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“Not human, dead already”: Perceptions and experiences of drug-related stigma among opioid-using young adults from the former Soviet Union living in the U.S

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Abstract

Background—Young people from the former Soviet Union (FSU) in the U.S. are engaging in opioid and injection drug use (IDU) in substantial numbers, paralleling nationwide trends. Yet opioid-using FSU immigrants face distinctive acculturation challenges, including perceived stigmatisation as drug users within their immigrant communities, which may exacerbate the negative health and psychosocial consequences of such use.

Methods—This qualitative study draws on semi-structured interviews with 26 FSU immigrant young adults (ages 18–29) living in New York City who reported opioid use in the past month and/or were currently in treatment for opioid use disorder. Interviews probed youths’ drug use histories, immigration/acculturation experiences, family and peer relationships, and service utilisation. Interviews or focus groups were also conducted with 12 FSU mothers of opioid-using youth and 20 service providers familiar with the FSU population. In a content-based thematic analysis, verbatim transcripts were coded for salient themes.

Results—All three participant groups emphasized that stigma towards drug users within the FSU community is pervasive and acute, in contrast to the cultural acceptance of heavy drinking, and is rooted in punitive Soviet-era drug policies, fostering widespread ignorance about drugs and addiction. Young adults and service providers reported instances in which anticipation of community stigmatisation deterred youth from accessing drug treatment and harm reduction services. Similarly, stigma contributed to parents’ failure to recognize early signs of their children’s opioid problems and their reluctance to seek drug treatment for their children until opioid use had become severe. Young adults described how drug-use stigma is frequently internalized, leading to shame and loss of self-esteem.

Conclusion—Findings indicate an urgent need for community-wide education about drugs within FSU immigrant communities, and suggest specific service modalities that may be less

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Conflicts of interest

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stigmatizing for youth, such as peer-delivered syringe exchange and harm reduction education, and technology-based interventions that can be accessed privately and discreetly.

Keywords

Stigma; Former Soviet Union; Immigrants; Young adults; Opioid use; Harm reduction

Background

Introduction

After several waves of immigration from the former Soviet region since the dissolution of the Soviet Union, the Russian-speaking immigrant population in the United States now numbers nearly one million current residents (U.S. Census Bureau, 2010a). New York City (NYC), the location of the present study, has the highest concentration of immigrants from the former Soviet Union (FSU) in the country, with about 200,000 FSU-born residents, most originating from Russia, Ukraine and Uzbekistan (U.S. Census Bureau, 2010b).

Although national data on the prevalence of substance use among FSU-born or Russian-speaking immigrants living in the U.S. are not available, recent evidence from NYC suggests that substantial numbers of young FSU immigrants are engaging in opioid and injection drug use (IDU) (Guarino, Marsch, Deren, Straussner, & Teper, 2015; Guarino, Moore, Marsch, & Florio, 2012; Isralowitz, Straussner, & Rosenblum, 2006). Emerging research has documented concerning patterns of drug use and related risk behaviour within NYC's Russian-speaking community that resemble trends seen in many other communities across the country; these include early initiation of nonmedical prescription opioid (PO) use, frequent progression to heroin use and IDU, high rates of injection-related risk behaviour within peer networks, and associated increases in hepatitis C virus (HCV) incidence among youth under 30 (Guarino et al., 2015, 2012; Prussing, Bornschlegel, & Balter, 2015). The experiences of opioid-using youth within NYC's FSU community also appear to have distinctive attributes, such as stress associated with immigration and acculturation, and perceptions of acute drug-related stigma within their immigrant communities, which may exacerbate the negative health and psychosocial consequences of opioid use and IDU (Guarino et al., 2012; Spicer et al., 2011). Despite these indications, drug use patterns and associated health implications within FSU immigrant communities in the U.S. remain largely unstudied topics in public health research.

This paper analyzes qualitative data from a larger mixed-methods study that examined the experiences of young adults from the FSU who were currently using heroin and/or POs or were in treatment for opioid use disorder (OUD). In light of the dearth of research on substance-using FSU immigrants in the U.S., the present analysis explores youths' perceptions of stigma attached to their opioid use within multiple life spheres, including the local Russian-speaking community and familial and peer networks. To contextualize youths' accounts and increase the rigor of the analysis, youths' perspectives are triangulated with those of FSU immigrant mothers of opioid-using youth and local drug treatment and related service providers, as these groups play major roles in perceiving and communicating drug-related stigma to youth.

Processes of social stigmatisation

A stigma, as defined in the foundational work of Goffman (1963), is “an attribute that links a person to an undesirable stereotype leading individuals to reduce the bearer from a whole and usual person to a tainted, discounted one.” More recently, Pescosolido, Martin, Lang, and Olafsdottir (2008) conceptualize stigmatisation as both the act of imposing a stereotype and the process through which a stereotype is perceived by the labelled individual. As such, stigma is a complex social process that involves experienced and imposed labelling, stereotyping, status loss and discrimination (Link & Phelan, 2001). Importantly, theorists have noted that both enacted and perceived stigma can negatively impact individuals’ self-concepts and well-being (Goffman, 1963; Lebel, 2008; Link & Phelan, 2001; Thetford, 2004).

Public stigma refers to the process by which social groups endorse negative views of and act against labeled individuals because of their tainted attribute (Corrigan & Shapiro, 2010; Semple, Grant, & Patterson, 2005). Public stigma can manifest within multiple spheres, from the macro-social level of a community to the micro-social level of interpersonal relationships. Although the various ways in which public stigma is enacted and perceived can have serious implications for health, it has been argued that the core problem of stigma occurs when the disparaging beliefs associated with a stigmatized identity are internalized (Link & Phelan, 2006). Internalized or self-stigma refers to a process of self-deprecation due to feelings of shame and culturally-generated expectations of rejection (Feldman & Crandall, 2007).

Societal and community stigma faced by drug users

Stigma towards drug users has been documented across a broad range of geographic regions and cultures (e.g., Fotopoulou, Munro, & Taylor, 2015; Mattoo et al., 2015; Lim et al., 2013; Myers, Carney, & Wechsberg, 2016). Research indicates that drug users are frequently viewed by mainstream society as dangerous, deceitful and morally unacceptable (Brenner & Von Hippel, 2008; Room, 2005; Small, Wood, Lloyd-Smith, Tyndall, & Kerr, 2008). As a result, individuals with substance use disorders (SUDs) may opt to hide or deny their condition to avoid anticipated labelling which imposes a significant barrier to treatment-seeking (Myers, Fakier, & Louw, 2009). In addition to impeding service utilisation, drug-related stigma can foster negative self-perceptions and promote a lack of awareness of drug-related risks such as HCV (Barocas et al., 2014; Lang et al., 2013; Treloar, Rance, & Backmund, 2013) and overdose (Wolfe, Carrieri, & Shepard, 2010).

Familial stigma faced by drug users

Research has also begun to trace how stigma is both constructed in and affects the micro-social sphere of interpersonal relationships and interactions. Recent studies have shown that individuals may report a loss of friendship and familial ties due to their drug use (Lee, Law, & Eo, 2004; Orford, 2005; Ryan, Huebner, Diaz, & Sanchez, 2009; Semple et al., 2005) and that experiences of discrimination and rejection can lead to social withdrawal as a means of coping (Ahern, Stuber, & Galea, 2007; Gunn et al., 2016; Room, 2005; Sanders, 2014). Women may face even greater societal and familial stigma than men to the extent their drug use is constructed as a moral weakness that tarnishes normative role expectations for women

and mothers (Haritavorn, 2014; Kirtadze et al., 2013; Spooner et al., 2015). Nevertheless, both men and women have reported perceptions of demoralisation and rejection from relational contexts such as their family due to their drug use, resulting in strategies of withdrawal and avoidance as well as confrontation (Ahern et al., 2007; Luoma et al., 2007; Spicer et al., 2011).

Intra-group peer stigma faced by drug users

Stigmatisation of drug users also takes place within and among various drug-using groups. Drug users may employ a range of hierarchical and implicitly moralized “us versus them” distinctions to distinguish between more and less socially desirable forms of use, with, for example, heroin users positioning themselves over crack cocaine users and “functional addicts” with jobs and active family lives positioning themselves over “junkies”, particularly homeless drug injectors, who are perceived as flouting these social norms of respectability in an especially flagrant manner (Furst, D. Johnson, Dunlap, & Curtis, 1999; Furst & Evans, 2014; Gunn & Canada, 2015; Simmonds & Coomber, 2009). Researchers have postulated that groups with similar stigmatized identities may confer stigmas within their larger membership group as a mechanism of coping with greater external threats of stigma and enhancing their self-esteem (Crocker & Major, 1989; Crocker, Thompson, McGraw, & Ingerman, 1987; Phelan, Link, & Dovidio, 2008).

Drug-related stigma in immigrant communities

Drug-using individuals within U.S. immigrant communities often navigate multiple sources of stigma attached to their drug use—from both mainstream American society and their immigrant community (Guarino et al., 2012; Kagan & Shafer, 2001; Kandula, Kersey, & Laurie, 2004; Nadeem et al., 2007). Across a wide range of immigrant groups, drug use is traditionally viewed as a mark of shame for the family, as well as a personal mark of failure for the individual (Fong and Tsuang, 2007; Warner et al., 2006). These imposed stigmas are rooted in common expectations for youth to achieve upward economic and social mobility and may be seen as the result of over-identification with American norms and values (Fong & Tsuang, 2007; Ja & Aoki, 1993; Nemoto et al., 1999; Vega, Alderete, Kolodny, & Aguilar-Gaxiola, 1998; Warner et al., 2006). Specific to the present study, research has found that, while heavy alcohol use is a common and relatively accepted practice within FSU immigrant communities in the U.S., particularly for men, use of illicit drugs is considered deviant behaviour that brings significant shame to the user as well as his or her family (Kagan & Shafer, 2001; Guarino et al., 2012).

Sociohistorical roots of drug-use stigma in the FSU immigrant community

Stigmatisation of drug users within the FSU immigrant community is historically and culturally rooted in the repressive environment towards drug users that was institutionalized in the Soviet Union and continues to be fostered by punitive drug-related policies in Russia today, including the prohibition of opioid substitution therapy (OST) for OUD and a lack of support for effective harm reduction measures such as syringe exchange (Elovich & Drucker, 2008; Rhodes, Sarang, Vickerman, & Hickman, 2010; Spicer et al., 2011). The public health impact of these retrograde policies over the past 25 years has been severe; they have contributed to the explosive epidemics of IDU and injection-driven HIV and HCV

which began in Russia, Ukraine and several other FSU countries in the wake of the socioeconomic turmoil following the collapse of the Soviet Union and which continue today (Kozlov et al., 2006; Rhodes et al., 2006; UNAIDS, 2010). Indeed, Russia's "moralistic and punitive approach to the epidemic" in people who inject drugs and sex workers has been cited as a key driver of the region's rapidly expanding HIV epidemic which is now in the process of generalising from these groups to the wider population (Clark, 2016; The Lancet HIV, 2016).

These macro-level policies also function to legitimize stigmatisation of drug users on multiple, mutually reinforcing levels of society including the micro-level of people's everyday social interactions. Not only does this deeply entrenched, dehumanising ideology towards drug users ramify throughout the former Soviet region, it also extends to the Russian-speaking diaspora, influencing the attitudes and behaviours of FSU immigrants, particularly members of older generations who came of age in the Soviet era and emigrated in adulthood (Isralowitz et al., 2006; Kagan & Shafer, 2001). Research on drug users in former Soviet countries has found that fear of stigmatisation from family members and the wider society deters them from seeking drug treatment and disease prevention services or even being seen in the vicinity of "narcology" (the Soviet model of drug treatment) centres (Spicer et al., 2011). Likewise, in our team's preliminary research, drug-using FSU immigrant youth in NYC have reported that, if their drug use were widely known within their immigrant community, extreme marginalization to the point of social death would likely result (Guarino et al., 2012).

Methods

Participants

This study is based on semi-structured interviews with 26 young adult FSU immigrants living in NYC who were current opioid users and/or in treatment for OUD, as well as interviews with 12 FSU immigrant mothers of opioid-using youth and interviews or focus groups with 20 drug treatment or harm reduction service providers who had extensive experience working with the local Russian-speaking community. The accounts of the study's primary sample of young adults were juxtaposed with data from mothers and service providers to ensure that the attitudes, beliefs and experiences highlighted in the analysis were supported by two key groups of community stakeholders with intimate knowledge of youths' drug use and life experiences. Indeed, triangulation of data from multiple sources is a recognized technique to enhance the validity of qualitative research (Creswell & Plano Clark, 2011).

The 26 young adults who completed qualitative interviews comprised a sub-sample of a larger sample of 80 youth recruited to complete a structured assessment. The qualitative sub-sample was purposively selected to include a diverse set of interviewees who represented key characteristics within the larger sample (according to drug treatment status, gender, age subgroup and country of origin; specific numbers in each category are presented in Table 1).

To be eligible for the parent study, young adults had to be 18–29 years old, born in the FSU or in the U.S. to FSU immigrant parents, and self-report current opioid use (i.e., nonmedical

use of POs and/or heroin use in the past 30 days) and/or current participation in any modality of drug treatment for OUD in brief verbal screening interviews. Eligible parents were born in the FSU and had an adolescent or young adult child (or children) with problematic opioid use (either currently or in the past). Service providers were current or former employees or volunteers of NYC drug treatment programs or harm reduction/advocacy organizations with substantial numbers of Russian-speaking clients.

For the parent study, an initial group of young adult participants were directly recruited from local organizations, while the majority were recruited by chain-referral from previous study participants. The representation of these recruitment sources in the qualitative sub-sample is as follows: an outpatient drug treatment program (n = 1); a homeless shelter for substance users (n = 1); a mobile syringe exchange program (n = 2); and peer-based chain-referral (n = 22). Most of the mothers who were interviewed were recruited from a Russian-language parents' support group sponsored by a drug treatment program for youth (n = 10), while 2 were recruited via the researchers' contacts in the FSU community. Fathers were not available to interview, largely because the membership of the parents' support group which served as their primary recruitment source consisted almost entirely of mothers. Providers were recruited from local treatment programs (n = 10), a mobile SEP (n = 3), a non-profit organization focused on drug issues in the FSU community (n = 1), and the researchers' community contacts (n = 6). Further details of the parent study are reported in Guarino et al. (2015).

Interviews and focus groups

Young adults and mothers participated in 60–90-min-long, digitally audio-recorded individual interviews. With regard to service providers, two 60-min-long, audio-recorded focus groups were conducted with staff of the youth treatment program (one session with 5 participants and one with 4 participants); the remaining providers were interviewed either individually (n = 7) or, in two instances where participants worked at the same facility, in dyads (n = 4). Young adult and provider interviews/focus groups were conducted in English by the Principal Investigator, an expert in qualitative research, while parent interviews were conducted in Russian by the study's native Russian-speaking Research Assistant (RA), who was trained in qualitative methods by the PI.

Interviews and focus groups used a semi-structured format (Bernard, 1995; Creswell & Plano Clark, 2011) with a defined list of topics followed by open-ended questions and optional probes arranged in a variable sequence to allow participants to introduce or elaborate on topics of importance to them. Young adult interviews were organized around four main foci: (1) youths' immigration and acculturation experiences; (2) multi-level contextual factors, including family and peer relationships, that influenced the onset and progression of their opioid use; (3) their perceptions of FSU norms and values regarding the use of opioids and other substances; and (4) their attitudes toward and use of drug treatment and harm reduction services. The parent interviews with mothers focused on the FSU community's views of alcohol and drug use, parents' knowledge and beliefs about addiction and drug treatment, and the social and emotional effects of immigration and acculturation on their families. Topical domains for provider interviews and focus groups included: substance

use norms and values in the FSU community; barriers and facilitators affecting FSU youths' utilisation of drug treatment; and treatment or service needs and preferences that distinguish FSU youth from other patients.

English-language interviews/focus groups were transcribed verbatim by a consultant; the Russian-speaking RA translated the parent interviews into English and transcribed them. All study procedures were approved by the Institutional Review Board of National Development and Research Institutes. Each participant provided written informed consent and was compensated US\$50. To promote open and honest dialogue, a Federal Certificate of Confidentiality was obtained from the U.S. Department of Health and Human Services, and participants recruited through treatment or service organizations were assured that none of the information they provided would be shared with program staff. All participant names referenced in the paper are pseudonyms.

Data analysis

The content-based thematic analysis (Braun & Clarke, 2014; Patton, 2001) involved an iterative process of reviewing and coding the transcribed data to identify key themes and patterns. Coding proceeded in a two-stage deductive/inductive process. In order to enhance the validity of the analysis, three individuals participated in the coding with discrepancies in interpretation resolved by consensus. First, the PI and the RA coded the dataset for a broad range of themes (not specifically focused on stigma) in the qualitative data analysis program *Atlas.ti*. Using an initial code list based on the aims of the larger study, the two coders independently coded approximately 10% of the transcripts, meeting for periodic consensus sessions to identify emergent themes, refine the code list and ensure reliability in the application of the codes to the data. The RA then used the final code list to code the bulk of the dataset. During this first-stage coding, two stigma-related codes were identified based on emergent themes in the data: *FSU community stigma* and *self-stigma*.

In the second stage of the process, the first author, in consultation with the PI, conducted an analysis specifically focused on stigma. Line-by-line coding generated an elaborated set of stigma-related codes; this was followed by the “constant comparison” method (Charmaz, 2006), which involved evaluating earlier codes against emerging categories and collapsing categories to eliminate redundancies. A final step involved evaluating the relationships among codes, resulting in the identification of four coding families representing distinct spheres in which FSU youth perceive drug-related stigma: *violating FSU community norms*; *self-stigmatizing*; *disgracing the family*; and “*othering*” *drug-using peers*.

Results

Participant characteristics

Socio-demographic, immigration and drug use characteristics of the 26 young adult participants are presented in Table 1. Most immigrated to the U.S. in childhood and initiated opioid use in the U.S. Youths' age at immigration was 6.7 years old, on average (SD = 4.6), and ranged from infancy to age 16. The majority were born in Ukraine (n = 11), Russia (n = 9) or Uzbekistan (n = 2); one young adult was born in Belarus, Kazakhstan, Latvia and the

U.S., respectively. Most immigrated with their nuclear (and sometimes extended) families in the late 1990s after the collapse of the Soviet Union (median year of immigration = 1998; range = 1989–2005); one left the Soviet Union before the 1991 collapse (in 1989) as a Jewish refugee.

At the time of their interview, 19 young adults were actively using opioids and 10 were participating in some form of drug treatment (3 youth in drug treatment also reported current opioid use). Among the active users, 4 reported POs and 15 reported heroin as their current primary drug, although most of the heroin users had transitioned from initial PO use. Nineteen reported current or past IDU. Among those in drug treatment, 3 regularly attended Russian-language Narcotics Anonymous (NA) meetings, 3 were in methadone maintenance, 2 participated in outpatient counselling, and 1 was in an abstinence-based residential program.

Of the 12 mothers interviewed, 7 emigrated to the U.S. from Russia, 2 from Ukraine, 2 from Uzbekistan and 1 from Lithuania. All except one left their countries of origin in adulthood; most emigrated with their spouses and, occasionally, young children, while a few emigrated in early adulthood, prior to marriage and children.

Among the 20 service providers, 12 were female and 12 were born in the FSU. Three were counsellors at outpatient drug treatment programs and 3 were former counsellors at such programs; 10 were clinical staff of an intensive drug treatment program for youth; 2 coordinated a mobile SEP and 1 was a peer outreach worker at this exchange; and 1 facilitated a Russian-language NA group.

Perceived and enacted stigma towards drug users within the FSU immigrant community

Young adults, parents and service providers consistently emphasized their perceptions of intense stigma directed towards drug users within the FSU immigrant community. A number of mothers located the origins of this pervasive drug use stigmatisation in the normative beliefs of the Soviet Union. This is evidenced by Nadia, in her explanation for why she chose not to seek medical assistance when her son experienced a heroin overdose in her presence in NYC:

In the Soviet Union we were scared into NOT calling the ambulance, and if your child was a drug user or husband was a drug user ... it meant that he will be taken to a mental institution, locked up there ... So, here I was afraid of the same thing and I did not call the ambulance or the police and I literally watched my child dying. We also at that time were not legal here and did not speak the language too well, we were afraid of everything. (Nadia, mother, born in Russia)

As Nadia explains, her fears of societal and community stigmatization, even possible punitive action by the state, were shaped by her familiarity with Soviet-era criminalization of drug users and continued to shape her behaviour in the U.S. Moreover, Nadia's anticipation of drug-related stigmatisation intersected with a fear of legal repercussions from her family's undocumented status, as well as their limited ability to speak English, creating added layers of isolation and secrecy.

Fuelling the stigmatisation of drug users in the Russian-speaking community is the fact that illicit drug use represents a threatening unknown to many in the older generations of FSU immigrants. Ludmila, the mother of a 25 year-old son who became dependent on POs in the U.S., attests that:

We knew of drug users and prostitutes and that was the lowest of the low and we had never come in contact with any of them. We saw drunks everywhere but a drug user – never ... If a child is coming from an intellectual family, is well educated and well-read, then there is no way that he or she will even be tempted to use... With alcoholics they live pretty functional lives in a family ... so drinking is thus accepted and not as stigmatized. They can work, maybe, buy something for the family. But a drug user, no money ... they can't do anything, well, they are not a person. (Ludmila, mother, born in Russia)

Ludmila directly connects her attitude toward drug users to her experience growing up in the Soviet Union (now Russia) where accurate knowledge about drugs was heavily repressed by the state. While excessive alcohol use was common and accepted (unless it was severe enough to interfere with a person's ability to function), illicit drug use was considered the province of threatening others, "the lowest of low," whom respectable people had little knowledge of and no contact with. As Ludmila went on to say, "A drug user, this person is nothing, not human, they are dead already." In her representation of the traditional Soviet ethos, drug users are unacceptable because they are perceived as violating norms of productivity in the familial and economic spheres. Seen as lacking purpose and, by definition, incapable of providing for a family, drug users do not even meet normative standards of personhood.

The narratives of young female participants reveal their perceptions that FSU women who use drugs face especially harsh stigma. Tatiana, a heroin user from Kyiv, attested that:

I think [there is] definitely more [stigma] in the Russian community. You are seen as a weak individual ... But I think you're judged a lot more harshly being a female because ... you're supposed to be the one telling the guy, "What are you doing?" ... And it's like always they automatically assume, "Oh, are you sleeping for it?" (Tatiana, 22 year-old female, born in Ukraine)

According to Tatiana, the FSU community attributes stigmatizing beliefs of moral weakness to all who use drugs. However, because traditional, patriarchal Russian gender norms dictate that women should exhibit greater moral rectitude than men and temper men's reckless tendencies (Leipzig, 2006), their drug use is seen as more deviant and shameful. Moreover, as Tatiana intimates, female drug use is associated with sexual promiscuity and sex work; therefore, women who use drugs are seen as violating normative expectations of sexual purity for women. Female drug use also violates role expectations of care taking and selflessness associated with proper motherhood, as Tatiana goes on to explain:

I think especially for women it's hard [when you use drugs] because we're expected to be a mother ... you know, take care of everything, always look good, always be happy, take care of everybody, and not care for ourselves as much as we care for everyone else.

While this passage illustrates Tatiana's perception of female drug users' greater stigmatization based on traditional FSU norms that cast the proper role for women as steadfast caregiver, her statements also affirm the important role women are assumed to play in the FSU community as the bedrocks of the family, preserving familial, moral, social and emotional stability. This suggests a complex and contradictory power dynamic at play in FSU gender role norms, particularly for women.

Both young adults and service providers described instances in which anticipation of community stigmatisation deterred drug users from obtaining drug treatment and harm reduction services. A coordinator of a mobile SEP that maintains regular hours in heavily Russian-speaking Brooklyn neighbourhoods described how fear of public stigmatisation and community-level discrimination shapes users' decisions to seek services:

I think there's a lot of that going on when we say we do syringe exchange. "Oh no, I don't want to be seen on the van or seen talking to you." They walk right away.

Although the program initially attempted to establish a visible and accessible presence in the community in order to attract a client base, this conflicted with their potential clients' need for privacy. FSU drug injectors expressed fears of being associated with the van and thereby being seen to have a drug problem. For many, the need to preserve an image of respectability was a sufficiently potent disincentive to patronizing the van that it superseded their health concerns.

According to this same outreach worker and her co-worker, community-level stigmatisation is also a driving force behind the popularity of secondary syringe exchange among the service's FSU clients. They described a common practice whereby one client picks up a large number of syringes for later distribution to a network of users:

Provider 1: A lot of the clients that come into that site, they take large amounts [of syringes], they tend to maybe be a little bit more affluent, drive a car, take a lot but then bring them all back. They take it very seriously the responsibility for returning their syringes ... So it's taboo within the community ... a sense of privacy kind of gets to them like that ... At first we weren't sure that being by that park would be too visible, but I think some of the clients that drive just like it because it's like they're just driving up in a parking lot, they're not doing anything—Provider 2: It's like drive-by [clients]...

Due to anticipated stigma, one individual, typically one with access to an automobile, is designated to pick up syringes for a larger group of users, thus decreasing the others' risk of public stigmatisation. Having access to these services through a mobile unit also allows the visiting client to maintain some anonymity due to the rapid nature of the exchange, decreasing the potential for public recognition, stigma and shame. At the same time, this stigma management strategy suggests emergent community solidarity among some young FSU injectors, as they have devised a collaborative strategy to promote their health amidst their fears of marginalization.

Perceived and enacted stigma within the FSU family context

Like many immigrants, FSU families may come to the U.S. with high expectations of success for their children. FSU immigrant family members also tend to communicate expectations to their children about the importance of transcending the struggles typical of life in the Soviet and post-Soviet society by acquiring American markers of success. An Ukrainian-born drug counsellor discussed these acculturation challenges in a focus group:

There's pressure, there are certain stereotypes that follow Russian people around ... with success, or you have to be the best, the smartest ... It's a fairly difficult issue for youth, coming into a country where you don't speak the language and not able to communicate so you go with a person that will accept you the most.

Thus, acculturation pressure from their families can intersect with the stress of the immigration experience, as young people try to adjust to their new environment while becoming fluent in English, forging friendship ties with accepting peers, and navigating the typical developmental changes of adolescence and emerging adulthood.

When parental expectations are threatened by a child's drug use, stigmatisation and shaming from family members can result. In the following passage, Pasha, a young man who transitioned from POs to heroin injection, discusses his father's disappointment in him:

My father was very disappointed because, you know, "How come you come from like having titles for the boxing and the soccer titles and now you become a junkie?" ... "How you become from that kind of person, going to a junkie?" He was so disappointed, he never thought that I would do such a thing ... He said, "Don't come back. Don't even call me until you're sober." So it took me a year and a half to regain a relationship with everybody, and my father still doesn't want to speak to me at times. (Pasha, 28 year-old male, born in Ukraine)

As evidenced, FSU youth who use drugs can be discredited within the family sphere for failing to uphold not only larger societal expectations for productive citizenship, but also their own family's standards for proper behaviour and acculturation.

Treatment providers explained that, because of the widespread ignorance about drugs and addiction among the older generations of FSU immigrants, parents often fail to recognize early warning signs of problematic drug use in their children, and the accounts of several mothers attested to this dynamic. Nadia, for example, acknowledged being oblivious to her son's escalating opioid use for several years, dismissing what she later understood to be clear evidence of drug use she had found in his room, like rolled-up foil for smoking crushed pills.

When a child's drug use is, often belatedly, recognized, parents' intense shame may drive them to promote secrecy within networks of social relationships, insisting their child deny and conceal the problem from members of their extended family as well as the wider FSU community, for fear of being judged as deviant. One treatment provider explained how this dynamic can play out at family events:

A lot of parents want to keep their child's addiction a secret from everybody in the family. So it causes controversy between the child ... like saying, "You know. I go to this house and I can't tell anybody that I'm in recovery," and the mother's like, "Well, no one needs to know." So a lot of the time, they went to a family wedding ... and then they feel like, "I have to lie to this family because my mother says so."

This enforced secrecy marks a young drug user as an outsider even within their own extended family, and can motivate young people to disengage and isolate from loved ones. Like Pasha and several other young adult interviewees, Josef experienced rejection, a form of enacted stigma, from family members due to his drug use. He animated his mother's complaints to him:

You are killing me. You're going to do heroin for the rest of your life? ... You're gonna leave now and you're not gonna come back, and if I see you anywhere, I'm not gonna say hello to you. (Josef, 28 year-old male, born in Russia)

This quote also highlights the emotional turmoil Josef's mother experienced as a result of his heroin use.

Indeed, parents of young drug users also face potential discrimination from the wider FSU community. Mothers consistently reported struggling with their own sense of shame, fearing they would be shunned by the FSU community if their child's drug use were to become publicly known and that their child's use would be viewed as a sign of their own failure as parents. Nina, the mother of two sons who became dependent on opioids, expressed her reluctance to share her painful experiences with fellow members of the Russian-speaking community, even close friends and relatives:

Of course, people who have never experienced this problem themselves will not understand it, that is why parents are in isolation. They can't share this information, there is no one to listen to their pain...I had friends at work, women, whom I could not tell anything, my relatives whom I could not tell anything because they would not let me back into their house. (Nina, mother, born in Russia)

As a result of this stigma by association, parents – especially mothers – of drug-using youth can become socially isolated, limiting their ability not only to support their child but also to access support for themselves.

The perceptions and experiences of young adults, mothers and providers illustrate that, while the family system can serve as an important source of support for young people struggling with opioid use and early recovery, FSU immigrant mothers' fear of community stigmatisation, and the shame and secrecy it fosters, can impede intra-familial support, leading them to reproduce community-level stigmatisation of drug users within the family sphere. According to treatment providers, a common effect of this shame-driven secrecy, combined with the ignorance about drugs and addiction typical of FSU immigrant parents, is a delay in treatment-seeking, as parents may first opt to deny the discreditable problem and pretend it does not exist. As a result, FSU parents often do not seek treatment for their child until the problem has escalated to such an unmanageable state that they see no other option.

Perceived and enacted stigma within drug-using peer groups

Another sphere in which stigmatisation was prevalent in the narratives of FSU youth is the drug-using community. While peer groups commonly provide support through shared lived experience, interviews with young adults demonstrate how in-group moralizing and judgement can also occur. Young adult participants used various means to create distinctions and promote hierarchies between “good” and “bad” drug users, often based upon the way an individual uses drugs and/or the type of drug used. Common explicit and implicit dichotomies used by young adults to communicate stigmatizing beliefs include “functional” versus “dysfunctional”, “controlled” versus “uncontrolled” and “moral” versus “immoral” drug users. Typically, participants mobilized these distinctions to position themselves as better than some other perceived group of users. The following interview segment from Viktor, a former PO user, illustrates this process of intra-group stigmatisation:

I...felt like I was functional, I was a functional addict, and I knew if I did heroin, I would not be functional. I'd stick that needle in my arm and fall asleep for hours... Like one guy says, “You're withdrawing, what are you gonna do? You gonna wait hours for your dealer?” I said, “Yeah, I'm not, I'm not doing heroin.” Like I was smart enough to know I should stay away from heroin (Viktor, 27 year-old male, born in Ukraine)

Viktor presents himself, in contrast to heroin users, as having been “a functional addict” because he exclusively used POs. Not only was he “smart enough” to avoid heroin, he implies that he possessed greater self-control than heroin users, as he was willing and able to “wait hours” for his pill dealer, even while in withdrawal, rather than succumb to the temptation to use heroin. Even though Viktor faced homelessness as a result of his opioid use, he portrays heroin users as leading more dysfunctional lives in which their sole purpose is to satisfy their need for drugs, as evidenced by the stereotypical behaviour of “fall[ing] asleep for hours” after injecting. A moralized dichotomy between PO users and heroin users is further illustrated by Maxim, who explained how he used to perceive heroin users before he himself progressed:

They [heroin users] had the look on their faces, you know, and they would do anything for that bag, you know? And, you know, ask me, “Hey, you have any lime juice or lemon juice in your house or vinegar?” The craziness that I saw, like, I didn't want to be a part of that. I thought that if I didn't touch heroin, I wasn't really a drug addict. Like, I was just taking pills recreationally (Maxim, 24 year-old male, born in Uzbekistan)

Like Viktor, Maxim portrays heroin users as lacking self-control and moral boundaries; they are willing to “do anything for that bag.” As alluded to by both men, a key distinction inherent in the moral dichotomy between PO and heroin users is route of administration, as heroin use is equated with injection, one of the most highly stigmatized drug use behaviours. The extent to which injection is considered degrading even among opioid users is implicit in Maxim's reference to the “craziness” of injection drug users desperately searching for supplies to prepare a speedball. (Lemon juice or vinegar is used to break down crack cocaine for injection—in this case in a speedball with heroin.) Maxim's larger narrative of progressing from “taking pills recreationally” to injecting heroin also demonstrates the

slippage from intra-group stigmatisation to self-stigmatisation that can occur as opioid use escalates. Like Maxim, many young adults reported engaging in behaviours such as heroin use or injection they had once considered the province of abhorrent others.

Other boundaries distinguishing “good” from “bad” drug users are formed on the basis of criminal behaviours, like theft, that out-of-control drug use is perceived to lead some individuals to commit. Although Ilya admitted to stealing to support his habit, he explained that there were some moral boundaries he was not willing to cross:

Like, say, like stealing baby’s money, like you know, like crazy shit like (pause) ... I steal too, but you have to know where to steal. You don’t steal from a poor family, you know?... Yeah, I don’t respect those people at all. (Ilya, 29 year-old male, born in Ukraine)

Ilya distinguished himself from truly immoral drug users who steal from vulnerable people, such as children or impoverished families, and are thus unworthy of “respect”.

Self-stigma

For a number of young adults, the experience of being marginalized and publically judged for engaging in behaviour normatively viewed as unacceptable fostered a personal sense of devaluation. A majority of respondents voiced self-stigma, reflecting the judgment communicated to them from multiple social spheres. Ilya discussed his sense of shame resulting from his failure to be a “good” son who met his parents’ hopes and expectations:

Well, sometimes, you know ... you’re an only child, all your parents’ hope for the future gets put on that one kid, right?... They thought I was gonna, be good, ...But I knew it was fucked up... Yeah, I do feel, I feel guilty about that, like I kind of failed them.

Several participants spoke of the shame they felt for bearing the physical stigmata of a tainted identity. For Rudolf, the physical deterioration that accompanied his heroin use was a source of shame, as it represented embodied evidence of his socially deviant behaviour:

Yeah, I tried to cover it up ... started being physically active, you know, I gained weight ... I didn’t look like a bum drug addict anymore. My face was really skinny before and pale face, like you could just see that I was a user. Nothing to be proud of. (Rudolf, 21 year-old male, born in Russia)

In Rudolf’s view, his shameful identity as a “bum drug addict” became manifest in his “skinny” and “pale” appearance, which reinforced his self-stigmatisation.

Drug injection can create other physical signs that are considered socially unacceptable—most saliently, visible track marks on the arms. As a result, participants who were current or former injectors sometimes opted to cover their arms due to fear of being publically identified as an injector. For Rudolf, the embarrassment he expressed over his track marks seemed to embody a larger sense of shame over his identity as a drug injector:

It's just the marks, like I'm embarrassed right now. I mean...I didn't want marks on my arms, right, and uh I knew that ... if I would shoot up, I'd want that fucking speedball rush.... I don't know, man, it's just (pause) if I just stayed with sniffing...

Sometimes stigma may become attached to certain physical spaces or locations that are closely associated with a stigmatized identity. For example, Dmitry, a heroin injector, explained his reluctance to utilize an SEP:

I kept hearing about this place, oh, needle exchange, needle exchange, and I'm like, to be honest, I don't want to go to a needle exchange, you know, 'cause then I feel like a real, like a real dope head (laughs), I feel like a real dope head. (Dmitry, 20 year-old male, born in the U.S. to FSU immigrant parents)

Dmitry chose to avoid the needle exchange in hopes of not feeling like a "real dope head." His internalized stigma thus impeded him from obtaining needed harm reduction services, illustrating the significant negative effects self-shaming and internalized stigma can have on health behaviour.

Discussion

The voices of these young, opioid-using immigrants from the FSU reveal that stigmatisation within multiple spheres of their lives plays a major role in how they perceive themselves, manage their drug use and traverse their world, including whether and how they seek prevention services and drug treatment. Findings suggest that, in addition to the general, societal-level stigmatisation of drug users normative to mainstream U.S. culture (Ahern et al., 2007; Link, Yang, Phelan, & Collins, 2004; Luoma et al., 2007), Russian-speaking youth who use POs and/or heroin perceive multiple sources of stigmatisation within their FSU immigrant community that deems them undesirable outcasts. These perceptions are confirmed by FSU immigrant mothers of opioid-using youth and service providers who located the roots of this stigmatisation in the prevailing socio-political climates of Soviet and post-Soviet society—climates hostile to the human rights and health needs of drug users. Mothers' narratives reveal their perception that their experiences growing up in the closed and authoritarian Soviet system conditioned their extremely disparaging stereotypes of individuals who use drugs and lack of accurate knowledge about drugs and addiction, and how this ignorance left them unprepared to address their children's drug use even after immigrating to the U.S. These stigmatising beliefs, which members of older generations of FSU immigrants understand to be inherited from the ideological context of their home country, are then communicated to their children, shaping youths' self-concepts and creating significant barriers to their use of drug-related services.

Findings regarding the added layer of community-level stigma faced by FSU immigrant women who use drugs due to their perceived violation of traditional conceptions of appropriate womanhood and motherhood reflect previous research conducted with a range of drug-using populations and demonstrate the common intersection of drug-use stigma with gender stigma (Gunn & Canada, 2015; Kirtadze et al., 2013; Sallman, 2010; Sanders, 2014). In the FSU immigrant context, this gendered devaluation of drug users rendering women who use drugs more deviant than men exists in tension with the dominant Soviet/post-Soviet

view of the woman as the stabilizing unit in the family system, who with these great expectations is also afforded great power. The passage by Tatiana illustrates this duality; her frank acknowledgement of the added stigma faced by Russian-speaking women who use drugs does not negate her awareness of women's critical role in the community as those who "take care of everything."

An important effect of this community-level stigmatisation documented in these findings is that opioid-using FSU youth often choose to distance themselves from available harm reduction services such as syringe exchange or strategize ways to limit visibility while accessing services in or near their communities—by, for example, relying on secondary syringe distribution within peer networks. These results are also consistent with prior research with other groups of drug users that has found stigma to function as a significant barrier to treatment-seeking behaviour (Myers et al., 2009; Sickel, Seacat, & Nabors, 2014). However, this self-initiated, peer-based syringe distribution simultaneously illustrates one way in which young injectors in the FSU community have collectively implemented strategies to protect their health amidst widespread fears of community marginalization and rejection. As such, these actions may serve as an example of what Friedman and colleagues have termed "invention," or in-group solidarity among injection drug users that serves a health-promoting function (Friedman et al., 2004).

While this study's findings support the existing literature on macro-level drug-related stigma, they also suggest that some of the most powerful forms of stigmatisation can be communicated within family and peer networks. The drug-related stigmas perceived by young adults within the larger community are many of the same norms and stigmas they perceive within their family sphere, which all participant groups, but particularly mothers, attested were powerfully shaped by the norms of their home country, demonstrating how macro-level stigmatisation can both influence and be perpetuated through intimate relationships.

The imperative for secrecy about drug use created by these mutually reinforcing processes of stigmatisation presents a formidable barrier for young people and their parents to seeking and accessing drug treatment and related support services. Not only do FSU immigrant parents typically lack awareness and understanding of modalities of drug treatment available in the U.S., notably OST, social stigma fosters reluctance to speak with their children about drugs, helping to perpetuate ignorance about the addiction process and the addictive potential of opioids in younger generations. Furthermore, FSU parents' drug-related naïveté frequently leads to a failure to recognize early signs of problematic opioid use in their children. As a result, drug treatment may not be sought until a child's problem has progressed to an unmanageable stage, thus prolonging the youth's exposure to harmful consequences of opioid use and/or IDU.

Like youth, family members navigate their own sense of stigmatisation. Parents' decisions to conceal a child's drug use may be due, in part, to a fear of "courtesy stigma" (Goffman, 1963), or stigma resulting from affiliation with a stigmatized person—in this case, fear of being labelled by the FSU community as bad parents. Parents' negative responses to a child's opioid use may also be indicative of secondary traumatising, as evidenced by some

mothers' despair over their children's drug use. These experiences suggest that close family members of opioid-using youth may experience substantial psychosocial harm as a consequence of remaining engaged and/or providing support (Tracy, Munson, Peterson, & Floeresch, 2009).

Another important finding is that FSU youth enacted stigma against other drug users, based on perceived behaviour and moral status. Distinctions were made on the grounds of other users' purported inability to live functional lives and maintain adequate control over their drug use, and their willingness to engage in "immoral" behaviours, such as certain kinds of theft. Scholars have postulated that intra-group stigmatisation via "downward comparison" can serve as a mechanism for self-esteem enhancement among individuals who share a common source of marginalization from the larger society (Phelan et al., 2008; Simmonds & Coomber, 2009; Tajfel & Turner, 2004). From this perspective, by comparing themselves favorably to other drug users who are presented as more unacceptable – for example, "junkies" who are presumed to have forfeited the ability to lead functional lives – young adults manage a discredited identity within a social world that acutely stigmatizes them. Thus, even instances of intra-group stigmatization illustrate ways in which FSU youth who use opioids navigate and resist threats to their personhood, highlighting the complex implications of strategies of resistance to dominant norms that serve as both a coping mechanism as well as a perpetrator of stigma for others.

Qualitative studies such as this that do not employ probabilistic sampling methods, large sample sizes and standardized measures do not seek to produce statistically generalizable knowledge; rather, the goal is to provide in-depth, contextualized understandings of the lived experiences of members of a social group from their own perspectives. That said, it bears emphasizing that the findings presented here are specific to this group of opioid-using young adults within NYC's FSU immigrant community and cannot be considered representative of FSU youth who use opioids in general, particularly those in other locations. Larger-scale survey research would allow for a more generalizable assessment of the impact of stigma on FSU youths' opioid-use trajectories, psychological well being and service utilisation and the degrees to which it occurs. Other limitations of this study include a reliance on participants' self-report, which is subject to social desirability bias, and the retrospective nature of young adults' and parents' accounts of earlier periods in their lives which are subject to recall bias. Indeed, the naturalized nature of stigma may have made it challenging for participants to reflect openly on their experiences of drug-related stigma or even to be fully aware of the extent to which stigma has shaped their behaviour and self-concepts.

These findings point to a number of implications for public health practice. Most saliently, results underscore a major unmet need for community-wide education about drugs, addiction and related health consequences, such as overdose and HCV, to address the widespread lack of knowledge and normative secrecy about these taboo topics in the FSU community. Such efforts should target youth, and critically, older Russian speakers who may be especially ignorant of these issues. Initiatives to foster greater understanding of OUD and greater familiarity with the range of available treatment options, including MAT, are a necessary first step to counter the widespread stigmatisation of drug users and may facilitate earlier intervention and treatment for opioid-using youth.

Given the reality of FSU community and familial stigma and the potentially debilitating social and psychological consequences for community members who are “outed” as drug users, harm reduction and drug treatment options that do not require public disclosure of one’s identity as a drug user and do not inadvertently perpetuate stigmatisation and shame are important. Data from providers indicating that some FSU drug injectors are, on their own initiative, engaging in secondary syringe exchange with their peers suggests that peer-based interventions – e.g., for syringe exchange, overdose education and naloxone distribution, and HIV/HCV prevention – may be appealing to and effective with FSU youth. With regard to drug treatment, the relative popularity of Russian-language NA meetings among interviewees suggests that Russian-language services may appeal to some FSU youth. However, because other young people may feel uncomfortable attending treatment with fellow FSU community members, it is important that youth be offered a range of treatment options, including youth-focused and low-threshold options, which strive to create a nonjudgmental space. For some FSU youth, treatment modalities that maximize individual privacy may be most acceptable; for example, buprenorphine maintenance received privacy of a doctor’s office may be preferable to methadone maintenance which requires daily attendance at a clinic. Similarly, technology-based tools, such as web-based programs or smartphone applications, that can be discreetly accessed from a range of settings including one’s home may be ideal for this group, and may be particularly useful for providing adjunctive behavioural and psychosocial treatment in combination with MAT.

On a more general level, these findings highlight the importance of considering cultural norms and historical context in the design and delivery of services and interventions for drug users, particularly young immigrants who may be facing distinct challenges such as shame, isolation and acculturation stress. To mitigate the harms associated with drug-use stigma, future research should seek to develop culturally-tailored stigma-reduction interventions and identify multi-level factors that are protective against the detrimental effects of stigma so interventions can build on these indigenous sources of strength and resilience.

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Table 1

Young adults' sociodemographic, immigration and drug use characteristics.

Characteristic (n = 26)	Mean, Range, SD or % (n)
Age (<i>M, Range, SD</i>)	23.3, 18–29, 3.6
Age subgroup % (<i>n</i>)	
18–23	54 (14)
24–29	46 (12)
Gender % (<i>n</i>)	
Male	69 (18)
Country of birth % (<i>n</i>)	
Ukraine	42 ^a (11)
Russia	35 (9)
Uzbekistan	8 (2)
U.S.	4 (1)
Other FSU country	12 (3)
Age at immigration to U.S. (<i>M, Range, SD</i>)	6.7, 0–16, 4.6
Marital status % (<i>n</i>)	
Single/never married	81 (21)
Religious affiliation % (<i>n</i>)	
Russian orthodox	31 ^a (8)
Jewish	23 (6)
Catholic	4 (1)
Evangelical protestant	4 (1)
No affiliation	39 (10)
Living situation % (<i>n</i>)	
With parents &/or other family	69 ^a (18)
With spouse/partner	8 (2)
With friends/roommates	8 (2)
Alone	8 (2)
Drug treatment facility	8 (2)
Highest level of education % (<i>n</i>)	
Did not complete high school	15 (4)
High school graduate/GED	39 (10)
Some college	42 (11)
College graduate or higher	4 (1)
Employment status % (<i>n</i>)	
Employed (F/T or P/T)	46 (12)
Primary source of support % (<i>n</i>)	
Parents or other family	54 ⁺ (14)
Employment	27 (7)
Public assistance/SSI	4 (1)
Illegal activities	12 (3)

Characteristic (n = 26)	Mean, Range, SD or % (n)
Other	4 (1)
Drug treatment status % (n)	
Currently participating in drug treatment	39 (10)

^aPercentages total >100 due to rounding.

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