"WATCH OUT FOR THE BOOGIEMAN": STIGMA AND SUBSTANCE USE RECOVERY AMONG MIGRANTS AND ETHNIC MINORITIES

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ABSTRACT

People with a migration background and ethnic minorities (MEM) with substance use problems are confronted with stigma due to their ethnicity and substance use. This study explores how living with multiple stigmatized identities impacts substance use recovery among MEM. We conducted 34 in-depth interviews with a diverse sample of MEM with substance use problems in Flanders, Belgium. A Qualitative Content Analysis using Earnshaw's stigma framework revealed that their recovery processes are challenged by accumulated stigma based on different intersectional statuses, namely ethnicity, substance use, psychological problems, criminal histories, poverty, unemployment and gender. These stigmas can negatively influence their wellbeing, increase problem substance use and act as a barrier to recovery capital. While stigma moderators, which determine how stigma unfolds within society, were spread across the micro-to-macro continuum (from personal to social, community and macro-cultural features), mediators that influence the role of stigma in recovery were mainly psychosocial. Hence, prevention and intervention strategies should be aimed at reducing stigma on the macro, meso and micro level, while individuals and communities can limit the impact of public stigma on recovery through constructive personal and collective coping and action mechanisms.

Key words: intersectionality, stigma, migrants and ethnic minorities, addiction, substance use, recovery

INTRODUCTION

Stigma to features that are considered deviant occurs universally and has a major impact on the wellbeing of those who are stigmatized (Campbell & Deacon, 2006, p. 2). Over the years, several sources of stigma have been identified, namely (1) physical appearances that do not comply with societal norms, (2) behaviors, beliefs, values and attitudes that are considered 'abnormal', including problem substance and mental health issues and (3) religion, race and ethnicity (Goffman, 1963; Wogen & Restrepo, 2020). Hence, migrants and ethnic minorities (MEM) with substance use problems carry two

stigmatized features (i.e. double stigma) (Gary, 2005). Furthermore, MEM are often stigmatized due to their language, culture, race, ethnicity or other characteristics, such as their socioeconomic status (De Kock, Decorte, Vanderplasschen, Derluyn, & Sacco, 2017; Wang, Li, Stanton, & Fang, 2010). This stigmatization is a known risk factor for mental health issues and problem substance use (McCabe et al., 2007; Reid, Aitken, Beyer, & Crofts, 2001). As stigma is culturally determined (Clair, Daniel, & Lamont, 2016), people from different ethnocultural backgrounds may experience stigma differently. Some MEM are described to encounter what is called 'triple stigma' (De Kock et al., 2020): they are not only confronted with substance use and MEM-related stigma by the majority population (first and second stigma), but may also encounter substance use stigma within their own ethnocultural communities (third stigma) (Buchman & Reiner, 2009; Pouille, Bellaert, Vander Laenen, & Vanderplasschen, 2021). Furthermore, stigmas concerning substance use problems, MEM-characteristics and other related social identities, such as socio-economic status, may accumulate and aggravate each other (Quinn, 2014).

Public stigma stems from an interrelated combination of stereotypes (negative public attitudes and opinions), prejudice (adverse emotional reactions) and discrimination (actions of social exclusion following prejudice and stereotypes) (Wogen & Restrepo, 2020). It occurs at the intersection of the micro (individual characteristics and attitudes), meso (culturally determined stereotypes and ideas) and macro level (structurally embedded power mechanisms and institutional practices that cause inequality) (Clair, 2018). The latter (also called structural stigma) restricts stigmatized populations' access to resources such as employment, educational opportunities, healthcare and housing (Earnshaw, 2020; Wogen & Restrepo, 2020), and restricts their access to recovery capital (Pouille, De Kock, Vander Laenen, & Vanderplasschen, 2020; White & Cloud, 2008).

Recovery capital is used to describe the resources that can be drawn upon to initiate and sustain recovery from problem substance use (Cloud & Granfield, 2008). While there are different ways to categorize recovery capital (Hennessy, 2017), this research departs from an ecological point of view that divides recovery capital into personal, social and community recovery capital (Best & Laudet, 2010; White & Cloud, 2008). Personal recovery capital contains both physical resources such as physical health and

financial assets, and human resources such as values, self-esteem and educational skills. Social recovery capital stands for recovery-supportive social relationship, while community recovery capital encompasses community and cultural attitudes, policies and resources. Cloud & Granfield (2009) added the concept of negative recovery capital as factors that undermine recovery processes and efforts. Recovery capital is mutually related to problem severity and recovery (Best & Laudet, 2010; Hennessy, 2017).

A recent study by Ashford, Brown, Canode, McDaniel, and Curtis (2019) showed that higher perceived stigmatization due to substance use problems is associated with less positive and more negative recovery capital. On a personal level, stigma may induce self-stigma (i.e., internalized negative representations), identity conflicts, low self-efficacy and low self-esteem, which are elements that have been shown to jeopardize recovery from problem substance use (Ashford et al., 2019; Campbell & Deacon, 2006; Corrigan, Larson, & Rüsch, 2009; Davidson, Rowe, DiLeo, Bellamy & Delphin-Rittmon, 2021).On a social level, stigma to problem substance use and the related courtesy stigma (the stigma experienced by associates of the stigmatized group) may result in social exclusion and isolation of people with substance use problems, and strengthen ties with substance using groups that are detrimental to one's recovery (Best et al., 2016). On a community level, (fear of) stigma and the resulting label avoidance raises the threshold of treatment (Wogen & Restrepo, 2020). In contrast, stigma has also been argued to serve as means of exercising social control, preventing people from using substances (Luoma, 2011; Pouille et al., 2021).

Studies offering nuanced insight into the role of multiple stigma in recovery and the recovery capital of people with multiple stigmatized identities are scarce (Earnshaw, 2020; Giftci, Jones, & Corrigan, 2013; Luoma, 2011; Turan et al., 2019). They rarely include the perspectives of marginalized communities, such as MEM with a history of problem substance use themselves (Hennessy, 2017; Hui et al., 2021). This study therefor addresses multiple stigma and its impact on recovery processes as experienced by MEM with problem substance use.

Earnshaw (2020) offers a comprehensive model of multiple stigma and problem substance use. This model discusses how multiple intersectional statuses can impact substance use outcomes through stigma

manifestations on a structural and individual level. According to the model, this impact is mediated and moderated by several contextual and individual factors. While moderators determine how stigma takes shape in society, mediating factors link stigma manifestations directly to substance use and recovery outcomes. Meyers et al. (2021) adapted this framework based on the literature on intersectional gender and substance-use stigma, but MEM-related stigma in relation to substance use stigma and recovery has not yet been explored. In our study, we explore the multiple stigmatized statuses that MEM with (a history of) substance use problems encounter and the stigma manifestations they experience. We investigate mediating and moderating mechanisms influencing this stigma process. Instead of focusing on their impact on substance use outcomes, however, these mechanisms are linked to substance use recovery and recovery capital as guiding frameworks in today's substance use research, treatment and policy.

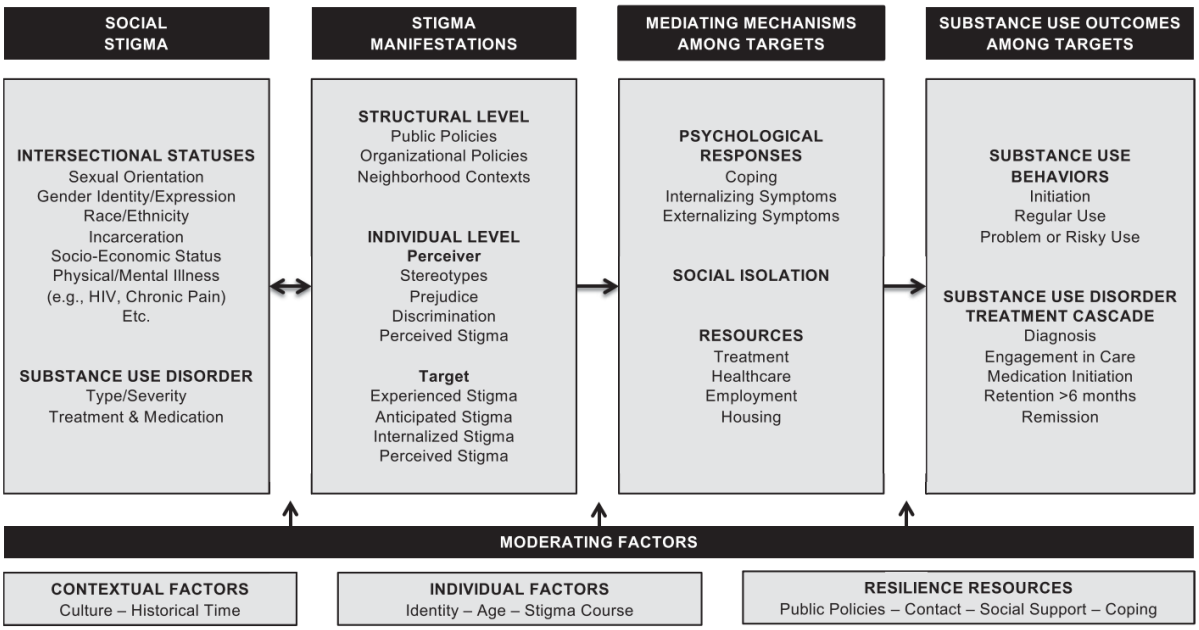

Figure 1. The stigma framework by Earnshaw (2020).

METHODS

To obtain insight into the role of stigma in recovery experiences of MEM with substance use problems, we conducted 34 in-depth interviews in Flanders (Belgium). Participants were recruited through venue-based methods (Mehdiyar, Andersson, & Hjelm, 2020) and the following inclusion criteria were applied: (1) being 18 + of age (adult age limit in Belgium), (2) self-identifying as person with a migration

background and/or belonging to an ethnic minority, and (3) having personal experience with recovery from problem substance use. Interviews were conducted in Dutch (n=29), English (n= 4) and French (n=1).

As MEM with substance use problems are considered a hard-to-reach population, we applied a four-fold strategy to lower the participation threshold (Alvarez, Vasquez, Mayorga, Feaster, & Mitrani, 2006). Specifically, we appealed to potential participants by 1) distributing flyers in places frequented by MEM with (a history of) substance use problems (e.g. residential and outpatient drug treatment centers and low-threshold community centers for people who use substances); 2) making contact with potential participants in these venues by talking to them in a non-judgmental and open manner; 3) addressing gatekeepers in- and outside these venues who can explain the research to potential participants and facilitate the initial contact between researcher and participant; and 4) adding snowball sampling. The purpose and methods of the research were clearly explained to the participants and confidentiality was ensured. The latter is especially important due to the power imbalance in the interviewer-interviewee relationship, as well as the sensitive topic that might trigger feelings of shame and fear of stigma among participants (Benoit, Jansson, Millar, & Phillips, 2005; Daley, 2010; Grant, 2014). Therefore, we aimed to create a non-threatening and informal environment where participants felt safe to open up about their lived experiences (Karnieli-Miller, Strier, & Pessach, 2009). For this reason, the interviews were conducted in places chosen by and familiar to the participants. Furthermore, the interviewer (the first author of this manuscript) was sensitive to participants' (body) language and adapted her interviewing methods to their needs (Grant, 2014), for example by not cutting participants off when they were speaking freely and guiding the conversation rather than strictly adhering to the interview guideline.

A total of 34 MEM, of which four women, with diverse backgrounds and in different stages of recovery, aged between 18 and 60 years old (mean: 38) took part in the study. Twenty participants were born in Belgium and fourteen migrated to Belgium as children or adults (having resided in Belgium for at least three years). Similar to the amount and distribution of migrant populations in Flanders, most participants had Moroccan (n=9) and Turkish backgrounds (n=7), followed by Algerian (n=5), Slovak (n=4), other

EU (n=5) and non-EU (n=4) backgrounds. Participants with a Moroccan, Turkish and Algerian migration background were predominantly second-generation migrants, while most participants from EU countries were first-generation migrants.

The interview guideline served to guide the conversation and focused on substance use problems, recovery, and the role of one's migration background and minority experiences in this process. Based on the literature, questions were added regarding experiences of stigma and discrimination related to one's migration background and substance use, while other stigmatized identities were spontaneously discussed by the participants. Most participants were interviewed once and the interviews lasted between one and three and a half hours.

To obtain a comprehensive idea about the role of stigma in recovery processes of MEM, we conducted a Qualitative Content Analysis (QCA) (Schreier, 2012) based on Earnshaw's conceptual substance use stigma framework (2020, see figure 1) and recovery capital theory (White & Cloud, 2008). QCA is a concept- and data-driven analysis method, which allows for the integration of the lived experiences of participants with prior thereotical knowledge. The overarching categories of the substance use stigma framework were applied as first order categories (i.e., intersectional stigmatized statuses, stigma manifestations, mediating mechanisms and moderating factors). To explore the role of stigma in recovery, we replaced 'substance use outcomes' with 'recovery' and added the subdomains of recovery capital as second order categories (i.e., personal, social and community capital). Other themes in the coding framework emerged inductively from the data. Five interviews were independently coded by the first two authors. The final coding framework was established through extensive discussion with all co-authors.

When illustrating the results via quotes, we refer to the participants by means of an alias. A summary of the results can be found in Figure 2.

RESULTS

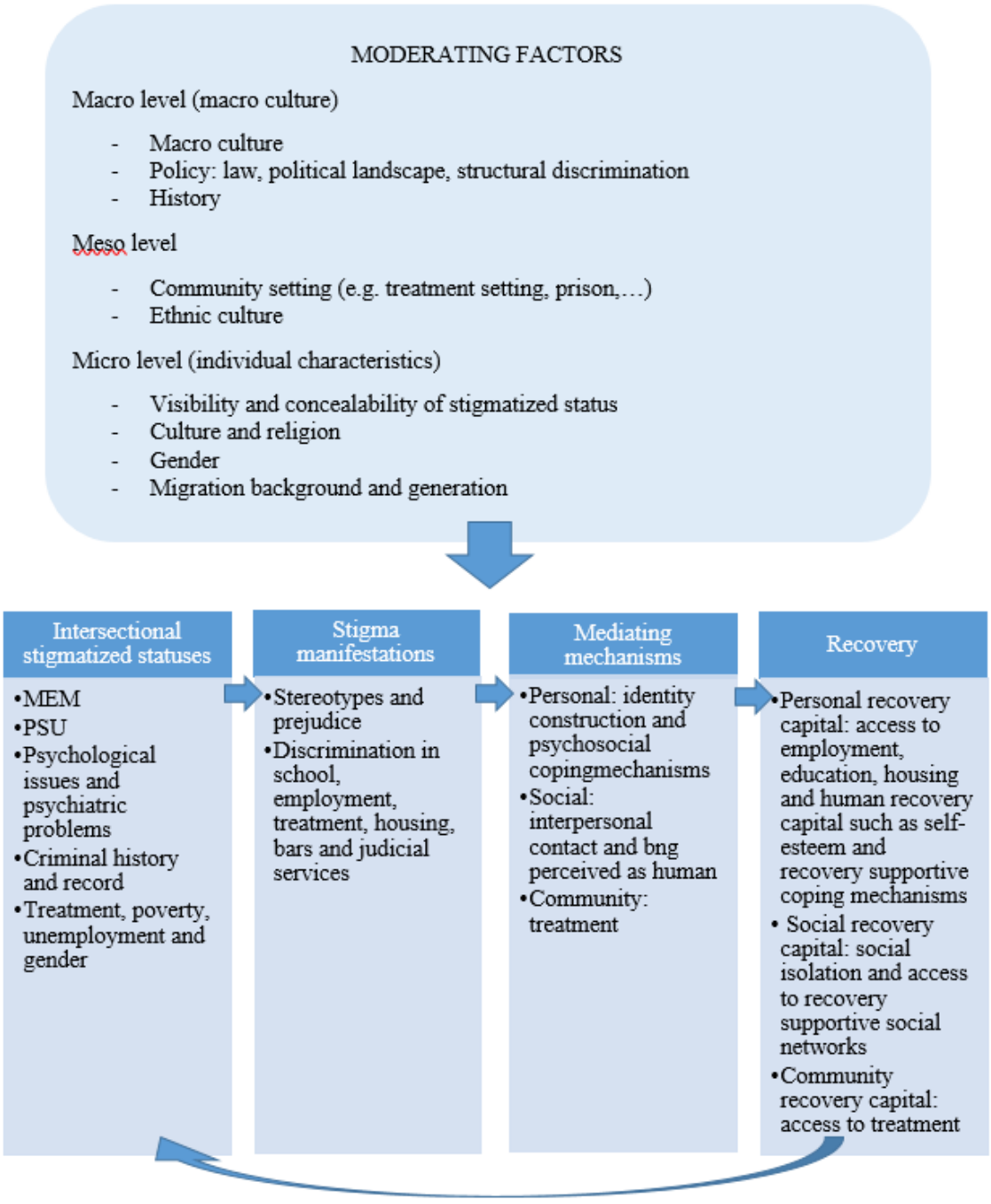

Figure 2. The stigma framework of Earnshaw (2020) adopted to the recovery experiences of MEM with (a history of) substance use problems

INTERSECTIONAL STIGMATIZED STATUSES

Several participants explained how various aspects of their identity led to multiple forms of stigma. First, almost all participants discussed the presence of stigma toward MEM in society.

> Us, people with a migration background, we collide everywhere. They gave us our nationality, but our name remains Turkish or Arabic. That's why we are excluded everywhere. If there's an elephant in the room, they say it's not there. There's polarization, there's division. (Mehmet, 45 years old, second generation, Turkish background)

Besides the stigma related to their MEM status, most of the participants experienced stigma related to (problem) substance use.

> People who have addiction problems, other people[say], watch out, here comes the boogieman. (…) People who use drugs or who have addiction problems, they are not the boogie man. They're normal people who require twice the attention than another human being. That's what I would change in the world if I could, people's mentalities, giving more information about the disease and the situation people like me are in. (Miguel, 44 years old, first generation, Portuguese background)

Even though other stigmatized statuses were not specifically addressed in the interview questions, participants discussed them spontaneously. First, more than half of the participants discussed how having psychological or psychiatric problems is highly stigmatized, both within general society and within some, mainly religious (Christian and Muslim), ethnocultural communities. This also contributed to the stigma surrounding treatment. To a lesser extent, participants described encounters with intersectional and accumulative stigma due to their criminal record, poverty, unemployment and gender.

> The problem was, I had no money, I had nothing, so my hair was terrible, my beard was terrible, I wore clothes that hadn't been washed in months, I stank terribly. No one wanted to believe that I was sober and that was difficult. I had to convince people, I'm really kicking the habit. (Kofi, 29 years old, first generation, Burundian background)

> If you choose a sober life as a mother, you have to compete against that [stigma] and prove yourself twice as hard as someone who doesn't have children, before people start to trust you. (Amina, 38 years old, second generation, Belgian-Moroccan background)

STIGMA MANIFESTATIONS

Almost all participants experienced MEM-related discrimination in different contexts, namely (from most to least common) in school, employment, treatment, bars, housing and judicial services. Some of the participants described how societal preconceptions about MEM subpopulations led people to jump to conclusions, for example by perceiving them as 'aggressive' due to prejudice or different communication styles. While most MEM-related stigma was located in Flemish macro culture, most participants with Islamic roots also described how they felt rejected by people from their own ethnocultural communities because of stigmatizing attitudes toward what they called "adaptation to a Western lifestyle".

Most participants described stigma manifestations related to substance use (for culturally condemned and illegal substances) or problem substance use (for substances that are more morally accepted and normalized). Stigmatizing attitudes toward (problem) substance use was attributed to the overall macro culture in Flanders and Europe, religious ethnocultural communities and stigmatizing social networks. Participants described the derogatory label of 'addict' and 'junkie', as well as the public opinion of problem substance use as a personal choice, moral weakness or a criminal act. Several participants described how they were perceived as unreliable due to their problem substance use. Among Muslim communities, substance use was described as forbidden or haram, a crime and "derailment caused by the West". A minority of the participants described encounters with discrimination based on their problem substance use, more specifically (from most to least mentioned) in employment, in mental health and substance use treatment, by judicial services and by child protection services.

Mental health stigma was described as manifesting within families, communities and general society. It was described as related to the stereotypical view on mental health issues as a weakness, especially for men. Both mental health and substance use stigma were related to treatment stigma, as this rendered the often invisible features of mental health and substance use problems visible to the outside world. A minority of the participants discussed how they were confronted with discrimination due to mental health problems, namely in substance use treatment (e.g., facing exclusion due to mental health issues) and employment. The latter was also hampered by the stigma related to longer periods of unemployment

and by discrimination due to having a criminal record. Four participants addressed how they were unable to acquire the Belgian nationality (even if they were born in Belgium) due to their criminal record.

MODERATING FACTORS

Moderating factors (i.e., factors that impact the diverse ways in which stigma manifests within society) may be divided into macro-level, meso-level and micro-level elements.

On a **macro level**, participants discussed how the political landscape determined the stigmas' strength and their manifestations. Concerning MEM-related stigma, they reported an increase in racism and discrimination in Flanders due to several historical and political changes. According to several participants, the rise of right-wing political parties in Flanders, recent acts of terrorism in Europe (especially for MEM with a Muslim background), as well as a rising share of MEM in Flanders, have worsened MEM-related stigma and discrimination. Participants also referred to the duality of the law, which both reinforces (through the administrative discrimination of people without a valid identity card) and condemns (by virtue of the anti-racism law) discrimination and racism. Some references were made to the segregation of socially vulnerable MEM in separate districts and school systems as a form of structural discrimination, strengthening MEM-related stigma.

Regarding (problem) substance use stigma, participants named cultural differences in the moralization of (problem) substance use on both the macro and the **meso** level. Alcohol use, for example, was described as highly normalized in Flemish culture and highly condemned in Muslim cultures. Two participants with a Christian background also discussed ethnocultural stigma and taboo surrounding problem substance use. Among these religious cultures, participants reported a high sense of pride, which both rendered mental health problems a difficult subject to discuss and formed a barrier toward treatment. Participants reffered to treatment as having the potential to decrease stigma among MEM, their families and communities (both internalized stigma and stigmatizing attitudes toward other people who are struggling with mental health or substance use problems), by educating and informing them.

> Addiction is bad in my culture. Other Moroccans, family, they keep their sons from hanging out with us (…). Addiction is the lowest of the lowest, especially in our community. (…) For me,

> someone who looks for help is weak, but now that I'm here [treatment setting], I know it's not like that. (Emir, 47 years old, second generation, Moroccan background)

However, participants also referred to discriminating and stigmatizing experiences in treatment settings. They felt as though they were not taken seriously or listened to, due to MEM, substance use or mental health-related stigma. Some participants reported being excluded from treatment due to MEM-related prejudice. Others recalled how they were judged by counselors for their self-medication, having discovered what helped them for their physical and mental inconveniences through the years, but simultaneously being prescribed less stigmatized substances. Two participants raised the issue that treatment may worsen mental health stigma by addressing mental health problems as chronic and individual illnesses, disregarding the impact of the social context on people's lives and recovery processes.

Hence, meso-level settings had an impact on the stigmatizing experiences participants had encountered within their lives. As discussed by several previously incarcerated MEM, prison was believed to be an example of an especially stigmatizing context.

On a personal, **micro level**, the visibility of the stigmatized status was crucial. Participants with a visible migration background (through skin color, language or name) often felt as if their migration background is the first and only thing other people see and react to. In addition, visibility and physical appearance determined the extent of the stigma regarding substance use (problems), mental health problems, criminal history, poverty and homelessness. A few participants described how the internet contained references to their (or their families') criminal and/or substance using past, hence reinforcing their negative consequences.

Second-generation migrants expressed feelings of injustice, reporting that they "have to prove themselves twice as hard" and that they "are not getting the same chances" as the majority population. First-generation migrants were more inclined to downplay the impact of stigma on their lives, compared to worse situations in their home country.

> Other cultures, Belgian culture, not knowing who you are, what you have to be, how you have to be. It's not easy. Especially because we're second generation. I have the impression that the second generation has the most difficult time. The first was welcome, they were allowed to work here, they were welcomed with open arms to work. The children are the victims. Because a lot of things happen in our culture that the Belgian people don't want to understand, and we don't understand them either. (Muhammet, 39 years old, second generation, Moroccan background)

Self-identification with Muslim culture was a negative moderating factor, as most participants with a Muslim background described Muslim culture as highly stigmatized in Flemish society. Furthermore, gender had an intersectional effect on stigma, as men and women with a Muslim background discussed how MEM-related stigma was worse for men. Both within and outside the Muslim population, stigma surrounding mental health problems and psychological vulnerabilities was considered to be worse among men, as "men are not supposed to talk about emotions".

MEDIATING MECHANISMS

While all participants agreed on the presence of stigma in society, and almost all of them had personal experiences with stigma in their lives, the extent to which it impacted their recovery processes was mediated through various factors, and ranged from only minor to all-important.

Most participants who identified mediators that limited the impact of MEM-related stigma on substance use recovery attributed this to the **personal resources** of identity construction and coping. First, being "labeled as different" from the majority population and related experiences of exclusion impacted many participants' sense of cultural identity and belonging.

> Few people perceive me as Belgian when they watch me walk across the street. So, I don't feel Belgian. I speak Flemish fluently, but I don't feel Belgian at all. Actually, I feel Haitian with no identity. (Anna, 36 years old, first generation, Haitian background)

While identity conflicts described as having "no" or an "in-between" identity (feeling rejected by both people with the same ethnocultural background and by the majority population) negatively impacted recovery processes, a positive perception of "double identity" (belonging to both groups) as added value

in their lives functioned as a protective factor for the harmful impact of stigma on substance use and recovery.

Second, the extent to which stigma dominated participants' recovery narratives was strongly related to coping. Many participants reported substance-using coping mechanisms to deal with feelings of inferiority and anger created by stigma. By contrast, the devastating impact of stigma was countered by "accepting" that this is part of our society, and, to a much lesser extent, trying to reduce stigma by informing others and actively challenging stigma through personal action.

> You are confronted with it [discrimination due to migration background] every day, trust me. It's been like that for a long time and it won't stop. But you have to put yourself above that, you have to be the bigger man. (…) I've had so much misery in my life, trauma, injustice, so much powerlessness, and that has to be a boost for me to do good. (Semir, 31 years old, first generation, Moroccan background)

On a **social level**, several participants discussed how they withdrew from (close) social networks and communities because they felt stigmatized and judged by them. Additionally, some also chose to isolate themselves from family, friends and their community, to protect them from courtesy stigma.

> I left my environment because I didn't want to bring shame on my parents, for the sake of me and my parents. I didn't want to bring shame upon them, because I know, or thought through my culture, they are going give my parents dirty looks. (Emir, 47 years old, second generation, Moroccan background).

Social mediators that reduce the impact of stigma on recovery were the support of others and experiences with non-fulfillment of perceived stigmatization in contact with others. Being perceived as "human" rather than being judged by one aspect of their identity was of central importance to many participants, also in treatment.

Only a few participants discussed a mediator on the **community level**, namely specialized mental health and substance use treatment settings that taught them how to understand stigma and adopt recovery-supportive coping mechanisms for dealing with it.

IMPACT ON RECOVERY

Stigma had both a direct (through substance-using coping mechanisms), and indirect detrimental impact (by influencing the recovery capital) on recovery.

The diverse manifestations of stigma may impede access to **personal recovery capital** such as education, employment and housing. Furthermore, individuals struggled with their identities and lower self-esteem through internalized stigma in the form of shame. As it was fear of substance use- and mental health-related stigma that caused participants to stay silent about their problems, it also created a barrier to other recovery capital such as treatment and building a supportive and understanding social network.

> For I have always had to hide my substance use from my family, even though they knew it. And I haven't had much support from my parents and from my siblings. I've always had to do everything myself, because heroin is taboo. (Aslan, 26 years old, second generation, Turkish background)

On a **social level**, experiencing social exclusion could lead to isolation from perceived stigmatizing networks and identification with social networks that were detrimental to their recovery process. In some narratives, it became clear how growing up in segregated schools and neighborhoods brought together socially vulnerable MEM who felt rejected by society. Although these networks were initially considered companions providing recognition and acknowledgement in difficult times, over time, it became clear to the participants that they contributed to the vicious circle of criminality and substance use, standing in the way of recovery.

> It was clear that we were doomed to fail. Success, good jobs, it’s not reserved for us, so we look for other ways to make money. You look at people who are older than you and they do robberies, drugs, dealing and stuff. And then you just say, I’ll take his place next. (Rayan, 39 years old, second generation, Moroccan background)

On the **community level**, some participants described how MEM-related stigma functioned as a barrier to and during treatment, as they felt rejected and unheard due to various stigmas. A few participants recalled discrimination in judicial settings. From their point of view, judges unrightfully imposed imprisonment instead of treatment due to MEM-related stigma, denying them opportunities for recovery.

> I've been asking for years, I have a drug problem, I need treatment. I didn't get it. (…). I commit new offenses to fund my drug use and a judge convicts me again. While I say, give me drug [treatment] court[1] so I can do something about my drug problem, but the judge won't believe me. (…) If my name was Danny and if I had blue eyes, I believe I would get drug court. Everyone with blue eyes gets it, but if you have a strange name, you don't. Then you are not addicted, you are just a thief. (Rayan, 39 years old, second generation, Moroccan background)

Although the effects of stigma on recovery processes were largely experienced as detrimental, stigmatizing environments in which substance use is discouraged may be considered helpful in reducing the urge to use. Cultures in which substance use is socially accepted (e.g., the social acceptance of alcohol within the Flemish culture), by contrast, hampered recovery due to the increased availability and confrontation with substances.

DISCUSSION

Through in-depth interviews with 34 MEM with substance use problems, this study explores the role of multiple stigma in substance use recovery among MEM, as well as possible moderators and mediators. The stigma framework by Earnshaw (2020), applied to MEM with (a history of) problem substance use for the first time, has proved to be a valuable framework to fully grasp the role of multiple stigma in substance use recovery. Qualitative Content Analysis allowed us to simultaneously centralize the perspectives of MEM and to include state-of-the-art knowledge on stigma. This resulted in a framework

[1] A drug treatment court refers offenders with substance use problems to (drug) treatment services instead of the criminal justice system, so their underlying substance use problems and associated psychosocial difficulties can be addressed (Wittouck, Dekkers, Vanderplasschen, & Laenen, 2014)

on the role of multiple stigma in substance use recovery among MEM that has some overlap with Earnshaw's stigma framework (2020) but is unique in its content (see Figure 2).

All participants addressed the presence of MEM-related stigma in society. However, to what extent they felt affected by MEM-related stigma depended on several macro-, meso- and micro-level moderators. The visibility (or concealability) of a stigmatized status is key in the extent to which individuals are confronted with stigma manifestations (Howarth, 2006). Hence, MEM-related stigma was mainly experienced by people of color. As problem substance use is often a more concealable feature, fewer participants, albeit still the majority, talked about being confronted with substance-related stigma. MEM from religious cultures described additional stigma surrounding problem substance use within their ethnocultural communities, confirming the presence of double and even triple stigma (De Kock et al., 2020; Giftci et al., 2013). Additionally, however, other stigmas may coexist within individuals, with one stigma determining how another manifests (Turan et al., 2019). Participants mentioned stigma based on psychological and psychiatric problems, criminal history and record, treatment adherence, poverty, unemployment and gender. These multiple stigmas can intersectionally interact with each other, with an accumulative impact on one's recovery process (Meyers et al., 2021; Turan et al., 2019).

On a micro level, personal characteristics dominated the way in which participants experienced stigma: first- and second-generation migrants face different challenges when it comes to MEM-related stigma, substance use stigma seems to vary depending on the substance used, and one's gender resulted in different experiences with MEM and substance use-related stigma. This was, however, strongly related to cultural and contextual moderators on the meso and macro level. For example, recent extremist terror attacks, combined with increasing right-wing political tendencies and fear-centered discourse, have strengthened Islamophobia in Europe, increasing the stigma and discrimination Muslim individuals experience (Ekman, 2015; Giani & Merlino, 2021). At the same time, these individuals may also suffer from substance use and mental health stigma within their own ethnocultural community due to religion-based perceptions (De Kock et al., 2017; Giftci et al., 2013). Regarding gender-differentiated experiences of stigma, these may arise from culturally prescribed societal preconceptions of what it means to be 'feminine' or 'masculine'. In general, women are more prone to suffering from stigma

surrounding substance use than men due to societal judgements of drug use, as opposed to the "normal, responsible, moral, rational and controlled behaviour" that is expected from them (Van Steenberghe, Vanderplasschen, Bellaert, & De Maeyer, 2021, p. 2). While, according to previous research, men are less prone to access mental health services then women and are more likely cope with mental health problems through risky behaviour and substance use, in order to avoid association with what is seemingly the opposite of the dominant social masculinity norm of emotional control and self-reliance (Milner, Kavanagh, King, & Currier, 2018).

Stigma is experienced through specific manifestations that may decrease recovery capital in a direct (e.g., limited access to housing) and indirect manner (e.g., reduced self-confidence through internalized stigma) (Campbell & Deacon, 2006; Earnshaw, 2020). The stigma manifestations expressed by participants confirm the examples of structural discrimination that have been reported in past stigma-related research (e.g., in school, employment, treatment, housing, social life and judicial services) (Clair, 2018). While participants mainly referred to discriminatory experiences in light of MEM-related stigma, some discriminatory encounters also stemmed from other types of stigmas or the accumulation thereof. For example, previous research has shown that MEM with substance use problems are more likely to be convicted for their crimes than their non-MEM peers, illustrating how the accumulation of MEM- and substance-related stigma causes an unequal representation of MEM with substance use problems in prison (Brennan & Spohn, 2008).

The shame associated with internalized stigma may impact recovery in a negative as well as a positive way. On the one hand, it decreases confidence in one's self and future, and increases isolation and social exclusion (Earnshaw, 2020). It may cause individuals to conceal important parts of their identity, keep them from disclosing difficulties such as substance use and mental health problems (Luoma, 2011) and discourage them from seeking help for their problems (Wogen & Restrepo, 2020). The so-called 'why-try effect' resulting from stigmatizing experiences and beliefs may lead MEM to become demotivated in trying to pursue personal goals (Corrigan, Bink, Schmidt, Jones, & Rüsch, 2016), standing in the way of recovery from problem substance use (Davidson et al., 2021, Luoma, 2011). On the other hand, stigma surrounding (problem) substance use in societies, communities and social groups may lead to

restricted availability of and access to substances, contributing to recovery from problem substance use (Best et al., 2016). Furthermore, the shame resulting from moral judgment of (problem) substance may also act as a motivator for recovery (Corrigan & Watson, 2002; Pouille et al., 2021).

The seemingly never-ending cycle of intersectional and accumulated stigma and its negative impact on recovery from substance use problems may be broken by personal, social or contextual mediators and moderators. While moderators were largely spread across the micro to macro continuum, with micro-level mechanisms being largely related to meso- and macro-level factors, recovery mediators were mainly situated on the personal and social levels. Hence, while perceived causes of stigma were situated mainly outside one's control, strategies for limiting its impact on recovery were mainly perceived as a personal responsibility. This resulted in mostly secondary control (i.e., adapting to a stressful event) and disengagement (i.e., avoidance) coping mechanisms. While the latter leads to isolation and social withdrawal, the former is considered more adaptive as it may help individuals to deal with stigma through distraction (e.g., paying less attention to the stigmatizing experience), cognitive restructuring (e.g., through disidentification) and acceptance (Miller & Kaiser, 2001).

Regarding disidentification, participants explicitly disidentified with stigmatized labels such as 'junkie' by emphasizing difference and creating symbolic boundaries (Copes, 2016). Furthermore, we discerned the importance of the concept of 'human being' as a way to avoid categorizing labels and emphasize unity among people (Kadianaki, 2014). This explicit humanization may be a counterreaction to the experience and presence of dehumanizing discourses, representations and acts (both the result and the cause of public stigma) regarding (among others) migrant and ethnic minority people (Esses, Medianu, & Lawson, 2013; Haslam & Stratemeyer, 2016), people with substance use and/or mental health problems (Brown, 2020; Martinez, Piff, Mendoza-Denton, & Hinshaw, 2011) as well as homeless people (Haslam & Stratemeyer, 2016) and people with a criminal history (Haslam, 2006). These discourses are linked to geographical, political and historical contexts, e.g., the so-called refugee crisis in Europe (Bruneau, Kteily, & Laustsen, 2018) as well as the more global politics of the 'war on terror' (Haslam & Stratemeyer, 2016) and the 'war on drugs' (Brown, 2020) and have a direct impact on the lived experiences of stigmatized individuals. As Martinez et al. (2011) have shown in their research on

mental health stigma, ascribing humanity to people with stigmatized statuses is a strategy for stereotyping and stigma reduction, both among those who stigmatize and those who experience the stigma.

Primary control mechanisms of compensation (e.g., proving themselves twice as hard) and, to a much lesser extent, action, were also identified (Miller & Kaiser, 2001). Only a few individuals took action to reduce external stigma, by standing up for their stigmatized group and informing others about their condition. These were mainly individual initiatives, with no references to collective action (Miller & Kaiser, 2001).

Historically, the recovery literature has mainly started from a personal point of view, exploring how recovery can be promoted on a personal level. In recent years, critical voices have argued that this approach foregoes the context in which people recover (Bellaert, Van Steenberghe, De Maeyer, Vander Laenen, & Vanderplasschen, 2022; Davidson et al., 2021; Fomiatti, Moore, & Fraser, 2018). This study has shown that stigma and recovery experiences are relative to their contexts and take shape across time (pre- and post-migration) and space (country of origin and country of residence). It confirms that, while stigma is a societal and community-related problem that has a major impact on recovery resources and efforts, the answer to this problem is mainly sought inter- and intra-personally (Kadianaki, 2014). As stigma may negatively influence individuals' wellbeing, increase problem substance use and act as a barrier to recovery (capital) (Wang et al., 2010;), it is pivotal, however, that stigma be reduced by prevention and intervention strategies on the macro, meso and micro level (Davidson et al., 2021; Livingston, Milne, Fang, & Amari, 2012).

On the macro level, political and institutional cultures that condemn stigmatizing legislatures as well as practices that watch over people's rights and support marginalized groups to gain recognition are crucial in reducing harmful stigma (Campbell & Deacon, 2006). Governments can also aim to reduce the consequences of stigma (e.g., inequality of resources and power) for vulnerable populations (Cloud & Granfield, 2008; Heijnders & Van Der Meij, 2006). On the meso level, targeted stigma-reducing interventions may tackle cultural, community and organizational beliefs and expectations that are at the core of stigmatizing attitudes (Horyniak et al., 2014; Kulesza, Larimer, & Rao, 2013). Treatment policies

and services should invest in cultural competence, i.e., being responsive to the needs of migrants and ethnic minority individuals, improving their access to high-quality care and reduce outcome disparities (De Kock & Pouille, 2022; Guerrero, Fenwick, & Kong, 2017). On the micro level, stigma was linked to the personal characteristics of participants and their stigmatized status (culture, religion, substance, gender, generation and the visibility of the stigmatized status). This study has confirmed that stigmatized individuals can adopt healthy coping mechanisms and develop personal agency to deal with stigma (Horyniak et al., 2014; Wang et al., 2010). Positive identity construction is a personal mediator of the impact stigma has on recovery (Horyniak et al., 2014; Kadianaki, 2014), and it can be facilitated by self-stigma-reducing therapeutic interventions (e.g., cognitive behavioral therapy and individual counseling) and supported through self-help and advocacy groups (Livingston et al., 2012). While challenged by mechanisms of self-stigma and social exclusion, a recovery-supportive social network can facilitate recovery and mediate the negative impact of stigma on recovery (Walsh, Kolobov, & Harel-Fisch, 2018). Intervention and prevention strategies can therefore focus on the interpersonal environment of those who are stigmatized (Heijnders & Van Der Meij, 2006).

Although several strategies were adopted to reach a diversified sample for this study, many MEM with (a history of) substance use problems still remain unheard. MEM who were not in contact with any of the venues or gatekeepers appealed to as well as those who are hesitant to make themselves known or share their story for fear of being stigmatized are not represented in the current study while it are precisely these groups that have valuable lived experiences in terms of treatment access and stigma. Response and social desirability biases might have occurred due to the sensitive topic and power imbalance in the interviewer-interviewee relationship, especially because the interviewer was a white, middle class and highly educated woman (Bergen & Labonté, 2019; Robinson, 2014). While we applied several methods to overcome researcher, selection and response biases (Pouille et al., 2021), further research can focus even more on minimising potential bias through community member engagement of what are called ‘hidden populations’ (Alvarez et al., 2006; Benoit et al., 2005).

While interviewing a variety of MEM with diverse migration backgrounds and in different stages of the recovery continuum has its advantages (Pouille et al., 2021), a more homogenous sample may give more specific information on stigmatizing experiences among certain subgroups, allowing for the delineation of targeted and tailored stigma interventions (Robinson, 2014). Continued research is required to advance our understanding of how multiple stigmas compound in the lives of stigmatized individuals, how these are mutually related to structural inequalities and how the vicious circle of stigma, problem substance use and build-up of multiple layers of marginalisation among MEM can be broken (Howarth, 2006; Meyers et al., 2021). As stigma plays a central role in creating and perpetuating structural inequalities, as well as impeding recovery, both stigma research and interventions, as well as recovery research and interventions should go beyond the individual level and address macro-social problems and opportunities (De Kock & Pouille, 2022; Howarth, 2006).

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