EXPERIENCING DRUG RELATED STIGMA IN MALTA

A QUALITATIVE STUDY

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This dissertation is presented to the Faculty for Social Wellbeing in part fulfillment of the requirements for the degree of Bachelor of Psychology (Honours) at the University of Malta.

May 2016
DECLARATION OF AUTHENTICITY

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I hereby declare that I am the legitimate author of this Long Essay/Dissertation and that it is my original work.

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Abstract

This qualitative research aims to explore and understand the stigma and possible barriers to reintegration experienced by problem drug users in Malta. In-depth interviews were held with four (2 male, 2 female) recovered problem drug users in order to gain their own point of view regarding the situation. The interviews followed Wengraf’s Single Question aimed at inducing a Narrative (SQUIN) which aimed at eliciting the various sources of stigma and how problem users negotiated their stigmatised identities that were imposed on them. The data was analysed using the constant comparative method of data analysis and emergent categories and themes were identified. Findings indicate that stigma is present within society in varying degrees. Some sources of stigma such as family were found to be subjective to the individual’s experience, while stigma from other sources such as agents of social control was encountered on a wider scale. However, the main concern for all participants was the lack of knowledge the rest of society possesses regarding the challenges faced by recovering drug users. While coping mechanisms varied, the participants’ narratives emanated a strong will and positive outlooks towards life. The study concludes with recommendations for future research, policy and practice.

Keywords: problem drug use, stigma, addiction
Dedication and Acknowledgements

Firstly, I would like to acknowledge and thank my tutor, Prof. Marilyn Clark. This dissertation would not have been possible without her constant feedback, encouragement and patience throughout the whole process. Her dedication and work within the field motivated me from the beginning of my studies.

Secondly, I would like to express gratitude towards the participants who offered their time and shared their experiences with me.

Finally, I would like to sincerely thank my fellow classmates and dear friends who stood by me and believed in me throughout this challenging journey and my family for their support.

I would like to dedicate this dissertation to my brother, who inspired me to delve into this topic and who inspires me daily to achieve my goals.
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Chapter 1: Introduction

Preamble

Problem drug use is a prevalent issue in Maltese society, with Malta holding one of the highest estimates of such use in Europe (2014, National Report on the Drug Situation in Malta). Problem drug use can be defined as “injecting drug use or long duration or regular use of opioids, cocaine and/or amphetamines” (EMCDDA, 2012). Drug users continue to face a number of challenges, even following successful intervention and desistance from substance use. These challenges may come about due to the attribution of stigma towards drug-using groups.

Stigma, in this context, is seen as negative and possibly unfair beliefs that society has towards a specific group of people, resulting in the attribution of shame and disgrace. Goffman (1963) acknowledges three different types of stigma: ‘Physical stigma’ refers to any type of body impairments; ‘Conduct stigma’ is characterised by the stigma resulting from behavior that goes contrary to the norms of society and is attributable to people with mental disorders, LGBT people and individuals who manifest addictions. Lastly, ‘Tribal stigma’ is attached to religion, race and nation (Goffman, 1963). Conduct stigma shall form the primary focus of this research. This type of stigma is particularly difficult to negotiate due to the harsh attribution of blame which may lead to significant issues for the stigmatised individual’s self-concept and future prospects. In fact, in a recent study the Dutch public showed high intentions to restrict people with an alcohol or drug addiction, which in turn has an extensive impact on problem users’ life opportunities (Van Boekel, Brouwers, Van Weeghel & Garretson, 2013). Perceived responsibility was one of the main factors associated with higher intentions to impose restrictions (Van Boekel, et al 2013).
Research Agenda

This qualitative research aims to investigate the possible struggles posed by the stigma attached to problem drug users. Problem drug users often continue to be stigmatised even following cessation from drug use, thus remaining outcast from the rest of conventional society. These topics will be explored via in-depth interviews held with recovered drug users, in order to gain knowledge from their perspective. I will be looking into the main facets of society, including work, family and relationships in order to explore whether any stigma is present and how this may affect the addict. Thus, the main question this dissertation will be exploring is; ‘to what extent is stigma present in the social reintegration process of problem drug users in Malta?’

In order to satisfy the central question, various sub-topics will be explored, particularly:

- Whether stigma is regularly experienced
- How this stigma affects the individual
- Which aspects of society (work, family and relationships) are the main sources of stigma
- What mechanisms are utilised to negotiate stigmatising labels.

Research Approach

This research question lends itself to a qualitative methodology as this provides a better understanding of the participants’ experiences. The research includes a review of literature pertinent to the topic of addiction and stigma, in addition to psychological theory to frame the study. A qualitative field study was also carried out in order to explore the issue of drug-related stigma in greater depth.

Separate interviews with four individuals (2 male, 2 female) were conducted, using the BNIM interview practice which utilises a single question aimed at eliciting a narrative (Wengraf,
The aim of these interviews is to encourage participants to share their story without being interrupted and to gain their perspective on the topic at hand. Data analysis was completed using the constant comparative method of qualitative analysis (Strauss & Corbin, 1998). As Taylor and Bogdan (1998) explain in Kolb’s discussion of the method, by coding and analysing at the same time the researcher is able to develop concepts from the data (Kolb, 2012). These particular approaches have been chosen in view of gaining the most suitable and valid information with regard to stigma towards recovering addicts in Malta.

**Rationale**

Drug use in Malta is a persistent issue and is on the rise according to the 2015 European Drug Report (EMCDDA, 2015). However, not all drug use has the potential to lead to addiction, thus not all drug users are viewed as equal in the eyes of society. Society has a tendency to view problem drug users as victims of a chronic relapsing condition with little control over their chaotic lifestyles. Concepts such as ‘once an addict always an addict’ have become somewhat ingrained within the community, further increasing stigma and creating barriers for problem users to successfully reintegrate into society. Alternatively, choice models hold the user accountable for his actions and result in the attribution of blame. Such discourses reinforce the idea that problem users will continue to pose a threat to society’s traditional standards long after seeking treatment (Heyman, 2009). Nonetheless, attitudes pertaining to drug use are varied and continually developing, and thus continual research is required in the area.

Understanding stigma in relation to drug use is crucial to gaining insight on the issue of addiction. In fact, according to NIDA (2005), stigma may act as one of the main reasons that some individuals fail to seek help. Research from the addicts’ point of view on this topic is lacking, and this study aims to bring forth the perspective of addicts through their own voices.
Thus, the wider scope of this study is to develop an understanding of the experience of stigma in order to reduce any possible barriers we may be creating for individuals to reintegrate into conventional society.
Chapter 2: Literature Review

The term addiction has been widely debated and, throughout the years, many have tried to define this construct (Sussman & Sussman, 2011). There now appears to be agreement that an ‘addiction’ refers to “continued use of mood altering addicting substances or behaviors despite adverse consequences” (Angres & Bettinardi-Angres, 2008). This is a broad definition including behaviours such as gambling, compulsive sexual acts and the use of substances. Specifically related to psychoactive substances, the DSM-V includes eleven criteria, out of which at least two must be present for diagnosing a substance use disorder. Characteristics leading to diagnosis include, but are not limited to: cravings, withdrawal symptoms, continued use despite physical or social problems caused by the substance, unsuccessful attempts to reduce substance use and recurrent use resulting in failure to comply with one’s daily obligations (NIDA, 2014).

However, the diagnosis of a substance use disorder does not provide us with sufficient understanding of users’ experiences throughout their addictive career. Here, available literature shall be explored in order to provide better insight as to how stigma and problem drug use in Malta are intertwined. The focus will be on the possible sources of stigma, the impact stigma may have on past drug users and the ways by which stigma may be negotiated.

The meanings attached to our experiences are partly constructed by how society perceives and reacts to our behaviour. This in turn shapes the way we interact with the world in future instances; therefore, the symbolism attached to experiencing stigma may be dependent upon each individual’s personal and societal interactions (Blumer, 1969). For this reason, while acknowledging the different approaches to addiction, this research shall adopt a symbolic interactionist perspective.
Stigma Defined

The concept of stigma has been around for many years and can be traced back to the Greek word meaning ‘tattoo-mark’ as defined by Osborne, 1974; he points out how at that time this term referred to a mark made with hot iron and impressed on people’s body. This was done to show that these individuals were “on the opposite spectrum of behavior, that they were criminals or runaway slaves” (as cited in Page, 1984, p.2). Often, rejection of a person or an act is effected in an attempt to exert social control over others (Wills, 1981, as cited in Palmar, Halkitis & Kiang, 2012). However, the attribution of stigma is dependent upon specific social contexts (Janulis, 2010). Attributes that were discrediting in a specific culture or historical period may not persist, since the rationale for a specific stigma may vary over time (Page, 1984).

Goffman (1963) separates stigmas into three categories: physical, tribal and conduct stigma. Physical stigma – taking into account the numerous physical impairments that exist; tribal stigma – that can be passed on through generations, including aspects such as ethnicity, and conduct stigma – dealing with the flaws of individuals’ characters. Substance users form part of the group dealing with ‘conduct stigma’ which will thus be the primary focus of this research.

It is also worth noting that stigma may be experienced in the form of ‘enacted stigma’ and ‘anticipated stigma.’ Enacted stigma deals with experiences of prejudice, discrimination and stereotyping received from people in the past; while anticipated stigma deals with the expectations of such experiences in the future (Earnshaw, Smith & Copenhaver., 2012). It is possible that problem drug users experience both enacted and anticipated stigma which may have different effects on the individual.
Symbolic Interactionism and Labeling Theory

Symbolic interactionism is a known primary theoretical tradition within the social psychological field (Denzel & Carrothers, 2003). According to Blumer (1969), there are three premises which form the basis of symbolic interactionism; the first, being that people act towards things depending upon the meanings which they represent. These ‘things’ include anything which a person may interact with, such as physical objects, people, and daily activities. The second premise is that, as human beings, the meanings we derive from such things are based upon the social interactions encountered with fellow members of society. Lastly, the third premise states that these meanings are then managed based on the unique interpretation of the person that is dealing with the situations or things that are being encountered (Blumer, 1969). All this can be applied to the concept of the self and results in what Mead (1967) describes as the ‘social self.’ If society continuously interacts with addicts in a stigmatising manner, then the individuals will start to internalise their new ‘junky identity’ which becomes more salient over time.

This approach emphasises the active participation of human beings, meaning that people do not simply respond to the environment, but willingly act back and forth, constantly influencing and challenging one another (Charon, 1998). In line with this theory, it can be inferred that drug users do play an active role in their addictive careers and are not simply products of their environments. While stigma may be experienced by many, the impact it leaves depends upon the ways in which it is interpreted and negotiated by the individual (Newheiser & Barreto, 2014).

Mead (1934) suggests that the formation of the self is influenced by ‘the significant other’ and ‘the generalised other’ referring to those who are close to us and to society as a whole,
respectively. He also acknowledges that not all social interactions and social groups are given equal importance in people’s lives. Furthermore, Cooley (1902) notes that people respond to situations differently as they learn that people hold different meanings and levels of importance in their lives. Problem drug users must endure stigma from both the significant other and the generalised other, leading them to incorporate such negative perceptions into their sense of self which may in turn bring about lowered self-esteem (as cited in Shrauger & Schoeneman, 1979).

Cooley (1902) describes the self in his notion of what he calls ‘the looking-glass self.’ According to Cooley (1902), the growth of the self is derived from reflected appraisals we create in our minds from social interactions we encounter. The self exists within the minds of others yet we do not blankly accept other people’s opinions of us. Rather, our own minds filter others’ opinions before constructing how we view ourselves, thus if society continuously interacts with substance users with the view that they are junkies or criminals, then these appraisals will be reflected back to them and will affect the way their ‘self’ is constructed (as cited in Jacobs, 2006). The integration of society’s stigmatising views into problem users’ self-concept may have serious implications for their future. Internalising a stigmatised identity may lead a recovering addict to relapse or choose to forgo any kind of treatment (NIDA 2005).

Labeling is often associated with enforcing social control over those who deviate from societal norms (Lemert, 1967 p.16; Raybeck, 1991). Deviants have often been seen as victims in the eyes of society, shaped by circumstances which they have little control over. According to Becker (1963), once the labels placed on individuals are accepted as true, they may alter one’s identity status. This means that due to the stigma received, an individual’s past and future actions start to be enacted in accordance with their new labels. Once a person is viewed as an addict they might no longer be described as intelligent or kind, as people will base their interpretations on
the new label; furthermore, when such labels cause a shift in one’s self concept, there is also a shift in the actions, beliefs and attitudes of that individual (Becker, 1963). Thus, a drug user who is labeled as a ‘junky’ may discard their personal view of themselves and start acting in ways expected from the junky identity.

**Sources of Stigma**

Most popularly, stigma is discussed through Goffman’s (1963) definition of a “socially discrediting, permanent and affecting perception of the person as a whole.” In the context of addiction, stigma is what shapes the way individuals who do not use drugs think about, feel and treat those who are linked to drug use (Earnshaw, Smith & Copenhaver, 2012).

The family acts as the first social unit in which we are taught how to interact with the world. Unfortunately, the family unit has been identified as a significant source of stigma. In fact, in a study conducted by Ahren and colleagues, 75.2% of drug users reported being stigmatised by members of their family (Ahern, Stuber & Galea, 2007).

Negative attitudes towards problem users may also stem from individuals working in treatment facilities (Earnshaw et al, 2012). Attitudes can vary depending on what type of treatment is being provided. Views of addiction as a disease seem to be more prevalent among those who provide for-profit treatment, are more spiritual, have dealt with a past addiction problem themselves and are held to be addiction professionals, while those who view addiction as a choice tend to provide non-profit treatment, hold weaker spiritual beliefs and do not make part of a group of professionals (Russel, Davies and Hunter, 2010).

According to Russel et al., spirituality and Religious beliefs play a significant role in people’s view of substance use. Those who are more religious or spiritual seem to be more
inclined to view addiction as a choice and form more stigmatising opinions of substance users. This may stem from lack of information regarding substance use and having little or no contact with individuals who were problem users (Palamar, 2013; Russel et al., 2010). With over 90% of the population being Catholic (World Factbook, 2011), religious beliefs tend to be rather influential in Malta, which may affect the way drug related stigma is experienced within our society.

The assignment of blame for one’s problem use may have an important role in the attribution of stigma from society. Stigma may be more excluding for those individuals whose stigmas are perceived as being more controllable and who are thus seen as responsible for their actions (Clark, 2012). According to Clark, once an individual deviates from the norms of a community, they are considered to be shamed. The small size of our country allows for the feeling of shame to be easily spread through social interactions and mindless gossip. Thus, once an individual’s reputation is tarnished, it will easily be known by the rest of the community. Those who engage in deviant behaviours such as drug use are more easily stigmatised and may be seen as an embarrassment in the eyes of their families and friends (Clark, 2012).

**Models of addiction.** Different models explaining addiction result in varied implications for how users are viewed and treated and thus some models may act as a further source of stigma. Most commonly, dependence on substances is either seen as an uncontrollable disease or as a lifestyle choice and both may have problematic follow-on effects.

In Leshner (1997), the disease model of addiction is defined as “a chronic, relapsing disease that results from the prolonged effects of drugs on the brain”. This approach considers addiction as an irreversible illness (Horvath, Misra, Epner, & Morgan-Cooper, 2015). Here, a
lack of choice is implied once continual drug use takes over brain functioning. This view has gained significant popularity and is commonly adopted in many professional treatment facilities and programs, including the framework adopted by Narcotics Anonymous (NA) (Russel, Davies & Hunter, 2011). The National Institute for Drug Abuse (NIDA, 2012), also defines problem drug use with this model in mind. Recovery is founded upon maintaining total abstinence from all substances that are considered to be addictive, thus keeping the ‘disease’ dormant. However, since there are barriers for achieving complete abstinence, this model stresses the significance of peer support groups such as NA to aid in the recovery process (Horvath et al, 2015).

The issue regarding this model is that it views addiction as a relapsing condition, insinuating that addicts are at constant risk of regressing back into their addictive lifestyle. This instills a lack of trust towards the individual and promotes the ‘junky’ view of addiction. Focusing on problem use as a medical condition may have positive implications in the removal of stigma towards addicts, yet it continues to view them as flawed and at risk of relapse (Clark, 2011).

Alternatively, the choice model views addiction as a motivated choice where drug use is maintained voluntarily (Russel et al., 2011). This view may increase the presence of stigma, since use is considered as a moral failure and thus problem drug users are held responsible for their actions and judged accordingly (Pickard, Ahmed & Foddi, 2015). However, one must consider the aspect of choice, especially when a great number of problem users age out of their addictive careers. Having previously made the wrong choices does not necessarily mean that one lacks the will power to improve their choices in the future.
It can thus be concluded that both the disease and moral model may result in the attribution of stigma. Also, it is important to note that these are not the only models of addiction that exist, and both have their limitations.

**Consequences of Stigma**

Crocker, Major and Steele (1998) and Jones et al (1984) note that individuals living with stigmatised identities often have to deal with prejudice, stereotyping and discrimination. All of these form biases that result in negative impacts on the individual’s wellbeing and prospective outcomes (as cited in Newheiser & Barreto, 2014). Since substance abusers are faced with conduct stigma, they may be held responsible for their moral failing, and thus treated unfavourably. It is common for those who stigmatise drug using groups to report addiction as being a choice (Palamar, 2013). One must keep in mind that stigma may have serious psychological consequences and all efforts should be made for it to be reduced.

Social stigma may be experienced in two forms: self-stigma and public stigma. According to Corrigan, Watson and Barr (2006), public stigma refers to the negative beliefs individuals in society hold regarding people from stigmatised groups. Self-stigma is concerned with the internalised beliefs that people from stigmatised groups form against themselves from already existing stereotypes. Luoma et al (2014) discuss the link between stigma and length of substance abuse treatment. Findings showed that individuals with higher self-stigma were more likely to stay in treatment longer since they may have lower self-efficacy and a greater fear of being judged, thus choosing to stay in a protective environment such as treatment facilities, for a longer period of time. Additionally, the fear of stigma may also act as a deterrent from entering treatment in the first place (Luoma et al., 2014).
Stigma has been identified as a major stressor in the lives of those facing it. The fear of rejection from others can result in social isolation as those with stigmatised identities refrain from forming ties within society (Hatzenbuehler, Phelan & Link, 2013).

**Stigmatisation and gender.** It is worth noting that certain consequences might be gender specific. A study on female repeat offenders conducted by Geiger and Fischer (2003) draws on the impact of criminality and substance use struggles faced by women. The main struggle for these women proved to be maintaining a positive relationship with their children, whom they longed to take care of. However, in many cases, the remorse of disappointing their children led to self-condemnation and further drug use (Geiger & Fischer, 2003). Sallmann (2010) focuses on prostitution, yet another issue exclusive to female substance users. Common experiences of stigma lived by these women included violence, discrimination and labeling which were brought about by varied people including: family, friends, lovers, male clients and individuals employed within the criminal justice system. These women’s narratives proved to be gripping “stories of injustice and oppression” (p.156).

In light of observed systematic discrimination and stigma experienced, therapeutic settings should be more reflective of and sensitive to women’s needs in order to help them successfully confront their past and present struggles (Geiger & Fischer, 2003; Sallmann, 2010). In Malta, efforts in this direction have begun by creating a program that is solely purposed for the treatment of women who face problem drug use (Caritas Malta, 2016).

**Negotiating Stigma**

Some stigmatised identities, such as race, may be immediately noticeable to others while other identities, including those carried by substance users, can go unnoticed unless outwardly
revealed (Newheiser & Barreto, 2014). These two ways in which stigma is conveyed is what Goffman (1963) defined as being ‘discredited’ or ‘discreditable.’ ‘Discredited’ refers to those individuals who believe their stigma is obvious to others. In contrast, ‘discreditable’ describes those whose stigma is thought to be less perceivable by others. Thus, it may be beneficial for the ‘discreditable’ to keep their stigmatised identity hidden from society in an attempt to avoid stigmatisation. Goffman, (1963), notes that ‘hiding’ or ‘passing’ this concealable identity in order to present a more socially acceptable self is, in fact, a typical primary coping strategy for those belonging to stigmatised groups. This is most commonly done “because of the great rewards in being considered normal” and thus “almost all persons who are in a position to pass will do so on some occasion by intent” (Goffman, 1963, p.74). Even though this widely used coping strategy has its advantages, Newheiser and Barreto (2014) also propose that hiding a stigmatised identity can instill a lowered sense of belonging which may lead to social rejection.

It has also been suggested that stigma may be reduced by portraying substance addiction as a treatable condition. A study conducted by Mcginty, Goldman, Pescosolido and Barry (2014) utilised vignettes of either treated or untreated individuals struggling with mental illnesses or addictions. Vignettes portraying successfully treated individuals elicited more positive attitudes and led to a lower desire for social distance and a heightened belief in treatment being an effective option. People exposed to these vignettes also showed a lower inclination to discriminate against individuals battling these conditions (Mcginty et al., 2014).

Gender is a crucial issue in the process of confronting stigma. Women who engage in drug use face harsher judgment from society especially due to the emphasis placed on their reproductive roles, which may act as a deterrent when seeking treatment and also affect the way
stigma is negotiated (Sanders, 2012). In her study, Sanders shows how a number of women battle this stigma through the use of gender-specific mutual support groups. Particularly - women only NA or AA meetings and Women for Sobriety (WFS). Women reported feeling able to be more honest in such meetings than in traditionally mixed gender meetings. The perception of drug-related characteristics as personal attributes proved to be the most challenging to overcome, especially the notion of being a ‘criminal’ or ‘ex-convict’, with over one third of the sample admitting difficulty (Sanders, 2012).

McKenna (2013) focuses on female users’ management of their ‘ego identity.’ According to Goffman (1963) the ego identity refers to the image one constructs of themselves. In order to navigate their stigmatised identities, many women chose to differentiate themselves from other substance users, thus adopting an ‘I am not like them’ attitude, while others chose to limit the information people in their lives knew about their drug use, thus having more control over how they are depicted. These mechanisms proved to be both empowering and oppressive (McKenna, 2013). The fact that many women chose to differentiate their actions from those of other users indicates that some level of stigma may also exist within the drug using community itself. Some actions may be normalised while others are looked down upon, thus creating further stigma and exclusion.

One indication of successful recovery lies in the ability avoid relapse (Nordfjærn, 2011). Relapse is currently defined by NIDA as “the return to drug use after a significant period of abstinence.” Unemployment has been identified as a factor that increases likeliness of relapse among recovering problem users (Nordfjærn, 2011). In order to successfully negotiate stigma and avoid relapse it is crucial that society provides means for increasing awareness and education. The ‘Bridging the Gap’ scheme in Malta has been designed in an attempt to help
problem users with their social reintegration process. This scheme is directed at supporting individuals through their transition from unemployment to employment and provides work exposure in order for prospective employees to demonstrate their skills to employers (National Report on the Drug Situation in Malta, 2014). This also increases employers’ exposure to those struggling with substance use without the need to make any commitments, which may aid in changing perceptions of problem users.

**Conclusion**

As one can note, stigma is a persistent concern that may debilitate individuals from moving forward in their lives. While some views and models may result in more stigmatising perceptions, the effect of stigma on the individual also relies on the degree to which stigma is actively or passively negotiated within one’s self concept and life journey.

Literature regarding experiences of drug-related stigma in a local context is lacking. This research aims to bring forth the experiences and perspectives of stigma, as described by past problem drug users themselves, which will bring to light whether stigma towards problem drug users is truly present in our society, where it stems from and how it is negotiated by the individuals being stigmatised. Society as a whole should aim to reduce stigma, with education and increased awareness holding the key to building a more inclusive community. Problem users’ points of view and knowledge are valuable assets when working towards bridging the gap between conventional society and those deemed as deviant.
Chapter 3: Methodology

This chapter explores the methodological aspects of the dissertation. The main aim of this research is to investigate how stigma is experienced by problem drug users whilst recovering within Maltese society. The main topics included in the methodology are the research approach, the research design, participant recruitment, ethical considerations and data analysis.

Research Approach

The research question lends itself to a qualitative approach. In order to understand and theorise the experience and negotiation of stigma, in-depth data needed to be collected. In this way, the voices and opinions of the interviewees could be expressed, allowing the researcher to form a rich account of recovered substance users’ point of view regarding drug use and stigma.

The methods involved in a qualitative research approach provide the tools required for gaining a broad perspective of such complex issues that quantitative methods do not allow. As explained by Strauss and Corbin (1998), a qualitative approach is “a nonmathematical process of interpretation, carried out for the purpose of discovering concepts and relationships in raw data and then organizing these into a theoretical explanatory scheme” (Strauss & Corbin, 1998, pg. 11). In this case, a quantitative approach would not have allowed participants to voice their opinions in such detail and would not have been successful in providing a detailed explanation of the complex relationship between recovering from drug use and stigma.

Research Design

The research design chosen is that of qualitative interviewing leading to analysis using the Constant Comparative Method (Strauss & Corbin, 1998). Rather than conducting the study with a preconceived hypothesis in mind, an explanatory framework can be formed from the data gathered throughout the research process itself. This is known as the inductive method.
Participant selection. Four participants were identified by the use of snowball sampling, which is a non-probability method where already existing participants help the researcher recruit future participants from among their peers. Snowball sampling is a technique that is often used with populations who are challenging to access, such as criminals and drug users (Cohen & Arieli, 2011). This constitutes purposive sampling, which implies that the sampling process is linked to the researcher’s objectives and thus the sample is sought out with a purpose in mind (Palys, 2008). Potential participants were identified at an NA open meeting and handed information sheets which initiated the chain sampling process. The sample consisted of a group of four recovered problem drug users, (2 men & 2 women), who were required to be free from drug use for at least three years and to be active within the NA community by attending meetings. This ensured that all participants were comfortable discussing their narratives and had a support system in place due to the sensitive nature of the topic.

Research tool. For the purpose of this study, data was obtained through the use of an in-depth interview with each participant. The structure of the interviews followed Wengraf’s Single Question aimed at Inducing a Narrative (SQUIN) interview, which provides a platform for participants to share their narrative without being interrupted (Appendices A & B).

The interviews consisted of two to three sub-sessions. During the first sub-session, an open ended question was directed at the participants, allowing them to speak freely about what they felt was relevant to the topic at hand. Throughout this time, the participants were not interrupted or asked further questions. Only prompts were used to maintain engagement with the interviewee and allow them to narrate further. Participants were also made aware that some notes may be taken in order to be used throughout the rest of the interview. The second sub-session
consisted of questions regarding topics that the participants had previously brought up themselves and using the same words used by the participants in the first sub-session.

If further information was required, a third sub-session was held. This session made use of a set of questions regarding the relationship between drug use and stigma within Maltese society which may help the participant reflect and provide further insight on the topic. By employing this interview method, the participants were able to speak freely and openly share their experiences.

**Procedure.** Each participant was sent an information sheet (Appendices C & D) and debriefed about the nature of the study before being contacted to set up an interview. Separate interviews of about forty minutes each were conducted and audio recorded. Prior to commencement of the interview, the participants were given consent forms (Appendices E & F), and the researcher explained that participation is purely voluntary with the possibility to withdraw at any time. Confidentiality was assured and participants remain anonymous throughout the study through the use of fictitious names. Each interview took place in a different location depending on the participant’s preference.

**Data Analysis**

All four interviews were concluded and transcribed verbatim. Each transcription was meticulously checked for accuracy before moving on to analysing the data. Data analysis was guided by the constant comparative method. Firstly, open coding was carried out in order to highlight the basic meaningful units of the text forming what is known as categories. This was followed by a second process called axial coding, where categories are re-examined in order to explore possible linkages and patterns between them. This process acts as fine tuning of the
initial coding results, allowing the researcher to refine and reduce the original categories and sub-categories that emerged from the data resulting in themes. Finally, selective coding was carried out in order to develop the core category – this is the category that ties all others together. The results were recorded in a table which lists all categories, sub-categories and themes (Appendix G).

**Ethical Considerations**

The researcher was required to seek ethical clearance prior to initiating the research (Appendix H). In order to ensure that there was no risk of psychological harm, all participants recruited were required to be free from drug use for at least three years and have maintained contact with NA, ensuring a sound support system was in place. All interviewees participated out of their own free will and were informed of all their rights prior to the interviews. Such rights include the right to withdraw their participation at any time and to abstain from answering any questions that may be deemed inconvenient or intrusive. The participants were required to sign a consent form beforehand guaranteeing confidentiality and privacy both during and after the research has been conducted. All interviews were audio-recorded with the consent of the participants and confidentiality will be maintained by using pseudonyms throughout the data analysis and results.

**Reflexivity**

Reflexivity is a prominent aspect within qualitative research since the researcher is closely connected to the data and the participants throughout the data collection process. Reflexivity is concerned with the awareness that both the researcher and the studied object exist in a mutual relationship in which each is affected. As researchers, we must be aware of what we think and of how we feel about our research topic whilst acknowledging that our understanding
is undergoing constant revision as new information comes to light, and that this affects our research (Alvesson & Skoldberg, 2000; Haynes, 2012).

To be reflexive in practice, a researcher must take the time to ask questions such as ‘what is the motivation for conducting this research?’, ‘in which ways, emotionally, experientially and theoretically am I connected it?’ And thus, ‘how can this in turn affect my approach?’ (Haynes, 2012).

Having dealt with addiction within the family, I was aware of my own assumptions and worked to maintain a reflexive approach by being in touch with my thoughts and feelings throughout each step of the research process.

**Validity and Reliability**

Measures were taken to maintain validity throughout the research process. Constant reflexivity is one of the ways in which validity has been maintained, along with accurate presentation of information and data throughout. The analysis was completed and checked meticulously to ensure accurate information represented the meaning of the data and to reduce limitations.

In qualitative research, reliability is associated with “generating understanding” in contrast to quantitative research where the main purpose of reliability is that of ‘explaining’ (Stenbacka, 2001). Reliability often refers to generalisability of research, meaning that a research method holds the ability to yield consistent results over repeated testing periods (Brink, 1993). However, in qualitative research it is often associated with the quality of the research with many researchers opting for use of terms such as applicability, consistency and trustworthiness. The methods used to conduct and analyse this research, along with the sample that participated in the
study have all been chosen in a way that represents the aim of the research topic. The constant comparative method allows for theories to emerge as a result of the research process rather than adopting preconceived theories as a framework to guide the analysis.

**Conclusion**

This chapter outlined and described the main aspects of the research methodology. Focusing mainly on data collection, the research approach and design, the ethical considerations required for carrying out such research and how the quality and validity of the research were maintained. The following chapter will explore the categories and themes that emerged from the data provided by the participants’ narrative.
Chapter 4: Data Analysis

This chapter presents, analyses and discusses the data that has emerged from the interviews in an attempt to understand the challenges and stigma that past problem drug users face within Maltese society. The types of stigma present, the ways in which such stigma seems to be experienced and how it is negotiated will form the main focus of the analysis (Appendix G).

Stigma Type

Each attempt at conceptualising addiction brings with it a variety of implications (Griffiths, 2005). The medical model of addiction views problem users as having a debilitating disease, implying that problem drug users are victims of their addiction due to chemical changes within the brain. On the other spectrum, the choice model views drug users as responsible for their drug use and attributes addiction to a moral failure within problem users (Clark, 2011).

The data indicates that some drug users have a tendency to view themselves as living with a disease which they must constantly battle in order to maintain a drug free life. “We aren’t the kind of people that can go out and enjoy a drink” (Chris).

She [mother] doesn’t understand that I am an addict for life. Sometimes she asks me ‘do you still go to meetings? Why do you go to meetings?’ She doesn’t understand I need them for my recovery. (Julian)

This view may stem from programs and groups such as NA which adopt a ‘once an addict always an addict’ framework of recovery which falls in line with the medical model of addiction. This may lead drug using groups and other individuals in society to view addicts as living with a chronic illness that requires constant care.
The medical model places individuals in a fragile state, enhancing the view that drug users can relapse at any given moment. This leads to severe lack of faith in recovered individuals. “They [the rest of society] treat you as if you can relapse right in this very moment or in an hour’s time” (Chris). “She [partner] keeps acting like she has no faith in you but in reality you need people who believe in you.” (Chris). In line with Goffman’s (1963) work on stigma, this indicates that addicts are seen as being overcome by an incurable disease which they are unable to control and thus incapable of functioning within society. In a local study about attitudes towards people with psychological disorders, Barbara (2008) highlighted that university students held particularly negative attitudes towards substance users when they were viewed as having a chronic, relapsing condition.

On the other hand, the choice model of addiction views problem users as responsible for their drug use which is seen as being maintained on a voluntary basis. Hence, judgment and stigma towards drug users increase as such persons are seen as incapable of making the wiser choice. This incapability is directly attributed to the person rather than being viewed as a consequence of the substance use (West & Brown, 2013).

There’s such lack of understanding of what drugs do to you to make you become somebody you’re not. You can be the sweetest, kindest, most gentle person, you take crack long enough, you’ll stab an old lady to steal her wallet you know and it’s not because in your nature you are like that so it’s yeah it’s really difficult. (Amy)

Here, the ‘junky’ view of drug addiction is further instilled within people’s minds and persists at times even when the drug user is a family member, resulting in recovering addicts
being seen as untrustworthy. “I’m still not trusted by my family, they still question me even if I’m going abroad alone and they still haven’t given me a key to my mother’s house.” (Julian)

Throughout my teens he [her father], had the attitude of drug addicts are losers…they should be imprisoned and he was very much ‘if I find out anyone is giving you drugs I would kill them’ … although time has gone by if I ever bring it up he dismisses it and he doesn’t want to talk about it. I remember when I used to tell him I’m going to NA he was very much like ‘why do you keep going to these places, what for’. His attitude was still...‘drug addicts are no good you know just very narrow minded and intolerant.’ (Amy)

**Self-blame**

Participants also showed a pattern of engaging in self-blame. They hold themselves responsible for the ways in which other people view them. Labeling theory (Becker, 1963) argues that other people’s definitions of social actors have a significant impact on self identity. The recurrent and consistent evaluations by significant others may be incorporated into one’s self concept. “It’s their [police officer’s] job. You can’t really blame them for losing faith in these people [drug users]. They see someone different every day and they’re always dealing with relapsing addicts.” (Chris).

According to Link et al (1997), ‘culturally induced expectations’ form the first step of the stigmatisation process. Through social interaction, people develop ideas as to whether some individuals in society will reject or devalue them. Once a person is negatively labeled, the significance of these ideas heightens, increasing the fear that the rejection will in fact occur. This
process leads labeled individuals to increase and internalise these expectations of rejection (Link, Struengberg, Rahav, Phelan & Nuttbrock, 1997).

Self-blame is considered to be a type of self-inflicted emotional abuse that often leads to shame, which paralyses the individual by instilling a deep sense of responsibility that is not their own (Formica, 2013). Problem drug users may see themselves as failures and feel ashamed at the lack of self-control over their substance use (Flanagan, 2013). This shame perpetuates the addictive cycle and thus should be addressed within rehabilitative facilities (Potter-efron, 2002). According to the ‘Affect Theory’, shame is an adaptive emotion that aids in the regulation of behaviour and only becomes problematic when the experiences of shame are intense, long-lasting or frequent. As a result, shame stops acting as a self-regulatory affect and is instead internalised into one’s self-concept (Wiechelt, 2007). Wiechelt (2007) describes the experience of shame as “emotionally and psychologically painful” (p.401), resulting in strong feelings of vulnerability, isolation and loneliness.

**Double Stigma**

Factors other than being a problem user may add another level of stigma. Gender plays a significant role in drug addiction stigma, with women generally experiencing higher levels of disapproval from society. As explained by Ridlon (1988), women are held to higher moral standards and are thus viewed as responsible for upholding such morality. “Many people just stare back at me, they see this petite woman and just don’t expect that you were a drug user...sometimes people don’t try to understand why, they just judge you.” (Sarah).

It often shocks people more when a woman admits to addiction than a man...it’s a difficult one when you get clean you know more than anything you need support and
when you don’t have support from the people you feel you can trust it’s a difficult place to be. (Amy)

Traditional expectations regarding women’s roles are ingrained within each member of society. As Conway (1994) highlights, males and females are socialised in different ways and are taught to uphold their respective gender roles and the expectations that are implied. Women are led to believe that they possess an innate instinct to nurture and to live up to their natural child-rearing capacities. Those who deviate from these imposed roles are seen as failures in the eyes of society, which results in high levels of stigma and rejection (Geiger & Fischer, 2003).

Society also places harsher labels on those whose drug of choice seems to be more deviant than others. Thus, although society may be adopting a more tolerant attitude towards certain drugs, such as cocaine and prescription drugs, this does not decrease the experiences of stigma for problem users. Rather, it increases the stigma towards those who become dependent on what society perceives as harder drugs, more specifically, heroin. Heroin is the epitome of drug addiction and heroin users are known as being the most stigmatised of all drug users (Isralowitz, 2004). Jones et al (1984) describe heroin as a ‘demon’ drug resulting in heroin users being the most stigmatised drug using group. Heroin users are those who are mostly associated with the ‘junky’ identity in which users are highly linked to crime and are seen as the ‘scumbags’ of society (Radcliffe & Stevens, 2008).

How often will you get a housewife who will point fingers at a drug addict and she’s popping valium and sleeping pills but because the doctor prescribed them it’s all okay …then this whole thing of like the ones who take cocaine all weekend it’s a normal thing
but if you take heroin…there’s still this attitude of ‘if you’re a drug addict you’re a messed up bad person.’ (Amy)

Alcohol has become too acceptable, drinking everyday is considered as normal for some people, even smoking a joint daily is completely normal…people tell you but what’s wrong with smoking a joint every day? Some things have improved but others have become too acceptable. (Sarah)

**Societal Reaction**

Due to the small size of our country, gossip plays a considerable role in society as deviant roles are very visible. Thus, shame is brought about by supposedly ‘honorable’ individuals who dismiss and these ‘shamed’ individuals (Clark, 2007). “Malta is a small country, it’s in Maltese people’s nature to judge.” (Chris)

With such little possibility for anonymity, gossip rates are high in Malta as people are constantly on watch for what’s going to be said or done next (Clark, 2007). “In Malta people tend to gossip so I’d rather avoid it.” (Julian) “It’s harder. It [Malta] is small and people always care about what are other people going to say.” (Amy)

As the stigma and shame persist, exclusion in society is often experienced by deviant groups. Experiencing social exclusion has been linked to feelings of sadness, anger and lowered self-esteem which may either cause aggression, ensuring further exclusion or initiate a submissive manner in an attempt to facilitate inclusion (Williams & Govan, 2005). Once the addiction becomes public knowledge, many ‘straights’ prefer avoiding contact with drug users. “When they found out they started ignoring me, they all stopped texting me apart from one coach.” (Julian)
However, recovering addicts may also experience exclusion from peers who are still active users. Whilst recovering they are no longer viewed as part of the social sphere and desisting from drugs becomes a form of deviancy within itself, thus resulting in a significant amount of loneliness throughout the recovery process.

The people I had spent 15 years of my life with didn’t want to be around me anymore ‘she doesn’t drink, she doesn’t do drugs!’…I wasn’t invited to anything anymore I wasn’t involved in anything anymore so that was very difficult because for me I felt very alone. (Amy)

This social exclusion may come about due to other users’ own insecurities about being judged as they are not quite ready to face their own addictions.

When somebody you’ve taken drugs with meets up with you and you’re clean and they’re not really clean…It becomes uncomfortable for them because it makes them look at themselves and then they don’t want to look at themselves so they’d rather not be around you. (Amy)

Although one would assume that exclusion is linked to a ‘junky’ identity, the data has consistently shown that for all participants, significant stigmatising attitudes from society persisted after cessation of drug use. Deviancy is then seen in the opposite form of addiction as most recovered users choose to fully abstain from any mind altering substances, including alcohol. In a society where social drinking is culturally ingrained, recovering drug users faced harsh judgment towards their new lifestyle choices. “Socially, it’s barely acceptable [not drinking], it was one of the biggest obstacles, some even put alcohol in what I was drinking.” (Sarah)
You’re not going to have a glass of wine? Why? ‘Because I don’t drink’...Ohh come on you have to take one drink you have to! And there’s a lot of pressure you know it’s amazing. If you’re going to go out at night you have to be really strong willed not to do anything. (Amy)

Sources of Stigma

The family context. Whilst stigma was experienced to some extent by all participants, the sources of stigma varied, thus resulting in unique experiences for each participant. Three out of four participants struggled with acceptance within their family to varying degrees, with attitudes ranging from denial, “at first your mother, your father, all the family would be in denial and they wouldn’t believe what they’d hear from other people” (Chris), to complete rejection, “I don’t think my family ever really got over it.” (Sarah)

Although the participants had been clean for a number of years, it was clear that certain actions carried out during the course of their addiction still defined them in the eyes of their family members.

I know I hurt them but five years after I stopped using and they’re still stuck to certain things I did when I was an active user...there’s this anger from their side, once my sister, even my mother had said they’re not sure if they can ever forgive me for things I had done in the past. They were very harsh with me. (Sarah)

The participant’s family who portrayed the least stigmatising attitudes had previous knowledge and experiences of dealing with addiction within the family. Education and increased awareness are crucial and effective tools for reducing negative perceptions towards substance users and creating a more supportive environment (Livingston, Milne, Fang & Amari, 2012).
It was devastating but everyone reacts differently, in my case, my brother was an addict too so we had already gone through it once before and I had a lot of support from my family, they didn’t make it worse. (Chris)

**Romantic relationships.** According to Stewart (1996), some couples face addiction together. However, when one is addicted and the other is not struggles will inevitably arise. Going through a rehabilitation process is an emotional roller-coaster and recovering problem users struggled to stay in relationships that were initiated prior to rehabilitation as their efforts for change were not always acknowledged. “After the rehabilitation programme I was a completely different person, but she was the same.” (Julian)

While support was given and acknowledged in some cases, the participants felt they could no longer connect emotionally with their partners. “I couldn’t be with him I had to be alone because I couldn’t deal with the dynamics of a relationship, it was impossible.” (Amy) This often leads recovering addicts to seek relationships with those who have shared similar experiences. “To be honest I’ve never been involved with someone who’s never done drugs.” (Amy)

**Power**

Stigma places individuals at a disadvantage within society as stigmatised groups are perceived as less worthy of voicing their concerns and opinions due to the labeling that occurs. Since experiences of stigma are often bound to result in a power struggle, ‘power’ has been identified as the core category of this research. As argued by Tannenbaum (1938), once society feels that deviants are challenging their status, society will exclude them, ensuring that order is not threatened. One participant particularly mentioned the frustration of “being treated like the rubbish of society” (Amy). It can be very challenging for individuals to gain back society’s trust
EXPERIENCING DRUG RELATED STIGMA

after being labeled as drug addicts. The ‘straights’ of society are held to a higher degree and often use their power to limit that of others. “Instead of helping me those who found out just reported me.” (Julian) “The management doesn’t deal with it the right way. They don’t tell you listen, why don’t you look for help? They just suspend you and it’s very difficult to reintegrate then.” (Julian)

The flaws that exist within the social justice system act as one of the most significant barriers to reintegration. “The person I stole from forgave me but the police still decided to take me to court…their intention was for me to lose my job.” (Julian). Drug users are also often treated with less respect.

There’s a lot of ignorance. Unfortunately even if you go to get your police conduct, first they smile at you, then if they realise you’ve done something they look down on you, you know? It’s like you’re seen as a bad person! (Chris)

The stigma is especially difficult to negotiate once a drug user has entered the prison system, and even stems from individuals who previously possessed a good relationship with the user. “Anqas isma hanžir trid xi hağa jew incemplu lil missierk forsi jğiblek xi hağa, xejn man.” (Julian). The language chosen by the participant shows strong feelings of betrayal and hurt in a scenario where he was sent to lock-up, and in fact continued by saying that the officers on call, who were acquaintances “couldn’t care less about what was going to happen to [him].” (Julian)

Labeling can have serious negative consequences on drug users. The labeling process often results in a ‘defective’ view of the self which may lead an individual further into a deviant lifestyle (Gray, 2010). The shame and stigma attached to drug users who face institutionalisation
seems to be a pertinent issue within Maltese society. “In Malta once you’re a prisoner, especially one with a drug problem, there’s no forgiveness.” (Chris)

They think prisoners deserve to be in there. In reality, these are the people who need most help. They had a problem within society and society isolates them, locks them up, when loneliness is the worst thing for a person at that time. (Chris)

**Negotiating Stigma**

Coping strategies are adopted by individuals in order to manage the recurring stigma. Goffman (1963) highlights two coping methods known as ‘passing’ and ‘covering’. At times, problem users will attempt to portray themselves as part of the conventional society and reject their ‘junky’ identity.

I use to try to show the image of ‘listen I’m not an addict, I don’t have that problem, I’m not a junky’. Even to go buy drugs, I always wore nice clothes to show them that I don’t have a problem. (Julian)

However, as time passes, the addiction becomes more difficult to conceal (Page, 1984), and users would resort to hiding their true selves in order to avoid being stigmatised. “I always liked being discreet and careful about who to tell, I never used to tell my employers.” (Sarah) “I thought nobody at work knew, when I started working I was already a full blown addict because I started using early, but I used to hide it a lot.” (Julian)

To further avoid stigmatisation and rejection, addicts also showed a tendency to avoid contact with straights altogether and surround themselves by fellow recovered users who understood their struggles. “My friends became the people I met at meetings.” (Amy)
We were lucky. The group that used drugs together supported each other and changed together. It helps a lot having friends that you used to do drugs with wanting to change too. (Chris)

Even if offered to join social groups, addicts may have experienced what is known as ‘felt stigma’ where one internalises negative perceptions regarding their inner-selves. “They told me I could go back to the team after my rehabilitation programme, but your pride just doesn’t let you go back.” (Julian) In this way, addicts reduce their chances of rejection and feelings of unease (Goffman, 1963).

On a final note, recovered problem drug users also show great efforts in moving forward within their and adopting a resilient, positive outlook towards life.

People will always talk but so what? Thank god I went through these things because they made me stronger. It depends on how much you choose to learn from these things as well; in my case I don’t regret it. (Chris)

Conclusion

Through exploration of this data we have seen that stigma towards drug users is in fact present to varying degrees, stems from various sources and is uniquely negotiated by substance users. While improvements can be seen, the attribution of stigma continues to create a strenuous experience throughout problem users’ re-integration process.
Chapter 5: Conclusions and Recommendations

Main Conclusions

The data that emerged from this research study highlights the varying degrees of stigma which recovering problem drug users face within the Maltese community. The lack of understanding that society shows towards problem users’ hardships is of primary concern. Although the participants accepted the responsibility of their actions, they felt that even those who did not judge them still possessed low levels of understanding towards the daily struggles of recovering users.

All participants expressed frustration towards the persistent negative attitudes within the justice system and felt that a change is required in the way substance users are treated. Whilst problem drug users persist in moving forward, they often do so within their own community. Although NA provides strong levels of support and elicits positive connotations, its members still at times feel unable to connect to people outside the community. Participants’ decision to abstain from alcohol consumption also brought about stigma thus acting as a further deterrent to building ties with the ‘straights’ of society. These findings prove that more efforts are needed in relation to awareness and inclusion within society. However, the avoidance of relapse, successful reintegration within workplace settings and a positive outlook on life indicate that the stigma experienced was successfully negotiated by all participants.

Recommendations

Whilst research on stigma in relation to addiction is currently available, I feel that there is a lack of emphasis on problem drug users’ own point of view. Conducting a study on a larger scale that voices users’ opinions may help in informing future policies that reflect the true needs
of this population. It may also be of interest to consider researching the correlation between experiences of stigma and relapse rates amongst drug users and in which ways the presence or absence of stigma affects the addictive career.

Effective awareness programmes could be implemented both within secondary and tertiary school settings. Multidisciplinary teams that conduct such programmes should include former substance users as their direct narratives will lead to a better understanding of addiction. Increased awareness may both reduce stigma and the onset of addiction in the future. Education and training could also be offered to police officers, health-care providers and other professionals in contact with problem drug users. With regard to active users, more harm reduction strategies need to be implemented as this will help reduce the ‘junky’ view of addiction.

**Limitations**

Ethically, I was bound to recruit participants that have abstained from drug use for three or more years. Had participants been in their earlier stages of recovery, the attitudes and narratives regarding stigma may have been considerably different. It was noted that although stigma had been experienced, it is at times disregarded due to the passing of time. Also, due to the small sample size of the study, results could not be generalised to the larger drug using population in Malta. The participants recruited all attended NA and thus shared similar values and experiences. Different narratives may have emerged had the research been conducted on a wider scale and with participants from varied backgrounds and rehabilitation programs. I must also acknowledge the limitation posed by my interview skills. At times, participants drifted away from the subject and more refined skills may have helped maintain focus on the topic at hand.
Final remarks

Upon initiating this study, I felt that the stigma towards drug addicts fully impedes individuals from moving forward in their lives. However, after having the opportunity to gain recovered problem users’ perspective on the situation, I came to understand that whilst stigma is present and at times debilitating, problem users do not blame other people for their reactions, but rather look inward to enact positive self-change. While I still believe that the Maltese community must persist in reducing negative attitudes towards deviant groups, through these narratives, I have learned that the change must start from within ourselves regardless of what those around us choose to believe.
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Appendix A

Interview Guide

**Phase 1:** During this phase one initial question is asked in order to elicit the interviewee’s experience/story from his/her own perspective. No further questions may be asked during this phase, only prompts can be used in order to support and encourage the interviewee.

The participants will be asked to start wherever they like and that they will not be interrupted. During this stage of the interview, I will only be facilitating without interrupting and taking some notes.

**Q:** Talk to me about how other people reacted to you while recovering from drug use. (opening question)

**Clarification:** let’s talk about how other people reacted and treated you when they got to know about your addiction

**Phase 2:**

During this phase questions may be asked. However questions asked must be on the topics the interviewee has already mentioned during the previous phase and are to be asked in the same order that the interviewee mentioned them.

**Phase 3:**

This phase is not necessary during each interview. It provides the opportunity to ask theory driven questions related to the topic at hand, regarding aspects which the interviewee did not mention.
Appendix B

Linji ta’ Gwida ghall-Intervista

l-ewwel fażi: Tul din il-fażi mistoqsija wahda hija mitluba sabiex tتانقإ l-esperjenza ta’ min qed jiġi interviżtat. Ebda mistoqsija ohra ma tista’ tiği preżentata tul din il-fażi, iżda jistgħu jintużaw kliem ta’ inkoraġġiment u sapport.

Il-mistoqsjija: Kif tiddeskrivi l-esperjenza tieghek u r-reazzjonijiet tan-nies waqt li kont qed tirkupra mill-vizzju tieghek?

Klarifikazzjoni: kif ireaġixxu u trattawk in-nies meta saru jafu dwar il-vizzju tieghek?

It-tieni fażi: Matul din il-fażi mistoqsijiet jistgħu jiġu preżentati. Madankollu, il-mistoqsijiet iridu jkunu dwar is-suġġetti li l-intervistat diġà semma matul il-fażi ta’ qabel u għandhom jiġu mistoqsija fl-istess ordni li l-intervistat semmihom.

It-tielet fażi: Din il-fażi mhix meħtieġa f’kull intervista. Din il-fażi tipprovdi l-opportunita sabiex jsiru mistoqsijiet rigward aspetti tas-suġżett li l-intervistat ma semmiex tul l-intervista.
Appendix C

Information sheet

Dear Sir/Madam,

I am writing this letter to see whether you are interested in taking part in the research that I shall be conducting.

I am currently attending the B.Psy (Hons) course at University of Malta and as part of the course I must fulfil a dissertation. The research topic I have chosen is as follows.

Experiencing Drug-related Stigma in Malta; A Qualitative Study.

I am looking for individuals who have previously struggled with drug use and who have now been clean for at least three years and attend NA. Research will take place by means of an individual interview.

In order do my work professionally and accurately, the interview will be audio-recorded and the recording will be destroyed two to three years after the interview takes place. Your participation in this interview is purely voluntary.

It is also important to know that your name will never be mentioned in the research at any point in time. This is done to ensure that what is discussed is confidential and anonymous.

If you are interested in taking part in my research or for more information, you can email me on michaela.pace.13@um.edu.mt or contact me on 79991150 where you can speak about any requests or queries you may have.

Thank you in advance for taking the time to read this letter. I look forward to hear from you.

Yours sincerely,

Michaela Pace.
Appendix D

Ittra ta’ Informazzjoni

Għażiż/a

Jiena studenta universitarja li qegħda naghmel riċerka ghad-dissertazzjoni tieghi dwar stigma relatata mal-użu tad-drogi f’Malta. Din ir-riċerka hija parti mill- B.Psy (Hons) degree fil-Psikologjija.

Qed infittex individwi li kienu tħabtu mal-vizzju tad-droga u ilhom li waqfu mill-użu tad-drogi minn tal-anqas tlett snin. Ghal din ir-riċerka huwa neċessarju wkoll li tkun tattendi m’bod regolari l-meetings tal-NA.

Nixtieq insaqsik jekk tixtieqx tippar-teċipa f’dan l-istudju permezz ta’ intervista waħda fuq is-suġġett imsemmi hawn fuq. Sabiex inwettaq xogħli bl-ahjar mod possibli, din l-intervista se tiġi rrekordjata u r-rekording ser ikun meqrud bejn 2 u 3 snin wara li ssir l-intervista. Il-partecipazzjoni tiegħek f’din intervista hija kompletament voluntarja.

Nixtieq ninformak li l-isem veru tiegħek mhuwiex se jintuża tul dan l-istudju sabiex tiġi assikurata l-anonimita u l-kunfidenzjalita tiegħek

Grazzi talli qed tikkonsidra din it-talba. F’każ li jkollok xi mistoqsijiet jew diffikultajiet, tista’ tikkuntatjani fuq michaela.pace.13@um.edu.mt jew fuq 79991150

Dejjem tieghek,

Michaela Pace.

___________
Appendix E

Consent form

Name of Researcher: Michaela Pace  Address: 132, Old Mill Str, Mosta, Mst 3719
Phone No: (+356) 79991150

Title of dissertation: Experiencing Drug-related Stigma in Malta; A Qualitative Study.

Statement of purpose of the study: To explore the possible struggles and stigma that individuals who use drugs face when reintegrating back into conventional society by involving individuals who have previously struggled with addiction and gain a better perspective on their experiences.

Methods of data collection: Interview
Use made of the information: For dissertation purposes only.

Guarantees:
I will abide by the following conditions:

(i) Your real name will not be used in the study.
(ii) You are free to quit from the study at any point and for whatever reason. In the case that you withdraw, all records and information collected will be destroyed.
(iii) There will be no deception in the data collection process.
(iv) The interview will be audio-recorded.
(v) The recording will be destroyed 2 to 3 years after the interview takes place.
(vi) A copy of the research will be handed to you through a CD should you request it.

I agree to the conditions:
Name of participant
Signature: Date:

I agree to the conditions
Name of Researcher: Date:
Signature:
Appendix F

Formula ta’ Kunsens

Isem tar-riċerkatur: Michaela Pace  Indirizz: 132, Triq il-Mithna il-Qadima, il-Mosta,
Tel no: (+356) 79991150

Titlu tat-teżi: Esperjenzi ta’ stigma relatata mal-użu tad-drogi f’Malta; Studju Kwalitattiv.


Metodi tal-ġbir tad-data: intervisi

Użu tal-informazzjoni: għall-iskopijiet tad-dissertazzjoni biss

Garanziji:
Jien se nirrispetta dawn il-kundizzjonijiet li ġejjin.

(i) l-isem veru tieghek mhux se jintuża fl-istudju.
(ii) inti liberu/a li tieqaf mill-istudju fi kwalunkwe punt u għal kwalunkwe raġuni. Fil- kaz li inti tieqaf, ir-rekords kollha tal-informazzjoni miġbura se jiġu meqruda.
(iii) mhux se jkun hemm l-ebda qerq preżenti waqt il-process tar-ričerka.
(iv) L-intervista se tkun awdjo rrekordjata.
(v) Ir-rekording se jkun meqrud bejn 2 u 3 snin wara l-intervista.
(vi) Kopja tar-ričerka tista’ tiġi mitluba u tingħatalek permezz ta’ CD

Jien naqbel ma’ dawn il-kundizzjonijiet:
Isem tal-partecipant:
Firma: Data:

Jien naqbel ma’ dawn il-kundizzjonijiet
Isem tar-ričerkatur: Data:
firma tar-ričerkatur:
## Appendix G

### Data Analysis

<table>
<thead>
<tr>
<th>Categories</th>
<th>Sub – Categories</th>
<th>Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. STIGMA TYPE</strong></td>
<td>1.1 Medical model</td>
<td>1.1.1 Fragile – can relapse at any moment</td>
</tr>
<tr>
<td></td>
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<td>1.1.2 Rehabilitation &amp; treatment methods view addiction as illness</td>
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<td></td>
<td>1.2 Choice model</td>
<td>1.2.1 Blame – addicts inherently ‘bad’ people</td>
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<td>1.2.2 Self blame/personal responsibility</td>
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<td></td>
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<td>1.2.3 Lack of trust from family and partners</td>
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<td></td>
<td>1.3 Double stigma</td>
<td>1.3.1 Females</td>
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<td>1.3.2 Heroin</td>
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<tr>
<td><strong>2. SOCIETAL REACTION</strong></td>
<td>2.1 Social isolation</td>
<td>2.1.1 Breaking social norms – no alcohol, no inclusion.</td>
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<tr>
<td></td>
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<td>2.1.2 Exclusion from non users</td>
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<td>2.1.3 Exclusion from active users</td>
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<td></td>
<td>2.2 Gossip</td>
<td>2.2.1 Labeling</td>
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<td>2.2.2 Small country – everyone knows</td>
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<tr>
<td><strong>3. SOURCES OF STIGMA</strong></td>
<td>3.1 Family context</td>
<td>3.1.1 Denial</td>
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<td>3.1.2 Disapproval</td>
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<td>3.1.3 Rejection</td>
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<td>3.2 Romantic relationships</td>
<td>3.2.1 No changes/adaptation seen by partners.</td>
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<td>3.2.2 Don’t acknowledge change</td>
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<tr>
<td>3.3 Social context</td>
<td>3.3.1 Disbelief</td>
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<td>3.3.2 Lack of awareness/knowledge</td>
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<td>3.3.3 Judgmental attitudes</td>
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<td>3.4 Corrective facilities</td>
<td>3.4.1 Ignorance</td>
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<td>3.4.2 No forgiveness</td>
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<td>3.4.3 Disrespect</td>
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<tr>
<th>4. POWER</th>
<th>4.1 Social control</th>
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<tr>
<td></td>
<td>4.1.1 No space for change</td>
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<td>4.1.2 Voiceless – “without my consent”</td>
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<td>4.1.3 ‘Junky identity’</td>
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<td>4.1.4 Intentional injustice – agents of social control</td>
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<td>4.1.5 Poor treatment/ignored requests</td>
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<td>4.2 Shame</td>
<td>4.2.1 looked down on</td>
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<td></td>
<td>4.2.2 Insecure</td>
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<td>4.2.3 low self-esteem</td>
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<tr>
<th>5. NEGOTIATING STIGMA</th>
<th>5.1 Coping mechanisms</th>
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<tbody>
<tr>
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<td>5.1.1 Hiding/passing</td>
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<td>5.1.2 Avoidance of non-users</td>
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<td>5.1.3 Social bonds</td>
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<td>5.1.4 Resiliency</td>
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</table>
Appendix H

Ethical Clearance

To be completed by Faculty Research Ethics Committee
We have examined the above proposal and advise

Acceptance Refusal Conditional acceptance

For the following reason(s):

Signature Date 12/05/15

To be completed by University Research Ethics Committee
We have examined the above proposal and grant

Acceptance Refusal Conditional acceptance

For the following reason(s):

Signature Date 13/08/15