Brief Report

Substance Abuse Stigma and Discrimination among African-American Male Substance Users

Melanie C. Scott, PsyD[1,*], Otto F. Wahl, PhD[2]

[1]Department of Psychiatry, Yale University School of Medicine
[2]Graduate Institute of Professional Psychology, University of Hartford

Abstract

Purpose: This qualitative study examined the experience, manifestations, and impact of racial discrimination and substance abuse stigma, also known as a double stigma, among 10 African-American male substance users.

Methods: Interviews were audio-taped, transcribed, and analyzed for themes using Grounded Theory methodology.

Results: Racial discrimination and substance abuse stigma were common experiences. In terms of a double stigma, interviewees perceived that their substance use problems were viewed differently, and less favorably, than the substance related disorders of non-minority clients. Spirituality also was an important aspect of coping for a majority of interviewees.

Conclusions: This qualitative approach utilizing Grounded Theory was successful in collecting and summarizing the narrative experiences of double stigma among African American male substance users. A double stigma experienced by African-American males with substance related disorders may cause potentially harmful effects on treatment engagement and success.

Keywords: African-American, discrimination, grounded theory, qualitative, stigma, substance abuse

Introduction

Stigma is a significant issue that results in social detriments and reduced quality of life for individuals with psychiatric disorders. Current research suggests that, due to stigma, many individuals with psychiatric disorders experience themselves as stigmatized, are targets of rejection and discrimination, and have expectations of rejection from society (Campbell & Schraiber, 1989; Wahl, 1999; Wright, Gronfein & Owens, 2000; Link & Phelan, 2001; Link, Struening, Neese-Todd, Asmussen & Phelan, 2001; Struening *et al.*, 2001; Corrigan *et al.*, 2003). In fact, the 2001 Surgeon General's Report on mental health concluded that stigma is *the most formidable obstacle to future progress in the arena of mental illness and heath* (U.S. Department of Health and Human Services, 2001).

Related to the stigma of mental illness are the negative societal perceptions of individuals who have developed substance-related disorders. Although substance-related disorders are categorized as psychiatric disorders, society tends to view these problems more harshly than other forms of mental illness (Rasinski, Woll & Cooke, 2005). In addition, research has found that higher degrees of shame are experienced by individuals with substance-related disorders in comparison to individuals with other forms of mental illness (Wiechelt, 2007). Furthermore, the magnitude and duration of the effects of substance abuse stigma may last far beyond that of other disorders (Link, Struening, Rahav, Phelan & Nuttbrock, 1997). Perhaps, harsher stigma occurs because particular features of substance-related disorders perpetuate increased

*Corresponding author: Dr. Melanie Scott, Department of Psychiatry, Yale University School of Medicine, Substance Abuse Treatment Unit (SATU), 1 Long Wharf Dr., New Haven, CT 06511, USA. Tel.: +203-974-5714.
E-mail: melanie.scott@yale.edu

 Stigma Research and Action, Vol 1, No 1, 60–66 2011. DOI 10.5463/SRA.v1i1.3

stigma and negative societal reactions. Such features are its association with personal choice and therefore blame, its link to violence, and its deviation from the orthodox norms of society (Rasinski *et al*., 2005). Societal reactions to individuals with substance-related disorders have been found to include anger, fear, blame, and avoidance (Link, Phelan, Bresnahan, Stueve & Pescosolido, 1999; Pescosolido, Monahan, Link, Stueve & Kikuzawa, 1999).

In some cases, the addition of racial discrimination may also play a role in increasing the magnitude of substance abuse stigma—forming a double stigma. Individuals from minority backgrounds who have substance-related disorders may have their disorders—and themselves—viewed more negatively than substance users from non-minority backgrounds. For example, one study examining multiple social stigmas and societal perceptions found that participants assigned more blame to black vignette characters than to white characters for either developing drug dependence or acquiring AIDS, even when acquiring either condition was out of the character's control (Rush, 1998).

Relatively little attention has been given to the unique confluence of discriminatory factors associated with being African-American and having a substance-related disorder. In addition, few if any researchers, have sought information directly from the individuals who might be experiencing stigma and double stigma. To expand the research literature on substance abuse stigma and to gain a better understanding of the experience of African-Americans with substance use disorders, this qualitative study used one-to-one interviews and Grounded Theory analyses to explore the experience and impact of a double stigma, specifically, substance abuse stigma and racial discrimination.

Methods

Recruitment

Participants were recruited by the first author as part of her doctoral dissertation at the University of Hartford, Graduate Institute of Professional Psychology. Participants were recruited from an outpatient substance abuse treatment facility located in an urban area of central Connecticut. Recruitment strategies included two methods: (a) fliers with a tear-off feature placed in the waiting room of the facility, and (b) a description of the study was briefly presented to four substance abuse groups. All individuals who contacted the first author by phone received another brief description of the study and were informed that their participation was voluntary, and that all of the information provided would be anonymous. Individuals who met the inclusion criteria for the study were substance dependent African-American men, aged 18 years and older, who agreed to participate in a lengthy, audio-taped interview, and provided informed consent. Recruitment and study procedures were reviewed and approved by the University of Hartford Human Subjects Committee and by the facility from which participants were recruited.

Procedure

Stigma and discrimination are complex topics of inquiry. Therefore, a qualitative approach utilizing one-on-one interviews was chosen for its strength in capturing multilayered meanings of complex concepts (Gilgun, 1992), as well as its ability to create what Geertz (1973) termed *thick description* of phenomena and processes. Interviews were approximately one hour long, were audio-taped, and later transcribed verbatim. To maintain confidentiality, each participant was assigned a unique alphanumeric code and narrative quotes did not include identifying information about the participants. At the end of the study, audiotapes were destroyed. To help direct the interviews, a semi-structured interview guide was constructed, which included open-ended questions about substance abuse stigma and racial discrimination. The interview guide included 38 open-ended questions on substance abuse history, substance abuse stigma, racial discrimination, and double stigma (the combined effect of substance abuse stigma and racial discrimination). Open-ended questions were organized into the three sub-sections of experience, impact, and coping to assure that important aspects of each topic were elucidated. For example, participants were asked about their experience with racial discrimination, how racial discrimination impacted their lives, and how they coped with racial discrimination.

Analysis

Verbatim transcripts were analyzed to identify emergent themes following the Grounded Theory method described by Glaser & Strauss (1967). Using this method, external categories are not imposed on the data; instead, emergent and recurrent themes are identified. Additionally, Glaser and Strauss suggest that data should be collected until theoretical saturation, which is the point at which enough data are collected so that solid and consistent themes emerge. We reviewed the data for theoretical saturation after every five interviews. Theoretical saturation was reached within 10 interviews.

Grounded Theory is an inductive approach used to capture meaning, thus, the process of data analysis began broadly, with broad interview questions as well as broadened categories, which became increasingly

narrower as the data were collected, analyzed, and interpreted. The process of coding used in data analysis followed open coding, selective coding, and comparative analysis developed by Strauss and Corbin (1998). This was accomplished by examining the data in the four open categories of (a) racial discrimination, (b) substance abuse stigma, (c) double stigma, and (d) spirituality, which were further organized into the selective subcategories of experience, impact, and coping strategies. First, open coding consisted of analyzing the data from transcripts line-by-line and assigning a label that described the general idea of the statement. The results of open coding were written into response summaries for each interviewee, which were divided into columns; one column for the line-by-line transcript and one column for the open coding label, as illustrated in Table 1.

The next step to coding was selective coding, where words, phrases, or events that appeared to be similar or repeated across narratives were grouped and some represented a theme, but were only identified as a theme during comparative analysis.

The final step and the key part of data analysis was the constant comparative analysis. Comparative analysis was accomplished when each participant's response summary was compared with other participants' response summaries in the same category, which was used to help identify emergent themes, as illustrated in Table 2.

Reliability

According to Strauss and Corbin (1998), reliability and validity should be discussed openly in a qualitative study in order to establish credibility. Credibility is based upon reliability, and in the case of qualitative research, enough information must be provided about the research methods used so that another researcher could repeat the study; although there need not be repeatability of results since many qualitative researchers believe that the study itself can affect results. To ensure reliability, the data collection procedures and direct quotations from the narratives were provided in their entirety in the original dissertation (Scott, 2008) as evidence of the phenomenon. Any data that did not fit what appeared to be the arising themes were included as well. In this way, readers could see the interpreted data. The evidence and its interpretation were described as clearly as possible so that readers could decide for themselves whether they agreed with the researcher's conclusions. The researcher's task was to understand the participants' experience with the phenomeon. Open-ended questions posed during in-depth interviews allowed participants to speak in their own words and the highlight what they themselves considered to be important. Participants spoke out of their experience as well as answering questions included in the structured interview if more data was necessary.

Results

Participant Characteristics

Ten substance dependent African-American male participants in recovery were interviewed. The age of participants ranged from 24 to 54 years, with a mean age of 33.6 years. The average years of education were 9.5 years. Half of the participants were unemployed, and two were on probation. Demographic characteristics are shown below in Table 3.

Table 1: Example of Substance Abuse Stigma Category – Impact

Verbatim Transcript	Open Coding with Line-by-Line Analysis	Labeling
Yeah, it's like people don't trust you anymore. They get scared about your attitude. I guess it's like a leach being around.	1. Yeah, it's like people don't trust you anymore. 2. They get scared about your attitude. 3. Guess it's like a leach being around.	1. Loss of trust 2. Fear of attitude 3. Like a leach

Table 2: Example of Racial Discrimination – Impact

Interviewee	Response Summary
1	Anger (*back in the day I got angry*) Avoidance (leave the situation, *don't associate with people like that*)
2	Anger (*upset people can get over on you*) Belittled (*upset people can make you feel so small*) Hopelessness (*there isn't anything you can do about it*)
3	Belittled (embarrassed and belittled when younger) Anger (*anger* as an adult)

Table 3: Demographic Characteristics (n=10)

Variable	% (n)	Mean (SD)
Age		32.6 (10.2)
Years of education		9.5 (1.4)
Employment status		
Full-time	20% (2)	
Part-time	30% (3)	
Unemployed	50% (5)	
Legal involvement		
Probation	20% (2)	
Substance abuse[a]		
Age of first substance use		14.4 (2.1)
Alcohol	10% (1)	
Crack cocaine	70% (7)	
Heroin	10% (1)	
Polysubstance	10% (1)	

Notes: [a]Variables within the substance abuse category are mutually exclusive.

Racial Discrimination

Racial discrimination was a common life experience for study participants. Sometimes the experience involved blatant or obvious discrimination, as in this report from one interviewee:

> *I grew up in the suburbs and back then there really weren't any black people living out there. And that really caused me and my brothers and sisters a lot of problems at school. A lot of fighting. A lot of racial name calling. We had problems with teachers, local stores, you name it.*

Other experiences involved more subtle manifestations of discriminatory attitudes, as in this description:

> *But I think people calling you stuff like that doesn't happen as much, or a least it hasn't happened to me straight up in my face since I was in my younger years. Now it's like people do it [discriminate] behind your back. Or they write it [racist remarks] somewhere for you to see it, but nobody is around so you know they did it.*

Whether subtle or blatant, discrimination was reported by nine out of 10 participants. The most common reaction to these experiences was anger, which was noted by all participants. Participants also expressed the perception of lessened self-worth, including feeling embarrassed, *like you don't belong*, and *lower than others*. Participants also described second guessing their racial discrimination due to uncertainty. *It just happens so often and sometimes you don't know if it happened or if you are just thinking too much.* Despite having strong emotional reactions such as anger, all participants reported mainly passive and/or avoidant coping strategies, such as, *If I was by myself, I would just have to walk away and not deal with it*. They also indicated that second guessing their perceptions sometimes helped to minimize distress. In addition, interviewees indicated that they sought social support to cope with their distress. *Talking to someone gets it off your chest. Especially if you talk to someone who would understand.*

Substance Abuse Stigma

Substance abuse stigma emerged as a category in which participants experienced themselves as deeply discredited by society and poorly treated because of negative stereotypes and labels associated with their substance use. Interviewees described the hallmarks of substance abuse stigma as the experience of social rejection that subsequently led to personal isolation. Furthermore, substance abuse stigma had a major impact on participants' psychological well-being, resulting in feelings of shame, embarrassment, and alienation.

> *It made me feel really, really embarrassed; probably more ashamed than anything else. Like, you could go to a friend's house, see the car in the driveway, and knock at the door, and they don't answer. And that's a horrible feeling and embarrassing.*

> *And people treated me like I was lower than them; like talking down to me. The sad part is that you kind of get used to people talking down to you like that…It made me feel like I was lower than people. And it made me know that I was doing something that wasn't right in other people's minds. Like, people really look at you with disgust, so it makes you know that you aren't right.*

> *I just felt different and like I had to stay away. It's not like people tell you to stay away, but it's like you know by the way they are looking at you. And you get used to people talking down to you and just feel like you're nothing.*

> *It was like I was an embarrassment to my family. You know, like when people say your name and shake their head and look down.*

> *It made me feel like an outcast. Like I was a bum on the street. I felt like a failure and like people didn't want me around. And that's a bad feeling. Like feeling like everywhere you go nobody wants you there.*

> *So like, if you are an alcoholic it's just one of those things where people look down on you.*

Avoidance of others was reported as a response to these experiences, although sometimes this avoidance

was also a mechanism to prevent non-users from interfering with the interviewee's ability to continue to use drugs and alcohol.

> *I just kept to myself. Stay away from people. That's really it. And that's all you can do. I felt like back when I was using I was so messed up that I wasn't in the position to fight back against how people were treating me anyway, so just stay away.*

> *I would just try to stay out of their way so that they didn't have to see me all drunk.*
> *You know what I mean? I wouldn't be around them because then they wouldn't know if*
> *I was drinking or not.*

Double Stigma

Eight interviewees reported experiences with racial discrimination and substance abuse stigma that produced a form of double stigma. Interviewees often perceived that, as African-Americans, their substance use problems were viewed differently, and less favorably, than the substance related disorders of non-minority clients.

> *It's like I expect it. Like, I expect people when they find out that I use to not be surprised because I'm black. But I feel that if a white person says they use crack or you find out that they use, people act like they are surprised. Like, any type of black person can be thought of as a drug user, but not every white person is. I don't know how things got to the point where things are seen that way, but it is.*

> *Well, it's like people treat you badly and I feel that the media has a lot to do with it. For example, if you watch TV, they always show black people as violent, and ignorant, and crazy on TV and the news. And I believe that when people see you out like in a program they assume that you are like that. It's like they expect that you're gonna be hostile when that's not the case. It's like they don't like you because you are a crack head but what adds to it is that they don't like you because you're black, too.*

> *If you ever meet a white person who has a drug problem nobody cares. But let a black man use cocaine or any other drug and it's a big deal. Like, I watch a lot of sports and ain't it funny that when [Mark] Maguire gets charges for steroid use nobody gonna bat an eye. But when [Barry] Bonds get the same charge, they talking about not letting him in the Hall of Fame and getting records taken away. Two men, same charge, one black, one white, and the white guy is the one who gets off.*

> *I'm not gonna sit here and try to lie and say that there is no racial [bias], you know, because I see it all the time. And I think, personally, yes I do think that other people do get better treatment. And that they cater to certain people more because they are the lone white person in a treatment program… And then when they hear you use crack, it's like oh no. But crack and coke is the same thing and I hear a lot of white people in treatment use cocaine, but it doesn't have the same bad effect on them.*

> *I remember being at this place [treatment facility] where there was a lot of black people and Spanish people up in there. And we had this new white guy who was a nurse. And he's going to wind up in our group because he was stealing pills from the hospital. And these counselors were talking low out in the hall at like a desk about him because he was new, like, we got a new group member and I can't believe he's an addict, he doesn't look like the type. And you know, you hear all kinds of things walking around, but I knew they were talking about him because he was the only new guy up in the group. And it's like, well what the he[ck] does an addict look like? You know, like what does an addict look like?*

Interviewees' responses to double stigma produced a variety of perspectives, ranging from complaints about the quality of addiction treatment in urban areas and media's influence on stigmatization, to stereotyping and current racially charged topics in baseball. Participants' emotional reactions to perceived double stigma were anger and frustration:

> *I just didn't worry about it. But don't get me wrong, it made me upset. I mean, it makes me mad and makes me question myself, and I feel bad. But, I've got to remember that that has to do with that person, not me. And that I've got to do for me."*

> *[I feel] just really upset. It's like you can't get away from negatives about us. The only positives are that we can play sports and dance good. You never hear any other good things. And I think that some people really think that that stuff is true. And that really upsets me.*

> *It makes me feel angry and slighted…it makes me feel like things aren't fair.*

Furthermore, interviewees' reported that a perceived double stigma while in treatment would encourage guarded behavior, affect their ability to engage in treatment, and disrupt trust with their clinician.

> *So it [stigma and racial discrimination] would hinder me. It would hinder me because if I'm already negative all I'm looking for is more negativity. I'm like a magnet. So you understand? It could hurt me, yes it can. And it*

would send me into a state of depression and make me feel more hopeless than I feel at the time.

I couldn't receive from a person like that. To see that you are favoring others over me, then you're not real about what you're talking about. I would shut them out, you know.

It can get you really upset and angry and you won't do good there [in treatment]. If I stayed, I didn't take the treatment serious.

Like I said, when that type of stuff is happening you just gotta get out of there. You might as well go somewhere else for help. There is no point in staying there. So, I just try to get into another place.

Trust me that mess makes me angry. And when it happened to me and I got treated bad in a program one time, I got angry and just left and went somewhere else.

Spirituality

Part of the Grounded Theory approach involves remaining open to themes that emerge even if they are not the ones anticipated. Spirituality emerged as a theme secondary to the main topics of interest. Eight interviewees made reference to the use of spirituality to cope with discrimination and other life stressors and to maintain their recovery.

You need help from a program, but what if the program is closed at 3 a.m. when you get a craving? You need someone to be there to talk to and understand you. You need someone who can see you vulnerable and not, you know, look down on you. So, that leaves God.

Like when I would get really bad urges to drink sometimes I would try to pray.

I feel like people in church are forgiving. Like I'm not the only one that I know of in church who had a drug and alcohol problem. I know of even pastors and evangelists who had problems with drugs too. But they're straight now and the church has helped them and accepts them now. That's really inspiring.

Discussion

Similar to previous research on racial discrimination, the African-American men in this study reported encountering racial discrimination and experienced psychological distress. Their primary reaction to racial discrimination was anger, but interviewees also reported using passive-avoidant responses, such as walking away or ignoring the situation. Second-guessing their experience of racial discrimination was also used to minimize emotional distress. Also consistent with previous research, African-Americans in substance use treatment reported feeling stigmatized and shunned because of their substance related disorder. Interviewees reported being alienated, patronized, ashamed, and embarrassed. Avoidance of others who might hold or express negative views was a common way of coping with such feelings and experiences. Thus, the first hand reports of African-Americans in substance abuse treatment is consistent with what one would expect based on studies of attitudes and prejudice.

We also found a confluence of racial prejudice and substance abuse stigma that resulted in a double stigma and a double burden for African-American males. Eight interviewees reported being aware of being viewed and treated differently than other, non-minority individuals at their treatment facility. They were sensitive to the discouraging messages in expressions of surprise at the problems of white substance abusers and casual acceptance of expected substance abuse among African-Americans. The experience of a perceived double stigma resulted in participants feeling angry, hopeless, and depressed, similar to the findings indicated by Thompson, Noel & Campbell (2004). A perceived double stigma had negative effects on self-reported substance abuse treatment engagement, retention, and outcomes. Additionally, more than half of the interviewees said that they would leave treatment if they perceived the occurrence of a double stigma within the treatment setting. In reaction to a double stigma, participants also reported resistant or guarded behavior. Treatment engagement and optimism about recovery, then, are undermined by the experience of double stigma.

One additional and secondary finding was within the area of spirituality. Research and cultural practices have identified spirituality as a cornerstone of the African American community (Randolph & Banks, 1993; Brome, Owens, Allen & Vevaina, 2000). Our results suggest that it appears to be important for African American individuals working to recover from substance related disorders as well.

Several limitations of the present study should be noted. This study was limited to African-American males. The experience of African-American females may differ. The study was also confined to a single treatment setting, leaving open the question of how well results apply to individuals in other treatment facilities or in the community. In addition, interviews and analyses were conducted by a single rater, which may raise issues of validity and reliability. Nevertheless,

our results provide a useful initial exploration of the phenomenon of double stigma from the perspective of those experiencing it. They reveal some of the ways overt and subtle discrimination and stigma may be experienced by African-American males with substance related disorders, and the potential harmful effects those experiences may have on treatment engagement and success. Results also suggest a need for care providers to reflect on their own attitudes and behaviors lest they inadvertently reinforce the sense of double stigma that can undermine their treatment efforts. There is a need for professionals to understand the significant impact of stigma on the lives of individuals in treatment and how multiple sources of stigma may interfere with those individual's ability to be open and willing to engage in treatment. Finally, results indicate that further exploration of the phenomenon of double stigma is important and fruitful. Future research should build on the recently demonstrated themes by quantifying the impact of a double stigma among African-American men while utilizing empirically validated assessments of psychological well-being. Future research should also consider investigating the phenomenon of a double stigma among African-American women as well as other ethnically diverse populations.

Acknowledgements

This work was conducted in partial fulfillment of Melanie Scott's doctoral dissertation at the University of Hartford, Graduate Institute of Professional Psychology. This study was supported in part by National Institutes of Health grants T32-DA007238, P50-DA009241.

References

Brome, D., Owens, M., Allen, K., & Vevaina, T. (2000). An examination of spirituality among African American women in recovery from substance abuse. *Journal of Black Psychology*, *26*(4), 470–486. doi: 10.1177/0095798400026004008.

Campbell, J., & Schraiber, R. (1989). *The well-being project: Mental health clients speak for themselves*. Sacramento, CA: California Department of Mental Health.

Corrigan, P., Thompson, V., Lambert, D., Sangster, Y., Noel, J., & Campbell, J. (2003). Perceptions of discrimination among persons with serious mental illness. *Psychiatric Services*, *54*(8), 1105–1110. doi: 10.1176/appi.ps.54.8.1105. PMid: 12883137.

Geertz, C. (1973). *The interpretation of cultures*. New York, NY: Basic Books.

Gilgun, J. (1992). Hypothesis generation in social work research. *Journal of Social Service Research*, *15*, 113–135. doi: 10.1300/J079v15n03_07.

Glaser, B., & Strauss, A. (1967). *The discovery of grounded theory: Strategies for qualitative research*. Hawthorne, NY: Aldine De Gruyter.

Link, B., & Phelan, J. (2001). Conceptualizing stigma. *Annual Review of Sociology*, *27*, 363–385. doi: 10.1146/annurev.soc.27.1.363.

Link, B., Struening, E., Rahav, M., Phelan, J., & Nuttbrock, L. (1997). On stigma and its consequences: Evidence from a longitudinal study of men with dual diagnoses of mental illness and substance abuse. *Journal of Health and Social Behavior*, *38*(2), 177–190. doi: 10.2307/2955424. PMid: 9212538.

Link, B., Phelan, J., Bresnahan, M., Stueve, A., & Pescosolido, B. (1999). Public conceptions of mental illness: Labels, causes, dangerousness, and social distance. *American Journal of Public Health*, *89*(9), 1328–1333. doi: 10.2105/AJPH.89.9.1328. PMid: 10474548. PMCid: 1508784.

Link, B., Struening, E., Neese-Todd, S., Asmussen, S., & Phelan, J. (2001). The consequences of stigma for the self-esteem of people with mental illnesses. *Psychiatric Services*, *52*(12), 1621–1626. doi: 10.1176/appi.ps.52.12.1621. PMid: 11726753.

Pescosolido, B., Monahan, J., Link, B., Stueve, A., & Kikuzawa, S. (1999). The public's view of the competence, dangerousness, and need for legal coercion of persons with mental health problems. *American Journal of Public Health*, *89*(9), 1339–1345. doi: 10.2105/AJPH.89.9.1339. PMid: 10474550. PMCid: 1508769.

Randolph, S., & Banks, H. (1993). Making a way out of no way: The promise of africentric approaches to HIV prevention. *Journal of Black Psychology*, *19*, 406–422. doi: 10.1177/00957984930192009.

Rasinski, K., Woll, P., & Cooke, A. (2005). Stigma and substance use disorders. In P. W. Corrigan (Ed.), *On the stigma of mental illness: Practical strategies for research and social change* (pp. 219–236). Washington, DC: American Psychological Association. doi: 10.1037/10887-010.

Rush, L. (1998). Affective reactions to multiple social stigmas. *Journal of Social Psychology*, *138*(4), 421–430. doi: 10.1080/0022454980960 0397.

Scott, M. C. (2008). The experience of stigma and discrimination in African American substance users. *Dissertation Abstracts International*, *69*(09), Mar 2009.

Strauss, A., & Corbin, J. (1998). *Basics of qualitative research: Grounded theory procedures and techniques*. Thousand Oaks, CA: Sage Publications.

Struening, E., Perlick, D., Link, B., Hellman, F., Herman, D., & Sirey, J. (2001). The extent to which caregivers believe most people devalue consumers and their families. *Psychiatric Services*, *52*(12), 1633–1638. doi: 10.1176/appi.ps.52.12.1633. PMid: 11726755.

Thompson, V., Noel, J., & Campbell, J. (2004). Stigmatization, discrimination, and mental health: The impact of multiple identity status. *American Journal of Orthopsychiatry*, *74*(4), 529–544. doi: 10.1037/0002-9432.74.4.529. PMid: 15554813.

U.S. Department of Health and Human Services. (2001). Mental health: Culture, race, and ethnicity—A supplement to mental health: A report of the surgeon General. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.

Wahl, O. (1999). Mental health consumers' experience of stigma. *Schizophrenia Bulletin*, *25*(3), 467–478. PMid: 10478782.

Wiechelt, S. (2007). The specter of shame in substance misuse. *Substance Use & Misuse*, *42*(2–3), 399–409. doi: 10.1080/10826080 601142196.

Wright, E., Gronfein, W., & Owens, T. (2000). Deinstitutionalization, social rejection, and the self-esteem of former mental patients. *Journal of Health and Social Behavior*, *41*(1), 68–90. doi: 10.2307/2676361. PMid: 10750323.