper explores the factors that contribute to stigma amongst populations who potentially face marginalization from larger society. Implications for treatment and group work are discussed.

### Keywords

peer group; stigma; motherhood; womanhood; intersectionality

### Introduction

Women with histories of addiction and incarceration face stigma regarding their roles in society, particularly with regard to their roles as mothers and women. The imposition of stigma during women’s recovery process can pose significant barriers and may even shape well-being. Although much is understood about the stigma experiences of individuals with addictions or incarceration backgrounds, little is known about women’s specific stigma experiences and how they perceive recovery in the context of these stigmas. This paper outlines the results of an analysis that examines the treatment experiences for women currently engaged in substance use treatment. Not only are these women in recovery, but they are also mothers who have recent involvement in the criminal justice system. We

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consider women's intersecting perceptions of stigma from peers in treatment, as well as the conditions that shape intragroup conflict as opposed to connection.

## Background and Significance

### Women in Recovery and Intersecting Stigma

Burgeoning research efforts have explored how marginalized groups experience stigma (Corrigan & Lundin, 2001; Lebel, 2008; Link & Phelan, 2001). Stigma is defined as an attribute that is deeply discrediting; it involves the individual being labeled as tainted and viewed as abnormal (Goffman, 1963). Scott Burris (2008) stated that stigma can be a, "cruel form of social control that turns individuals into their own jailor and chorus of denunciation" (476). That said, the problem of stigma is not just the act of viewing an individual as discredited, but how stigma shapes well-being (Link & Phelan, 2001). Studies have examined how stigma is experienced by marginalized individuals seeking employment (Pager, 2007; Holzer, Raphael & Stoll, 2006), social services (Alvidrez, Snowden & Kaiser, 2008; Larios, Davis, Gallo, Heinrich & Talavera, 2009) and re-entering the community (Lebel, 2008; Winnick & Bodkin 2008). Findings reveal that individuals with a mental disorder (Corrigan & Lundin, 2001; Pescosolido & Martin, 2007), certain physical illnesses or syndromes such as HIV/AIDS (Larios et al, 2009), or a criminal background (Lebel, 2008; Winnick & Bodkin, 2008) perceive stigmas that shape psychological well-being and access to support.

It would be difficult to argue that women with addictions escape stigma. In fact, women may face not just one stigma, but multiple "intersecting" marks attached to their addiction-related behaviors. Intersectionality is useful for exploring how categories such as race, ethnicity, class, gender, disability and age converge to create oppression and social inequality (Crenshaw, 1999; Davis, 2006; Hills-Collins, 2000; Samuels & Fariyal, 2008). Intersectionality has emerged as an anti-exclusionary framework used to theorize identity processes and understand oppression (Crenshaw, 1999; Nash, 2008; Zack 2005). All women are intersectional subjects due to the possibility that their gender, which is already a socially marginalized status, will intersect with other statuses to multiply experiences of disadvantage (Nash, 2008; Zack, 2005). Following in this analytic tradition of examining overlapping oppressed identities this study will explore stigmatized categories, beyond race and gender, which shape the recovery process for women.

To fully understand the study respondents' intersectional experiences with stigma, it is important to examine two dominant socially constructed identities that shape their abilities to transcend and recover from their histories of addiction and incarceration.

**"The Good Woman"**—In the United States, the "good woman" is a gendered construct characterized as one who upholds exceptional moral standards; the good woman embodies an image of sexual purity, trustworthiness and innocence (Harris-Perry, 2011; Raddon, 2002; Thetford, 2004). Some scholars articulate that these images are also racialized, placing white woman as the hallmark image of the "good woman"—a mutually reinforcing construct of sexual and racial purity characteristic of societal ideals of whiteness (Anderson, 2001; Hills-Collins, 2000; Harris-Perry, 2011). Though scholars have long critiqued these societal ideals

of femininity as discriminatory and unrealistic, the good woman image persists as a cultural identity that both women and men espouse (Hills-Collins, 1990; Raddon, 2002; Thetford, 2004).

For a woman with a substance use problem, the stigma attached to being a “user” can tarnish her ability to meet these unrealistic standards. Studies reveal that substance-using populations perceive others to view them as dangerous individuals who are selfishly focused on supplying their drug needs and doing whatever it takes to sustain their addiction (Campbell & Ettore, 2011; Sanders, 2014). Considering societal expectations of womanhood,, women with substance use addictions violate gender norms of femininity (Thetford, 2004; Thompson, 2000). Compounding the aforementioned factors, substance addiction is often linked with promiscuity and engagement in sex work, another stigmatized behavior (Ettore; 1992, 2004, Mulia, 2000; Sallmann, 2010). “The image of the crack-using prostitute has come to epitomize the ultimate shame and sexual degradation of women” (Carstairs, 1998, p. 70). Thus, negative stigmas associated with sex work intersect with those of addiction and crime to further script the female user as deviating from the “good woman.”

**“The Good Mother”**—The “good mother” is another socially idealized identity for women, which overlaps with and reinforces constructions of the “good woman.” Idealized beliefs postulate that mothers must be the bedrock and moral compasses for their family (Hays, 1996; Ladd-Taylor & Umansky 1998; Bemiller, 2010; May, 2008; Thomson, Kehily, Hadfield & Sharpe, 2009). She performs this role by placing the needs of her children before her own and all other roles. Even with the breakdown of romantic partnerships or challenges of poverty, women are criticized for their circumstances and held accountable for their children’s wellbeing (Jackson & Mannix, 2004). Like the good woman, the good mother is self-sacrificing and devotes her efforts to giving and nurturing others (Bernstein, 2001; Ettore, 2004; Raddon, 2002).

Researchers have also critiqued this image for its unrealistic construction of motherhood, which scripts many populations of marginalized women as unacceptable caretakers. Mothers with addiction experiences face challenges to embodying this identity as they are viewed as caretakers who have failed to place their children’s needs above their own (Reid, Greaves & Poole, 2008; Lewis, Klee, & Jackson, 2002; Thomson et al, 2008). In a study conducted with women in Narcotics Anonymous, over 60% of the sample believed “addicts” were viewed as “dishonest” and 40% believed they were seen as “bad mothers” (Sanders, 2014). Other relevant studies of mothers managing drug-related illnesses such as Hepatitis C (Thetford, 2004) and HIV/AIDS (Wilson, 2007), revealed that respondents perceived stigma due to how their “disease” challenged their ability to embody cultural expectations for mothers.

Incarceration backgrounds create more stigma for mothers. The image associated with criminal conduct is often of an overly aggressive and violent individual, which is the complete opposite of how society expects a mother to behave (Anderson, 2001; Copeland & Hall, 1992; Ettore, 2004, 2007; Opsal, 2011). Unfortunately, experiences with incarceration frequently collide in the lives of women with drug problems (Anderson & Bondi, 1998; Burke, 2002; Huebner, 2009) due, in large part, to social policies that have sought

punishment as opposed to treatment and rehabilitation (Burke, 2002; Roberts, 1997). For impoverished minorities, stigmatization can be even greater due to the characterization of ideal motherhood being the white middle and upper class women (Glen, 1994; Opsal, 2011) and contrasting racialized stereotypes of Black, poor criminality (Davis, 2007; Roberts, 1997; Richie, 1996). Historically, impoverished mothers of color were viewed as vastly departing from the stereotype of “the good woman.” They were viewed as deviants from the U.S. social standards of self-sufficient, hardworking, and moral citizens. For example, stereotypes like the “undeserving poor” (Katz, 2013), “Black welfare queen” and “Crack addicted mother” (Harris-Perry, 2011; Roberts, 1997) have historically been prominent in U.S. culture and shaped both policy and popular opinion. Thus, the drug use experiences of women of color must be understood within the context of how race, gender, class, and poverty shapes larger structural oppressions and positions of marginality (Maher & Hudson, 1997; Measham, 2002; Roberts, 1997). Together, the esteemed and problematic identities of the “good woman” and “good mother” become tarnished by the devalued identities of being an “addict,” “criminal,” “bad mother,” and “sex worker.”

### Peer Support in Recovery

There is considerable evidence for the importance of social support throughout the substance use recovery process and for people involved in the criminal justice system (Huebner, 2009; Salmon, Saylor & Mann, 2000; Tiberi, 2007). In light of the intersecting stigmas that women in recovery face, it is no surprise that social support, particularly emotional (i.e., esteem, trust, concern, listening) and appraisal support (i.e., feedback, affirmation; House, House, J., Umberson, D. & Landis, K., 1988) are crucial for successful transitions. For example, research on social support among people in custody demonstrates social support shapes treatment adherence (Canada & Gunn, 2012), the successful completion of parole and post-release family unification (Schafer, 1994) and reduces recidivism (Bales & Mears, 2008). For women in recovery, familial support can be positive as women navigate recovery from drug addiction. However, family support may not always be health-promoting (Anderson, 1996; Tracy, Munson, Peterson, & Floersch, 2009; Westerich, 1997). Moreover, the quality of support is often complicated because women with addictions are more likely to have family members who use drugs and have criminal involvement (Burke, 2002; Leverentz, 2006; Tracy et al., 2009). Considering this, alternative forms of support may possibly be more effective.

Researchers have postulated that populations experiencing stigma are more likely to engage in peer groups for support and mutual understanding (Davidson, Pennebaker, & Dickerson, 2000). In fact, researchers such as Thoits (1995) argue that connections formed between “similar others,” defined as non-related individuals dealing with common experiences, may be more supportive than familial networks. In a study conducted of women in drug treatment, the peer group culture cultivated within the Twelve Step program served as an effective context for overcoming stigmas communicated through their interactions with family, friends, and individuals in the workplace (Sanders, 2014). These women viewed their peer community as possessing a collective desire to generously give affirmation (Sanders, 2014) as expressed in quotes from women stating they were able to “talk about shameful events and feel accepted because other women have gone through it too” (Sanders, 2014, p.

67). Together they worked through their Twelve Steps alleviating feelings of shame and stigma that threatened their burgeoning identities and ability to heal. Peer support not only provides connection important for recovery (Davidson et al, 2000; Jason et al, 1997; Sander, 2014) but promotes behaviors such as sobriety (Groh, Jason, Davis, Olson, & Ferrari, 2007; Weisner et al, 2003) and treatment adherence (Galanter, 2003). In a study by Knight, Wallace, Joe & Logan (2001) the effects of peer relationships were evident such that as clients increased time spent in peer treatment groups, they decreased their engagement in unhealthy relationships outside of treatment and substance usage. In a study by Davis (2005) of a sample of residents in a community-based recovery home, peer support fully explained how longer stays in treatment related to greater abstinence for women. Other studies have linked participation in peer groups to increased abstinence and a lessened likelihood of relapse (Ellis, Bernichon, T., Yu, Roberts & Herrel, 2004; Havassy, Wasserman & Hall, 1995; Laudet, Magura, Vogel & Knight, 2000; Majer et al, 2002; Moos, Finney, Ouimette & Suchinsky, 1999). Illness and recovery are social experiences where an individual learns and understands their condition through accessing support from similar others (Davidson et al, 2000).

### Peer Support and Intragroup Stigma

While predominant research efforts emphasize the benefits of peer group contexts, some studies have documented oppositional group dynamics such as intragroup peer stigma. Goffman stated, “the stigmatized individual exhibits a tendency to stratify his ‘own’ according to the degree to which their stigma is apparent or visible. He can then take up in regard to those who are more evidently stigmatized than him the attitudes that the normals take toward him” (1963, 107). Notable efforts have been made to empirically examine this process of intragroup comparison and stigma particularly with people who use substances. For example, Furst, Johnson, Dunlap and Curtis (1999) noted that heroin drug-using individuals distance themselves from other heroin users who they consider to be “out of control dope fiends.” Their ethnographic work in New York found that illicit drug users imposed the label of the “crack head” to stigmatize others who used crack cocaine, invoking terms that were similar to those used by non drug-users directed at people using any type of illicit drug (Furst et al., 1999). This divide between heroin drug users is further substantiated in more recent studies. In another study conducted by Furst, heroin users made distinctions between “addicts” who were able to work and participate in family versus “junkies” who gave up on life and didn’t engage in everyday expected norms for living (Furst & Evans, 2014). Studies have also found that heroin users report significantly more discrimination and stigma than cocaine users (Crawford, Rudolph, Jones & Fuller, 2012). Similarly, among injection drug users (IDUs) Fitzgerald (2004) found IDUs viewed IDUs who contracted Hepatitis C as being irresponsible, uncaring and lacking morality while Simmonds & Croomer (2009) found that many drug using individuals stigmatized IDUs who were homeless and viewed them as criminal and lazy due to assumptions that they shared “unclean” needles. Simmonds & Croomer (2009) further identified bifurcation among steroid-using individuals and all other drug users, because steroid users believed they didn’t exhibit what they saw as addictive symptoms of withdrawal, dependence, and other “junkie behaviors” such as engagement in crime to support drug use. In group stigma has also been examined within the treatment context. Anderson’s (1996) study examines the experiences

of individuals in drug treatment finding that along with family and workplace settings, AA and NA meetings were also environments where stigma management took place. Respondents who remained abstinent discussed passing judgment and distancing one's self from those who had relapsed, and AA and NA members also communicated stigma and questioned the "abstinence" of those who were taking mood-altering prescription medications for injuries. As noted, intragroup stigma has been explored among people who share commonalities of drug use. While these studies highlight processes of intragroup discrimination and stigma, they do not inform understanding of how women with drug use experiences uniquely perceive stigma due to their intersecting experiences with crime, addiction and motherhood and how it tarnishes gendered ideals of the "Good Woman" and "Good Mother".

### Current Study

Women with both histories of addiction and criminal justice involvement face multiple stigmas. Although existing research suggests that peer support is important for this population, we know less about how women in treatment experience peer support when peer-to-peer interactions communicate stigma. Moreover, examining the stigma perceptions of individuals possessing not just one negative group status, but multiple group memberships can extend research efforts on the ways intersectional stigma is perceived and imposed. This study will explore both women's perceptions of stigma attached to their addiction-related behaviors as well as accounts of women disclosing their beliefs about others. Previous studies have shown that perceptions are important to study; for example, perceptions of social support can be more predictive of well-being than measures of support received (Turner & Brown, 2010). Likewise, stigma can be both real and perceived (Goffman, 1963; Link & Phelan, 2001) and both instances can negatively affect well being (Link & Phelan, 2001; Thetford, 1994). This paper will convey the complexities of understanding this social phenomenon examining both accounts of perceived and imposed stigma.

### Methods

This study was guided by a constructivist grounded theory approach developed by Kathy Charmaz (2006), which emerged from the larger grounded theory methodology created by sociologists Glaser & Strauss. Constructivist grounded theory seeks "to define conditional statements that interpret how subjects construct their realities". The constructivist approach focuses on peoples' perceptions and meaning making process, particularly how individuals perceive their lived experiences (Charmaz, 2000). This paper sought to understand how women make meaning of the stigmas they perceive from their peer relationships.

Data used in this analysis is from a qualitative study on women with addiction experiences in recovery during the spring of 2012 to the winter of 2012. Data was collected through 30 semi-structured individual interviews with women engaged in a residential substance use treatment facility in a Midwestern city that will be fictitiously called the Renewal Program. Interviews were one to two hours in length and conducted onsite at the treatment facility. All interviews were conducted by the primary investigator. Questions were constructed in advance of the interviews. For example, the interview included the following questions: what

was it like addressing substance use problems? In what ways did you feel or not feel supported by family, partners and peers within treatment? How did you believe others (society, family, friends etc.) view your experiences with addiction? with incarceration? and with motherhood?

### Sampling and Recruitment

Purposive sampling was the study's chosen recruitment strategy as the researcher sought to saturate multiple categories until core concepts emerged. To do this, the researcher recruited women with diversity in ethnic background, age and length in program. However, the researcher also kept some characteristics constant: all participants had to be mothers with incarceration experiences. As initial analysis developed, the principal researcher chose to continue sampling based on theoretical propositions. For example, the interviews revealed patterns in perceptions of stigma based on drug use type. Thus, the interviewer decided to seek greater variation in drug use type to uncover potentially significant findings. Initial analysis revealed differences along racial/ethnic status, thus the researcher oversampled Latina and Caucasian participants with respect to their actual representation in the treatment center.

As a result of these recruiting strategies, participants ranged in age from 19 to 56 years old, 24% of the sample was Caucasian, 62% was African American and 14% Latina, even though African American women made up almost 70% of the general body of women at the Renewal Program. Years of addiction experiences ranged from three to 37 and 15% of the sample were pursuing or had acquired some level of college education. Lastly, time spent at the treatment center ranged from three months to two and a half years. Table 1 outlines a brief description of the study sample.

Everyone signed a consent form that explained the aim of the study, risks and benefits and confidentiality protocols such as the use of pseudonyms and de-identified information for presentation purposes. After informed consent was received, all interviews were tape recorded and transcribed. All procedures were approved by the university Institutional Review Board.

### Data Analysis

Data analysis followed a systematic process for grounded theory research which included three primary processes: initial coding, focused coding, and theoretical coding. After interviews were read thoroughly, line-by-line initial coding was used to reduce data into manageable chunks (Charmaz, 2006). Coding often involves maintaining the action-oriented nature of the data (Charmaz, 2006) thus many of the codes were framed as performing an act such as *Promoting Drug Use Differences*, *Perceiving Stigma Hierarchies* and *Imposing Bad Mother Label*. Next, focused coding involved a constant comparison method (Glaser, 1992; Strauss & Corbin, 1990) which consisted of comparing earlier codes with new emerging codes to elevate the most salient ones to categories (Charmaz, 2006). Finally, theoretical coding took place, where the researcher evaluates how the earlier codes relate to each other to formulate theoretical conceptualizations (Glaser, 1992). To facilitate this, researchers often use coding families such as the six Cs: Causes, Contexts, Consequences, Conditions,

Covariations and Contingencies (Glaser, 1992). As such, the researcher grouped codes by the causes and consequences of stigma, contexts in which women perceived stigma and conditions that shaped responses to stigma.

## Findings

The Renewal Program's stated goal is to help women develop the necessary tools to maintain substance use sobriety. However, study participants report stigmas from their interactions with peers. Specifically, women who use what is described in the literature as "hard drugs" of heroin and crack cocaine and "soft drugs" of alcohol and marijuana (Golub & Johnson, 2001; Johnson, Golub, & Dunlap, 2000) hold negative views about each other. The women perceive stigmas based on what their substance use signifies about their womanhood, moral character, and value as mothers. Moreover, they perceived stigmas based on the belief that certain drug users are undeserving of treatment. Because the respondents in this study also referred to themselves by such terms in the literature of "hard" and "soft" users, we decided to utilize these categories in our analysis.

While this is a study analyzing peer group relationships within a treatment center, it's important to understand the overlapping systems the women are embedded within and how they communicate stigma. One such context is their familial system. The data from the larger study suggests that women's relationships with their mothers, siblings and children also communicate stigmas that the women have violated gendered norms of proper behavior (Gunn, Sacks & Jemal, under review). This can be seen in this passage below expressed by Sheryl:

My sister is always calling me an unfit parent. Because I never raised any of my kids...But I didn't understand how can you judge me when you drink alcohol everyday as I got high. But by me doing heroin and losing my kids they think mine was worse, more out of control.

Even though Sheryl's sibling drinks alcohol excessively, Sheryl is the more problematic drug user because she lost custody of her children. Moreover, her intersecting "harder" drug use and parenting challenges violate societal expectations for mothers (Gunn et al; under review). Lisa also perceives stigma from family. However, to her family she has not only violated gendered norms but racialized community norms:

Definitely within my family, in my culture ...the women hold it together...,that that's just not what we do...we're strong, Hispanic mothers. I haven't held my family down...They say, we are not like others. In my race, they're mostly pointing to Blacks,.I mean I haven't had a whole lot of experience with society, but in my family they always point to Blacks that's where all that stuff is at.

Lisa's comments point to an additional layer of judgment based on socially constructed stereotypes of black criminality (Gunn et al, under review). In her family, mothers with substance use problems are looked down upon because they violate gendered norms of appropriate behavior. Moreover, mothering with an addiction is seen as "another race's problem," or a "black dilemma." Thus, Lisa has violated ethnic community norms, which are based largely on hegemonic stereotypes that connect blackness with crime, drug use, and

problematic parenting (Gunn et al, under review). Amy, a Caucasian mother, expressed similar beliefs of stigma based on stereotypical views of Black criminality:

It's not socially expected of me as it might be for a black person... So yeah, it's even worse, like 'Oh, what have you done, you've been incarcerated...like you've embarrassed our family, our entire group.' So definitely I don't think that I have the racial privilege that society gave me anymore.

This quote suggests that Amy perceives stigma attached to her incarceration past that is embedded in contrasting conceptions of "whiteness" and "blackness". For Amy, her past engagement in crime negates her ability to embody what society believes to be acceptable behavior for white women.

These narratives suggest that women perceive not just gendered but racialized stigmas from their familial members as a result of their inability to meet community norms. While the familial system represents a separate context, it's important to illustrate how it can also communicate negative views that may shape how women perceive and impose stigmas within their peer relationships in the treatment context.

### **Intra-group stigma among peers in the substance use treatment context**

This current analysis aimed to explore the peer group experiences of women with histories of addiction through the lens of multiple, intersecting stigmas. Although study participants discussed the positive role of peers, more salient findings reveal that women experience "intragroup stigma" or stigma that peers impose upon each other (Dovido, Kawakami & Gaertner, 2000; Fitzgerald, 2004; Simmonds, 2009). The women's accounts of intragroup stigma are presented along with the conditions that can shape conflict as opposed to support.

#### **Hard users: "You out there bad, doing whatever to get a fix"**

Roughly 70% of the study participants were considered hard users, and the remaining 30% were the soft users. While the soft users' drug use contributed to their incarceration, they viewed the hard users more harshly often referring to them as "out of control." Sheryl, an African American, woman recovering from heroin, discusses these perceptions:

One girl says because she smoked weed, she wasn't like us,... she says she was never on the streets out there bad, doing whatever she could to get a fix...her issue was just stealing for clothes...I was like well if you was not like us you would not be sitting on these same blue chairs in meditation.

Sheryl's quote describes her perceptions of stigma from a peer who uses marijuana. According to Sheryl, the soft user views herself as more socially acceptable than Sheryl who used heroin. In this soft user's opinion, her drug use is perpetuated by and connected to her want for material items that can be controlled, not an addiction that leaves one "out there bad, on the streets." In this quote we see gendered stereotypes attached to what it means to be a "good woman" intersecting with negative beliefs attached to the identity of the "addict", someone who does whatever it takes to meet their substance use needs.

Anne, who is African American woman recovering from heroin use, also alludes to how a lack of control is linked to hard user behaviors.

You look at me and go, ‘Well, I smoked weed, but at least DCFS didn’t take my kids,’ Or, ‘I ain’t never sold my pu--y for no heroin. I was never loose.’

Anne perceives soft users to link her heroin use with involvement in survival sex or what participants called prostitution. Anne perceived her heroin use to link her to engaging in survival sex, scripting her as promiscuous and loose. Additionally, Anne perceived stigmas attached to her motherhood due to her drug use resulting in her children being placed into the custody of child services, even though the soft user’s use also impacted her children. These intersecting stigmas attached to “hard drug use”, survival sex and impaired mothering script individuals like Anne as violating norms of behavior for women and mothers.

The perception that hard users have a loss of self-control is further expressed by Evelyn, a soft user who uses marijuana:

Stuff that happens while they're on heroin, crack they let people take control of 'em, like five or six men, rape 'em....my thing is stealing, can't say I know that life.

Evelyn, an African American woman, associates heroin or crack-cocaine with involvement in survival sex and indicative of a moral deficit. The hard users are perceived to lead a lifestyle that degrades their bodies and defies expectations for being a “virtuous” woman, thus beliefs attached to sex work and addiction intersect with beliefs attached to proper womanhood to communicate stigma. Not only is a woman who exchanges sex for money sexually loose, but according to Evelyn such a woman has lost so much control over her life that she allows others to assault her. In fact, having a lack of control over one’s sexual behavior is viewed as more morally corrupt than a woman who commits theft, which is Evelyn’s problem.

Behaviors are not the only distinctions made between different drug users that mark some as out of control and signify norm violations. Sheila, a Caucasian respondent, discusses stigmas based on the physical transformations taking place due to persistent drug use.

A person on hard drugs normally don’t care about themselves. They just let themselves completely go, their clothes, their teeth, they look a hot mess, all smelly.

Sheila is a soft user that views hard users as not being able to uphold their physical appearance and maintain their hygiene and this signifies that a woman has lost control of her life. Thus, beliefs about hard drug use are intersecting with beliefs about proper womanhood to label Sheila a “bad woman.” This quote mirrors what has been supported in previous studies where certain types of drug use are associated with “looking like you don’t care about yourself.” This physical deterioration and lack of control violates expectations for productive human beings but also norms of proper womanhood making hard users more tarnished women than the soft users.

As evidenced throughout these passages, hard users perceive gendered stigmas from soft users concerning their drug use. In addition, some of the soft users confirm these views by communicating stigmas of hard users as tarnished women and mothers. But soft users aren’t the only ones perceived to stigmatize the hard users; some of the hard users express stigmatizing views of their in-group. Valencia, an individual in recovery from crack-cocaine, conveys this:

There are things doing harder drugs I never did....dunno whats it like to not wash my butt ....I may have acted crazy, but I had to look like I knew how to comb my hair.... I don't know what its like to rip off my momma for cocaine....

Even though Valencia is a recovering hard user, she still draws distinctions between her own use and that of other hard users. To Valencia, a hard user who physically deteriorates signifies a more out of control user than a hard user who maintains a groomed appearance. Valencia also draws a distinction between an individual who commits crimes against their family (e.g., stealing money or valuables from family to support drug addiction). A woman who commits crime, particularly against family, violates the ideals of womanhood; “good women” are nurturers and the moral compass of their families. Valencia’s quote illuminates how stereotypes attached to being a “bad woman” intersect with stereotypes attached to being “an addict” to communicate multiple stigmas. Like Valencia, Talia is also judging other hard users:

Heroin is a downer. they don't have no teeth in they mouth. And like if you're pregnant in treatment, they put you on methadone 'cause your baby still needs that .... I never did heroin, that stuff is crazy.

Talia, a Latina respondent, is making reference to how heroin causes bodily decay; she also perceives heroin use as more harmful to unborn children than crack cocaine, which suggests she may perceive mothers who use heroin as more neglectful. Talia’s views highlight how negative stereotypes attached to addiction intersect with stereotypes about what behaviors epitomize “the bad mother.” Lisa, another Latina hard drug user also expresses negative views about her peer hard drug users when she says,

when you are on that stuff, you don't know what you are doing, you all skinny, just don't care about anyone, I wasn't thinking about my kids, I wasn't thinking about anyone.

As seen in these comments, even hard users hold stigmatizing views of other hard users as violating norm expectations for women. Even though they are also recovering from the same drug uses, their ability to maintain perceived functionality saves them from the same stigma of being a “bad hard-drug user”.

### **Soft users: “You don’t have a real problem, you don’t know how it is”**

While stigmas were associated with the hard users’ drug use behaviors, there is another layer of stigmas suggested in the data to permeate the treatment program. The soft users also perceive stigma. However, these stigmas were based on how their substance use was seen as not being a valid or severe drug use experience.

Sharon, a African American, who is recovering from an alcohol addiction, expresses her perception of stigma:

Girls would say, ‘I wonder what her drug of choice was. She ain't did none, she just lied to get’—you know....’We can look at you and tell that you don't do no drugs.’  
Stereotype, you know?

Sharon perceives her peers to view her as not having a real substance use problem, because she doesn't look the way they stereotype addiction to look (i.e., the abuse of illegal street drugs). As a result, her peers see her as a deceiver, someone who falsely claims to have an addiction to gain entry into treatment. In order to be released from the Department of Corrections into the Renewal Program, a woman has to identify herself as having an addiction; thus women who are marked as not having a problem become labeled as undeserving of the program's offerings.

Tammy, a Caucasian hard user recovering from crack-cocaine, conveys similar views regarding how her hard user peers see soft user participants:

Yeah I heard them say, 'She aint done nothing. Why is she here just taking up room? Taking a bed from someone else.'.... They think just because they aren't a crack head they don't need to be here.

Tammy's quote expresses her beliefs that the hard users view the soft users as utilizing resources that can better assist women with "harder" drug use problems. This is a problematic view to project on soft users considering the treatment program is difficult to obtain entry into. This kind of character defect label of not only being a deceiver but taking services from others mark soft user clients as undeserving.

Star is a African woman with a marijuana drug problem who perceives the hard users to see her as not having a real drug use problem as seen here:

We were outside talking, me and two of the other ladies were like, 'Well, you can't really relate, you didn't really do nothing, you haven't been on the hard drugs, we know this life...' and I'm like, 'Well, I'm here too... I got into the trouble... So something wasn't right.'

In the larger society, a soft user is viewed as more acceptable, having a less problematic drug use. Paradoxically, in the treatment context, not having a severe drug use experience becomes a mark that can marginalize individuals. In this passage perceived stigmas invalidate Star's drug use experience and create barriers to peer connection.

### **Finding Commonality Amidst Intragroup Stigma**

Even with the group tensions, participants such as Talia assert that the women have collective substance use experiences that transcend drug type.

You still getting high off that weed, you don't know who your baby daddy is. You drinking, it's still a mind, mood altering substance. It's a gateway drug to other addictions. You still ain't in your right mind, you need help. We all need help.

According to Talia, all of the women's drug use has led to out of control behaviors, and thus they all share a need change. Valencia also expresses similar sentiments in her statement:

We are all mothers who have made bad decisions, whether its heroin or marijuana. They all affect how we raise our children. The older ladies need to be role models to the younger group using marijuana. We have that common factors regardless, to men, going to the stores ripping them off, drugs, we all mothers.

According to Valencia all of the women share common challenges with mothering that transcend their different drug use. Thus, she asserts the need for increased efforts to promote community around these commonalities. Additionally, Valencia believes that the older women, who she sees predominantly as the hard users, have a responsibility to empower the younger women who use the less severe drugs. Valencia's proposal of the hard users guiding the soft users is interesting considering who larger society constructs as the problem user: individuals on heroin and crack cocaine. Valencia's views suggest that the treatment center may serve to empower hard users as experienced users with valuable insights to offer others. To Valencia, the hard users possess years of drug use experiences characterized by trauma and turmoil that may serve as a warning for those women who have not experienced as long a past of addiction. Their lengthy past experiences then become a preventive tool to help others.

Even amidst perceived stigmas and division, participants also asserted the need to promote a more unified community. For participants who perceive stigmas from their larger society, the Renewal Program could serve as an environment that combats external threats.

## Discussion

Previous scholars such as Thoits (1995) have postulated that similar others, non-related individuals who share common challenges, can be more effective for support than familial members. Supporting studies conducted of women participating in 12-Step programs find peer contexts to be an important for accessing support and ameliorating stigmas communicated through relationships with family, friends, and individuals in the workplace (Sanders, 2014). However, what happens in drug treatment communities where the diversity in experiences supercedes the commonalities? In this study, similar others posed threats to well-being.

Findings revealed that participants who engaged in crack-cocaine and heroin use, the hard users, perceived their peers to view them as having more severe drug problems, which created their lack of self-control and violated behavioral expectations for women and mothers. Thus, the hard drug users were viewed as possessing attributes that were devaluing, however these attributes also afforded them power within the treatment context, thus occupying a social space of superiority and inferiority. The soft users also perceived stigmas; these stigmas were based on beliefs that their drug use did not embody a real drug use experience and thus rendered them undeserving of treatment services. Thus, while the soft users also experienced devaluation as their drug use was seen as less authentic, they also occupied a space of superiority as their drug use is more socially acceptable. While the soft drug users, individuals who used marijuana and alcohol, perceived stigmas and invalidation, the data suggests the overwhelming perceptions of stigma were felt from hard users. This paper seeks to suggest a process of competition, rather than a fixed state of being either a hard or soft drug user, where two groups are in essence fighting for validation, which simultaneously promotes a culture of ridicule and devaluation.

Scholars sought to conceptualize why individuals who belong to a stigmatized group may impose stigmas upon individuals within their marginalized group. Some scholars explain

intragroup discrimination as mechanisms for dominating over others and enforcing societal norms and control (Phelan, Link & Dovidio, 2008). Alternative hypotheses that are more relevant to this study view intragroup discrimination through “downward comparisons” as a mechanism of self-esteem enhancement (Crocker & Major, 1989; Wills, 1981). Previous research provides evidence that downward comparisons within groups can improve self-esteem (Crocker, Thompson, McGraw & Ingerman, 1987; Crocker & Major, 1989; Jones et al, 1984). Considering the scarcity of resources in the culture, attempts at raising one’s esteem by invidious intragroup comparison can be viewed as a small effort to access power within a hierarchy of status (Preble & Casey, 2001). From a societal standpoint, seeking to raise one’s esteem is a fundamental component of social organization (Crocker & Major, 1989).

In the case of the soft users it’s more clearly understood how comparing their drug use to those of the hard users can improve their beliefs of their own behaviors, considering their drug use is viewed in larger society as more acceptable (Ahern, Stuber, & Galea, 2007). However, downward comparison strategies are particularly interesting to consider in regards to the hard users who are perceived to impose stigmas that contradict societal views.

Within the treatment center, the hard users are able to construct a counter narrative that stigmatizes the other in-group members who are less socially pathologized by society. Jones and colleagues (1984) state that comparisons made between other stigmatized individuals can allow the marked person to redirect their energies towards the attributes and qualities they possess that can mitigate stigma. The Renewal Program provides a context where the hard users can reframe their narrative as one of triumph as opposed to destruction. Their ability to construct their drug use experience as “real” suggests they view themselves as possessing great resiliency to overcome circumstances others may not be able to. The ability to harness this positive attribute allows the hard users to see themselves more positively and combat internalization.

While such intragroup tension may pose harm to overall peer group support and connection, data suggests it may serve as a mechanism for managing stigma. Stigma trumping, manifesting as a contest and sign of group pride, may combat perceptions of stigma that extended beyond the treatment center. The hard users ability to boost their self-esteem by creating intragroup hierarchies can be a mechanism for coping within a larger societal context that views them as the problematic drug users. Likewise, even though the soft users are socially constructed as the less problematic drug users, they too exist within a societal context that views them as “deviants” due to their intersecting drug use, incarceration and impaired mothering.

Considering that the treatment center predominantly serves a population of impoverished African American women, coping strategies utilized within this context can become very important for navigating their larger sociopolitical world. Researchers have postulated that impoverished African American women live in a society where they experience discrimination and marginalization based on their group membership such as gender, race, poverty, drug use or incarceration history (Amaro, 1995; Keslo, 2014; Windgood & DiClemente, 2000). Social welfare and criminal justice policies have historically

disproportionately criminalized their substance use, imposed harsher drug sentences (Burke, 2002; Roberts, 1997) and promoted self-shaming and stigmatization (Harris-Perry, 2011; Wingood & Diclemente, 2000). Considering this larger oppressive structural system, a treatment center context where women engage in various coping strategies is important to study and understand.

While the narratives presented in this study of women's peer relationships did not point to racialized stigmas, it is important to consider the potential role of race. Many scholars (Harris-Perry, 2011; Richie, 1996; Roberts, 1997) have examined social constructions of addiction and motherhood undergirded by racialized beliefs of impoverished Black criminality. Thus, it is important to consider that the stigmas that the women are communicating and perceiving about what constitutes bad "mothering and womanhood" could be shaped by racialized beliefs, as suggested within women's familial systems. This study increases knowledge of the complex ways in which marginalized groups cope with stigma through not just avoiding their discredited identity but also embracing it, seeking legitimacy and sometimes devaluing others.

### **Implications for Practice/Drug Treatment Intervention**

While peer support groups have been found to be important spaces for connection and improved health, they may also promote turmoil and disconnect. Sometimes the ties that can cultivate common understanding of experiences can be impeded by differences and discrimination. It is important that substance use treatment professionals acknowledge and address the different experiences women have with their peers. If intragroup stigma is acknowledged and addressed in peer support groups, it can be used as a tool in recovery.

Because this intragroup stigma mirrors the stigma women may experience outside of the treatment setting, treatment groups can be a place to practice strategies for empowerment and management of multiple sources of stigma. It is crucial for practitioners to help facilitate these conversations among women; without therapeutic facilitation, some women may feel marginalized resulting in unsuccessful recovery. Specific strategies practitioners can use include directly acknowledging stigma, exploring the ties between in-group stigma and the larger social context, discussing the impact of stigma on self-evaluation, and brainstorming strategies to assist women in managing the impact of stigma.

When considering the implications for study results, there are some key limitations to keep in mind. This study drew from a random sample of mothers with addiction and incarceration experiences who reside in a multi-faceted treatment facility. Outside of this study many women with addiction and incarceration experiences do not participate in such a comprehensive residential treatment facility, thus this paper presents significant but a limited set of experiences between peers. In addition, this study includes interviews with women at one point in their recovery, thus their perceptions of stigma may vary at other points in time. Moreover, the peer group narratives did not reveal stigmas embedded in racialized stereotypes, even though outside data from this sample conveyed racial implications. Thus, it is important for future research on ingroup comparisons to explore potential intersecting gendered and racialized stigma processes. However, this paper still provides meaningful insights into perceptions regarding peer group connection and conflict.

## Conclusion

Research studies have explored intragroup forms of stigma among peers. However, few efforts have examined gendered-forms of stigma within peer support groups, which aim to build connections important for recovery and stigma management. This grounded theory study focuses on the peer group experiences of mothers with histories of addictions and incarceration engaged in residential treatment. Findings reveal that women perceived multiple stigmas through their peer group interactions. Through analysis, this study seeks to promote understanding of how processes of power and oppression can manifest within the micro relationships of groups that share common struggles as they fight for legitimacy. Although peers may be supportive components of recovery, this study extends literature by finding peers can also be perpetrators of stigma, which may create barriers to successful recovery and community reintegration.

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**Table 1**

## Description of Study Participants (N = 30)

Participant*	Age	Race/Ethnicity	Education	Drug Type	Months in Recovery	Charge
Amy	29	Caucasian	In college	Marijuana	36	Drug trafficking
Gloria	39	African American	10 <sup>th</sup> grade	Crack cocaine	20	Solicitation & Possession
Evelyn	27	African American	11 <sup>th</sup> grade	Marijuana	10	Retail theft
Tanya	37	African American	In college	Crack cocaine	48	Retail theft
Debra	32	African American	GED	Marijuana	12	Forging checks
Jane	30	Latina	In college	Crack cocaine	36	Possession
Leah	31	African American	12 <sup>th</sup> grade	Heroin	17	Residential burglary & Unlawful use of controlled substance
Lena	25	African American	12 <sup>th</sup> grade	Crack cocaine	13	Possession
Nieki	40	African American	9 <sup>th</sup> grade	Crack cocaine	19	Possession
Valencia	47	African American	In college	Crack cocaine	24	Possession
Delila	32	Latina	9 <sup>th</sup> grade	Crack cocaine	30	Possession
Tammy	23	Caucasian	10 <sup>th</sup> grade	Crack cocaine	18	Delivery with intent to sell
Katty	25	African American	11 <sup>th</sup> grade	Crack cocaine	30	Possession & Residential burglary
Amelia	28	Caucasian	11 <sup>th</sup> grade	Heroin	21	Possession
Pamela	31	African American	10 <sup>th</sup> grade	Heroin	19	Retail theft
Vanya	31	African American	GED	Alcohol	27	Retail theft
Lisa	33	Latina	10 <sup>th</sup> grade	Crack cocaine	15	Possession
Sheila	29	Caucasian	9 <sup>th</sup> grade	Marijuana	17	Possession
Anne	34	African American	GED	Heroin	9	Possession
Kimba	42	African American	GED	Heroin	32	Intent to distribute
Delinda	42	African American	11 <sup>th</sup> grade	Crack cocaine	9	Retain theft & Solicitation
Tamara	46	Caucasian	HS Grad**	Alcohol	24	Fraud
Danny	33	Caucasian	HS Grad	Crack cocaine	28	Possession
Talia	34	Latina	11 <sup>th</sup> grade	Crack cocaine	20	Retail theft

Participant*	Age	Race/Ethnicity	Education	Drug Type	Months in Recovery	Charge
Charlene	48	African American	9 <sup>th</sup> grade	Crack cocaine	16	Solicitation
Hope	52	African American	10 <sup>th</sup> grade	Heroin	24	Possession
Sheryl	43	African American	9 <sup>th</sup> grade	Heroin	11	Burglary & Intent to sell
Sharon	35	African American	12 <sup>th</sup> grade	Alcohol	15	DWI & Manslaughter
Jamila	32	Caucasian	B.A.	Heroin	26	Possession
Star	25	African American	12 <sup>th</sup> grade	Marijuana	13	Possession & Intent to sell

\* All names have been changed

\*\* High School Graduate