

Social stigma and perinatal substance use services: Recognizing the power of the good mother ideal

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Abstract:

People who are diagnosed with a substance use disorder can experience stigmatizing interactions with health and social service providers, which may decrease both quality and continuity of care. For women with a substance-exposed pregnancy (SEP), this stigma can increase exponentially. Stigmatizing interactions can be difficult to identify due to social sanctions against expressing stigmatizing attitudes, beliefs, and behaviors and because stigma often resides in accepted cultural norms. Examining discourses around care provision can serve to identify instances of social stigma as well as illuminate the cultural norms in which they are embedded. Using data from a seven-year grounded theory study on perinatal substance use service provision, this paper reports on the perceptions and experiences of service providers working with mothers who have an SEP and illustrates complexities behind stigmatizing patient-provider interactions. Data collected included observations at meetings, workshops, and conferences addressing best practices across the continuum of care for perinatal substance use as well as interviews and focus groups with providers. The construct of “good mothering,” or hegemonic motherhood, was identified as an important cultural norm that supported social stigma and was embedded in providers’ interactions with mothers with an SEP. Discursive elements found in providers’ descriptions of perinatal substance use service work are presented and highlight the role of hegemonic motherhood as a stigmatizing agent.

Keywords: stigma | reproductive health | perinatal substance use | MAT | discourse

Article:

Introduction

The rise in maternal opioid use (Haight et al., 2018; Hand et al., 2017) has increased concern about identifying, connecting, and sustaining healthcare and social services for mothers with substance-exposed pregnancies (SEP) (Martin et al., 2015; Shepard-Banigan et al., 2017). Provider-patient interactions are a critical element for getting women connected to care services and for keeping them engaged throughout pregnancy and the postpartum period (Harvey et al., 2015; Roberts & Nuru-Jeter, 2010; Stengel, 2014; Stone, 2015). Mothers with an SEP report experiences of stigmatization and feeling judged as “bad mothers” by providers (Harvey et al.,

2015; Howard, 2015). Both stigma and fear of prosecution can create significant barriers for women to access services and/or to disclose substance use to their provider (Howard, 2015; Stone, 2015). Best practices promote providing compassionate, family-centered care and using nonjudgmental language (Alexander, 2017; Marcellus, 2014), however barriers to providing this type of care have been underexplored. A deeper understanding of the discourse constructed around perinatal substance use within a care community can illuminate barriers and facilitators to non-stigmatizing interactions. This article examines provider discourse on service provision to mothers with an SEP and grounds the examination in ideological beliefs surrounding motherhood. A better understanding of the provider discourse surrounding SEPs may serve to unveil stigma against mothers with an SEP that lies hidden within service provision and models of best practices, providing opportunities to address these stigmas and improve patient outcomes of engagement with healthcare services.

Literature Review

The following section provides theoretical and conceptual grounding for our study. First, we discuss levels of stigma with an emphasis on how stigma is part of social processes. We then bring together intersections of stigma and perinatal substance use to deepen and specify understandings of stigma. Exploring the literature around provider perceptions of caring for mothers with an SEP allows us to consider how stigma may become embedded in daily practices. Finally, we weave together our theoretical lenses of social constructivism, intersectionality, and critical feminism to situate our work as part of a collaborative interrogation of social location and power.

Stigma Theory

Stigma theory (Goffman, 1963; Link & Phelan, 2001) defines stigma as a culturally bound and context-specific process that functions to identify, distance, and dis-empower people who have or express attributes and characteristics considered undesirable by society. Stigma processes can be categorized by levels of operation. Although terms may differ slightly, most scholars identify three levels of stigma: (1) internalized or self-stigma, (2) social or interpersonal stigma, and (3) structural stigma (Hatzenbuehler, 2017). Processes of self-stigma include the stigmatized being aware of the stigma, agreeing with the stigma, and then applying the stigma to themselves (Sheehan et al., 2017). Social stigma has been defined as how non-stigmatized people react—cognitively, affectively, and behaviorally—to others they perceive as stigmatized (Matthews et al., 2017). These reactions include “interactional discrimination,” a concept similar to microaggressions, where smaller, every-day practices are imbued with and enact social stigma (Sheehan et al., 2017). Structural stigma refers to processes that occur through societal ideologies, policies, institutions, and systems and function as ways to oppress and marginalize the stigmatized.

Social stigma is central to how stigma is conveyed and perpetuated (Bos et al., 2013). Interactional discrimination, often consisting of subtle changes in people’s behaviors when around the stigmatized (Sheehan et al., 2017), occur frequently and can create feelings of shame and self-loathing that comprise self-stigma (Matthews et al., 2017). Visibility becomes an issue as stigma can become harder to identify when it occurs within the course of routine behaviors.

This is especially salient since interactional discrimination does not always manifest negatively. While Link and Phelan (2014) note that “hesitance, uncertainty, [and] superiority” (p. 25) are some behaviors/attitudes associated with stigma, they underscore that “even excessive kindness” (Link & Phelan, 2014, p. 25) can be part of how stigma is conveyed.

These small daily interactions are embedded within institutional practices and policies, demonstrating overlaps between social and structural stigma. Because interactional discrimination is woven into institutional policies and procedures, it may be especially detrimental to provider-patient relationships where stigmatizing cultural norms manifest as medical care (Zescott et al., 2016). In this study, we examine provider discourse as it relates to social stigma, including interactional discrimination, expressed toward pregnant women using substances.

Intersectional Stigma and Perinatal Substance Use

The stigma that surrounds perinatal substance use is not singular but intersectional and consists of multiple overlapping stigmas which can include stigma around addiction, stigma around harm reduction approaches, stigma around drug type; as well as stigma around gender, race, and economic status. Stigma surrounding addiction is considered especially severe (Lloyd, 2013), with some providers not recognizing or accepting a substance use disorder as a mental illness (Olsen & Sharfstein, 2014). Additionally, socio-cultural understandings of substance use differ based on (presumed or actual) reasons for substance use (medical, recreational, dependence) and who is using the substance (age, gender, race, and class differences). Licit drug use is viewed less negatively than illicit drug use and misuse of prescription drugs, while intravenous drug use may be the most stigmatized (Kulesza et al., 2014). Even substances used as a part of a treatment protocol (e.g.: medication-assisted treatment or MAT) are stigmatized, with a particular level of stigma reserved specifically for methadone users (Earnshaw et al., 2013).

While all genders are subject to the stigmatization that surrounds substance use, stigma against women is especially fierce as it is associated with deviant sexual morals and inadequate mothering (Bjønness, 2015; Ettorre, 2015). Stringent societal beliefs around mothering, or hegemonic motherhood, idealize the role of traditional heteronormative, white, middle-class mothering as a “good” mother and prescribe norms of maternal sacrifice, particularly around caring for children (Arendell, 2000; Hays, 1996). More recent manifestations of hegemonic motherhood extend the realm of mothers’ intensive practices to developing engaged and authentic relationships with their child(ren) (Martin, 2019). The dominance of these norms makes the use of any substance, unless considered necessary for the health of the fetus, subject to scrutiny (Lupton, 2012). Pregnant women diagnosed with substance-use disorders risk being “viewed as lethal fetal containers” and their ability to care for their child, physically, socially, and emotionally, once it is born is frequently called into question (Ettorre, 2015, p. 796).

The intensity of stigma against mothers with an SEP differs by race and class, with harsher condemnation targeted toward low-income mothers and mothers of color (Bridges, 2020; Kennedy-Hendricks et al., 2016). Several authors have noted differential media-perpetuated narratives by race and class, with substance use by middle-class, white mothers conveyed sympathetically while poor mothers and mothers of color are demonized (Daniels et

al., 2018; Hansen, 2017). Studies have also demonstrated disparities in screening and reporting of prenatal substance use by race, with one study finding Black infants were four times more likely to be reported to child welfare services (Kerker et al., 2006; Roberts & Nuru-Jeter, 2012). Terplan and colleagues (2015) assert women of color with an SEP are more likely to be prosecuted and incarcerated. Others have portrayed a more complex relationship between race and prosecution in response to the opioid epidemic, attributing the increase in prosecution of white women to the “double-edged sword” of white privilege (Bridges, 2020, p. 771). The juxtaposition of these negotiations contributes to the invisible discourse around the anomaly of hegemonic motherhood infringed upon women of color that increases their subjection to stigmatized surveillance and experience with an SEP (Amnesty International, 2017).

Moderators of stigma

Stigma is moderated by several factors which affect the intensity of the stigma response, including responsibility, controllability, and fear (Sheehan et al., 2017). Responsibility and controllability speak to the degree the stigmatized person is held responsible for having the attribute/behavior and their ability to control it. In perinatal substance use, these moderators are embedded in hegemonic norms of women’s “reproductive citizenship” (Stengel, 2014, p. 37). Women are held responsible for all aspects of reproduction, including both getting pregnant and protecting the fetus once pregnant (Lupton, 2012). If a woman is pregnant, she is held responsible for controlling any drug use that could be harmful to the fetus. If a woman has been using substances (licitly or illicitly) and discovers she is pregnant, she is held responsible for discontinuing the substance once the pregnancy is known and is sometimes further judged for substance use that occurred before she is aware of the pregnancy (Stengel, 2014). Even if a woman is medically required to receive a drug that can negatively impact a fetus, she is often held responsible for putting her fetus at risk (Whittaker et al., 2019). In short, women are expected to control and calibrate their behaviors to ensure fetal wellbeing even above their own. These societal expectations leave no room for the realities of a substance-exposed pregnancy. For example, pregnancy cannot always be controlled, and a substance use disorder is defined as an inability to control drug use. Likewise, these expectations eclipse the desires and rights of women who require medication, such as MAT, to reproduce. The privileging of fetal protection as the ultimate maternal prerogative illustrates the way that stigma hides within social norms and how it can impact provision of healthcare.

Fear, another moderator of stigma, focuses on the degree to which the stigmatized group is perceived as dangerous to a person’s well-being (Sheehan et al., 2017). For perinatal substance use that fear is expressed as a danger to the fetus and subsequent child. Fear about fetal wellbeing (Stone, 2015) intensifies stigma, as does anticipatory fear of the mother’s ability to care for and engage with the infant once it is born. In the United States, this fear is reflected in the widespread use of punitive, rather than supportive, policies (Thomas et al., 2018). Currently, 23 states have a policy where using/misusing substances during pregnancy is considered a form of child abuse and 25 states require mandated reports of suspected prenatal substance use (Gutmacher Institute, 2020). Even when states have supportive policies, they are more likely to require mandatory warning signs, which may increase social stigma, than to provide priority treatment for women (Thomas et al., 2018).

Provider Perceptions of Perinatal Substance Use

There is a robust literature on how mothers with an SEP experience stigma when interacting with healthcare and social service providers (Atwood et al., 2016; Harvey et al., 2015; Howard, 2015; Martin, 2019; Stengel, 2014; Stone, 2015; valentine et al., 2019). Fewer studies focus on / include provider perspectives on working with mothers with an SEP. Studies that do cover this perspective suggest providers perceive mothers with an SEP as challenging to work with (Shaw et al., 2016) and that they present an increased “burden of care” (Whittaker et al., 2016, p. e72). Providers have also described feelings of resentment, frustration, and anger when caring for families with a child exhibiting symptoms of withdrawal (Maguire et al., 2012; Murphy-Oikonen et al., 2010; Romisher et al., 2018).

Provider-focused studies highlight the strong concerns providers hold regarding child safety and their perceptions of mothers with an SEP as “risky” (Fraser et al., 2007; Maguire et al., 2012; Murphy-Oikonen et al., 2010; Shaw et al., 2016, Whittaker et al., 2019). When met with resistance from women with an SEP, healthcare providers have expressed difficulty in carrying out their professional obligations (Heimdahl, 2018). These tensions can impair healthcare and other service providers’ ability to separate their emotions from decision-making in treatment to meet the needs of women with an SEP (Heimdahl, 2018; Miles et al., 2014). While many providers report empathy for mothers and understand the complexity of their situation, they still struggle with their own biases and judgmental thoughts (Benoit et al., 2014; Geraghty et al., 2019). This demonstrates both the normative aspect of bias against mothers who use substances and the ability for providers to hold both empathetic and judgmental perspectives simultaneously. These biases can lead to interactional discrimination during provider-patient interactions (Cleveland et al., 2016; Harvey et al., 2015). However, they can also present a pathway for provider growth and development. In one study, midwives who embodied compassion and respect for mothers with an SEP reported their perceptions evolved as part of a continuous process as they come to understand the complexities of their patients’ lives (Miles et al., 2014).

Studies that detail provider perspectives also highlight structural and systematic issues, such as time constraints, funding, workloads, and the lack of cross-training between reproductive health and addiction medicine as barriers to effective care delivery (Fraser et al., 2007; Geraghty et al., 2019; MacAfee et al., 2020; Shaw et al., 2016; Syversten et al., 2018; Whittaker et al., 2016). These structural level concerns are also significant drivers of providers’ frustration and can contribute to difficulties in providing compassionate care (Sweigart, 2017). Caregiving and provider-patient interactions occur within specific sociocultural and organizational contexts. Because stigma is embedded in overarching sociocultural practices (Bischoping & Gazso, 2016), stigmatized caregiving is embedded in and constructed by healthcare practices’ guiding principles and clinical best practices. However, the natural tendency of discursive practice is to remain hidden, where it often goes unrecognized by individuals and operates covertly (Mogashoa, 2014). Since non-stigmatizing interactions are critical to care engagement, it is important to examine discourses that seep into the construction of professional care and best practices in perinatal substance use.

Theoretical Perspectives

The aim of the study was to understand how a broad-spectrum of healthcare and social services providers made meaning about the provision of care practices to mothers with an SEP. We were particularly interested in rhetorical devices used that suggest avenues by which social stigma can become embedded in provider-patient interactions and thus paid particular attention to how providers described and discussed their work. Social constructivism is a perspective that posits personal truth as being situated within a social narrative. This narrative is specific to cultural and historical context and is where people make meaning of their experiences (Amineh & Asl, 2015). Utilizing tenets of social constructivism, and a discursive analytic approach, data were examined through the assumption that perceptions of reality are shaped by the socially accepted norms created by and within a group (Amineh & Asl, 2015). The lens of social constructivism allowed us to view the data as a microcosm of cultural norms, specifically the microcosm of maternal/child healthcare and support professionals.

The study also applied intersectional (Bowleg, 2012) and critical feminist (Gangeness & Yurkovich, 2006) lenses to understand how perinatal substance use care practices were constructed. Intersectionality posits that a person's identities, social locations, and social positions cannot be understood simply as a combination of individual variables but instead are intertwined and transactional (Collins, 2015). These intersections, which often include socioeconomic status, race, and gender both create and are created by social inequalities. A central tenet of intersectionality is the recognition of the inequitable distribution of power which manifests as oppression both structurally (e.g. differential policies) and individually (e.g. differential experiences) (Bowleg, 2012). Research that employs an intersectional lens usually has an element of activism—a desire to illuminate inequalities as part of their elimination (Collins, 2015). The present study recognizes the foundational intersections of race, class, and gender and also offers illicit drug use and the addiction treatment continuum as additional key intersections that influence (and are influenced by) care provision for mothers with an SEP.

Like intersectionality, critical feminism recognizes oppression as the result of inequitable distributions of power. Critical feminism suggests that gender is socially constructed and cannot be separated from the social contexts within which it occurs (Rhode, 1989). Because of its emphasis on social construction, critical feminism underscores the importance of human experience and perspectives as a central component of knowledge (Gangeness & Yurkovich, 2006). Research that uses a critical feminist lens focuses on how people's experiences, interpretations, and contexts interact in meaningful ways particularly around gender. Taken together, intersectionality and critical feminism ground our study in the acknowledgment that social locations are inseparable, that social construction is central to our behaviors and our interpretations, and that individual experiences and perspectives are key to understanding the hows and whys of our world.

Methods

Study Context and Design

During the life of the study, North Carolina was experiencing a dramatic increase in neonatal abstinence syndrome [NAS], that was affecting multiple healthcare and social service

organizations (HCUP Fast Stats, 2019). North Carolina is located in the southern part of the United States, which has higher incidences of maternal opioid use and is the region least likely to offer the gold standard practice of MAT (Hand et al., 2017). The state is a member of the “bible belt,” has enacted conservative policies, such as refusing the expansion of Medicaid (Taylor et al., 2019), and is geographically surrounded by states that have a history of prosecuting women for using substances while pregnant (Amnesty International, 2017; Bridges, 2020). In spite of this, North Carolina has had a progressive response to the opioid epidemic generally (Kasanga & Cohen, 2018), and to the issue of maternal opioid use specifically (Nichols & Gringle, 2020).

Data presented in this paper are derived from a larger grounded theory study designed to understand how care is provided to mothers with an SEP. The first author served on a community advisory committee addressing perinatal substance use care provision that generated the need for the larger study. The advisory group, along with other coalitions across the state, educated themselves and others on best practices in caring for mothers with an SEP. Although the study addressed substance use broadly, maternal opioid use became a central focus of these educational practices given the rise in opioid use nationally and regionally (Haight et al., 2018). The study captured provider perspectives, explanations, and interactions over a 7-year period that were central to how ideals of care and best practices were constructed within the state.

Situational analyses (Clarke et al., 2018), conducted as part of the larger grounded theory study, identified stigma as a critical contextual construct of perinatal substance use service provision. The relationship between perinatal substance use and stigma’s influence on service provision warranted further examination. Therefore, this paper reports on additional analyses conducted to examine the role of stigma in the construction of care practices by service providers. Discursive analysis provided a pathway to investigate how the expressions of the participants functioned within the microcosm of the professional group norms (Bischoping & Gazso, 2016; Mogashoa, 2014). In that way, a particular expression of a participant or audience member is not being used to represent a specific attitude or belief, but rather the analysis is looking at how a community constructed meanings of care provision. Therefore, results describe the active social construction of service provision to mothers with an SEP through a discursive analysis of interactions of the healthcare providers and support professionals, including interprofessional meetings and conferences. The authors’ Institutional Review Board approved the study. Pseudonyms were used for participants and observational settings.

Recruitment and Sampling

The advisory committee was the initial starting point for recruiting healthcare and social service professionals for interviews as well as conducting observations of how care was constructed in committee meetings. Theoretical sampling, as per the grounded theory design, occurred throughout the study. As maternal opioid use became central to the committee discussions, participant recruitment focused on professionals with experience in the topic. This included a focus group with a multidisciplinary clinic providing opioid treatment services. Likewise, recommendations for practice-focused conferences and workshops on maternal opioid use resulted in observations conducted at these events, providing rich opportunities for understanding professionals’ experiences and perspectives. Information gleaned from events led us to a more robust search of publicly available documents related to contextual elements of the topic. As data

collection and analysis progressed, preliminary findings were presented in focus groups that included a combination of new and former participants. Focus groups were conducted to deepen our understanding of how care was constructed over time.

The majority of interview and focus group participants identified their race/ethnicity as Caucasian. Other participants identified as African American, Black, or Human. Participants were predominantly female, ages ranged from 25 to 73, almost all had an advanced degree, and the number of years they had worked in the field ranged from 2 to 40 with an average of 16 years. Demographic characteristics could not be collected at observational events. However, presenters represented a variety of professional categories including academic researchers, clinical researchers, advocates, program directors, and front-line professionals. Disciplines included social work, nursing, neonatology, obstetrics, addiction medicine, and child welfare services. There was also no information provided on the backgrounds of participants at the events, but flyers and other announcements targeted nurses, professionals working in NICUs, social workers, counselors, case managers, and law enforcement professionals.

Data Collection

Data collection lasted 7 years (November 2011 through October 2018). Extensive field notes, taken from observations conducted at committee meetings, planning meetings, conferences, and workshops, comprise the majority of data collection. Field notes focused on sharing of information, participants' questions, any actions proposed and/or taken, along with identified issues that affected the population. Documents were collected during observations and included attendance sheets, informational handouts/slides, meeting minutes, and shared notices/emails. Publicly available documents collected included reports on regional initiatives, newspaper articles, blog posts, and policy documents on maternal substance use and the growing national opioid epidemic.

In addition, nine in-depth interviews and four focus groups were conducted with providers who worked with pregnant mothers with an SEP. Guided interviews were used to query participants on experiences working with the population, challenges they faced providing services, and descriptions of their work coordinating services with other agencies. One focus group used a similar format to better understand service provision within a specific institution. The remaining focus groups were conducted toward the end of the data collection period. Preliminary findings were presented to elicit providers' perceptions of initial interpretations and explore the relevance of presented findings to providers' own work. Interviews and focus groups were audiotaped and transcribed verbatim. The average length of an interview was 45 minutes and 90 minutes for focus groups.

Analysis

Analysis began with data immersion, consisting of reading and rereading of transcripts, field notes, and documents. Memos were written to capture initial reactions and any critical issues identified. Open coding, conducted with field notes and transcripts, led to a developed codebook used for focused coding. Simultaneously with the coding process, situational analysis (Clarke et al., 2018) techniques, specifically situational and social arena mapping, was used to identify and

integrate contextual issues relevant to the topic. Memos were written throughout, including memos documenting the analysis process, identifying and exploring contextual issues as they emerged, and examining relationships between situational elements.

This analytic process identified stigma as a critical contextual construct. Additional analyses, conducted for the findings reported here, included a re-immersion into a subset of the coded data. Because interactional discrimination often remains hidden, it was especially important to examine rhetorical devices, such as the words chosen by participants and examples provided in presentations and discussions. Each author completed independent readings and shared memos detailing different components of stigma identified within the data. The group met bi-monthly to share and discuss their findings. Discussions evolved beyond simple reporting and consensus-building to shared meaning-making and reflexive practices.

Reflexivity was done through authors writing and then sharing reflexive memos that captured their positions vis a vis the data. The group shared important similarities, such as gender identity, but also included diversity in terms of academic discipline and position as well race and class backgrounds. Two members of the group were mothers of young children and one member was a provider who had worked with mothers experiencing an SEP. These memos and positionalities were then revisited during analytic discussions. Meetings often produced diagrams that were preserved along with written notes and audio recordings of the discussion. The original data was revisited to ensure themes and interpretations were grounded in and supported by the data. Social constructivism holds that research is not a neutral act and that findings are co-constructed through deep engagement with the data (Creswell, 2018). Our reflexive practices and consensus building allowed space for researcher reaction while also ensuring that no single opinion or reaction could change the direction and/or content of our findings.

Limitations

It is important to note several limitations embedded within the study design. Since the sampling procedures originated in an advisory committee convened to advocate for the population and observations occurred at conferences and workshops that were geared toward providers who were already invested in working with mothers with an SEP, the study represents voices of individuals who are predisposed to see the population as deserving help. Therefore, findings are likely to underrepresent what occurs more generally in healthcare and social services. We were also unable to determine the demographic and professional backgrounds of study participants during observations. Instead we had to rely on disclosures made during study activities as well as descriptions of the audiences targeted to attend. Further, voices and experiences of mothers are not represented in this study nor were provider-patient interactions observed. Future research should examine differences in provider and maternal perceptions and experiences of social stigma as well as include observations of interactional discrimination.

Findings and Discussion

In the following section we present evidence and discuss our interpretation of the data as they relate to five prominent themes: best practices, stigma hiding as judgment, interactional discrimination, stigma and mothering ability, and intersectional stigma. Each one of these themes

is at once distinct and interconnected. Taken together findings offer a sense of the ubiquity and also the invisibility of stigma that arises from and impacts caring for mothers with an SEP. The cohesive presentation of these findings displays examples of where stigma lives and breathes in perinatal clinical and support settings, leading the way forward to address clinical implications to improve care practices and impact outcomes for families. We then discuss implications for practice and future research.

Best Practices

Findings illuminated the degree to which stigma is embedded in societal norms and everyday institutional practices. This may be most apparent in the observational data, which represents the construction of best practices in perinatal substance use through educational presentations as well as provider dialogue that occurred during these events. Presentations grounded evidence in a combination of research, practical experiences, and clinical expertise. Anecdotal examples were presented, and, at times, stigmatizing language was used. In the quote below, a frontline provider presenting at a training workshop describes an activity she used with clients in which she directly associated people diagnosed with a substance use disorder with lying and stealing:

She got up to draw another picture. This included a car and some stick people, three curved lines and some houses on the other side. She said she does this for her clients. The car and people are called “Liarsville,” the three lines are “Methadone Mountain” (at different dosages), and the houses are “Pleasantville.” She explained that addicts are liars (and thieves) and will do anything to get their drugs. (Training Workshop)

The choice of examples and the use of stigmatizing language among a group of providers who were actively advocating for quality care provision demonstrates the degree to which stigma is woven into best practices. Audience responses also demonstrated that providers were fairly comfortable sharing stigmatizing beliefs toward substance use. A conference activity brought forth some of the stigmatized views attendees held:

She asked us to call out our first thoughts about alcoholics and drug addicts. “Don’t think about it, just call it out...what do you think?” The audience called out the following words: low self-esteem, lowlife (as [presenter] was writing this word down she paused and laughed while she said “Wow, I didn’t think you were gonna be that honest!”), abuse, sloppy, manipulative, selfish. (Educational Conference)

Providers also appeared to endorse the stigmatized hierarchy of substance use, in which illicit use is more stigmatized than licit use. Conference presenters frequently mentioned that not all perinatal substance use can be attributed to a substance use disorder often underscoring the use of opioids for chronic pain (“*a lot of women are coming out of pain clinics and have been doing exactly what their doctors told them*”). While this may have been an attempt to lessen the “judgment” faced by mothers with an SEP, this messaging also implicitly stigmatized mothers diagnosed with a substance use disorder and those misusing prescription medications. Additional implications of this type of messaging can be found in a provider’s description of opioid use attribution as a “running joke” with a colleague:

Once we started getting it more often, we're like, we're saying "well why they on it?" It became not the running joke but "Ok must have been a motor vehicle accident. Must have been from back pain." And then they started taking all these pain pills and got addicted. (Lisa)

This type of sarcasm can reinforce the stigmatized belief that people who use substances are liars as well as promote hierarchies among substances used. The embedding of these beliefs in everyday banter among colleagues could provide a pathway for social stigma to shape provider-patient interactions. Sharing and critiquing patient stories among coworkers can influence norms of acceptable behavior as well as reinforce bias against mothers with an SEP, which can negatively influence provider care, including the development of a trusting relationship (Welborn, 2020).

Stigma Hiding as Judgment

Social stigma also appeared in provider language particularly within examples of real and/or hypothetical care provision. Overarching societal norms and more specific professional norms contributed to concealing/normalizing stigmatized views about mothers with an SEP. One example is the word "judgment," which providers used when describing their perceptions, beliefs, and behaviors. The meaning of judgment was flexible, sometimes used as a kind of stand-in for stigma; sometimes as a way to illustrate professional assessment. Below, a provider discussed her perspective by recounting and expanding upon a story shared by a mother during a presentation.

...there's a lot of judgment, unfortunately, in the hospital. I think it's gotten A LOT better but remember [mother] saying she was so exhausted? And people were accusing her of being high? And, you know, sometimes the parents are. So, it's a hard, it's a very hard call. And the nurses, honestly, I can understand how they feel. They're responsible for the life of that child, when that child's there and, so they do have to kind of judge everybody—are they, can they take this baby home and take care of it? (Janet)

In this quote, the term "judgment" was used with both a negative and neutral connotation. Initially, the term represented a stigmatizing behavior "*there's a lot of judgment.*" Later, it is used with a neutral connotation, describing clinical assessment.

Another discursive strategy that concealed stigma was locating judgment within mothers' perceptions instead of providers' behavior. When describing interactions with mothers, providers emphasized the actions of mothers ("*mothers watch for judgment*") instead of the actions of providers. This emphasis shifted the responsibility for engaging in stereotypes from provider to patient: "*Women expect you to look at them funny, to talk down to them, so we need to work on ourselves as professionals and reduce the stereotypes they have of us.*" Some providers also expressed difficulty distinguishing the origins of judgment. It was hard for them to parse when judgment was originating with the provider and when it was originating with or anticipated by the mother. Elizabeth explains the tangled sources of judgment around mothers with an SEP.

It really just goes back to they have a new baby and helping them not to feel judged, which most of them tell me they do and I don't know if it's just their perceptions that they're going to be judged and therefore they feel judged or if things are really happening in the surroundings where they are being judged. (Elizabeth)

Field notes from a conference designed to share best practices captured a provider's perspective that judgment arises from a combination of mothers' perceptions and providers' behaviors:

She said the women she works with perceive judgment from the nursing staff. She said it might be a combination of being "thin skinned" (because they are often judged) and some nurses being not as kind to these mothers as they are to other mothers. (Dissemination Conference)

Presenting stigma as judgment and emphasizing judgment as a perception rather than a reality conceals the impact of stigma and allows it to become more accepted (and acceptable) within the social environment of healthcare. In the quote above, stigma was downgraded twice; once by substituting the term "judgment" and again when stigma was veiled by the phrase "not as kind." It is also important to note that providers' hold a privileged position, which allows them to consider distinctions between real and perceived stigma/judgment. For mothers with an SEP, perception is reality. In this way, questioning mothers' perceptions can become a form of stigmatizing power (Link & Phelan, 2014), which can lead to keeping mothers away from accessing care services.

The extent to which clinical judgments are biased by moral beliefs is unclear but acknowledging that they are not the same is necessary to uncover and visualize stigma within healthcare practices. Questions remain about why providers used the word "judgment" instead of the word stigma. It is possible that "judgment" was used because of discomfort with the conceptualization/label of stigma. Presenters may have used "judgment" or focused on mothers' perceptions of being judged to acquire "buy-in" from an audience of providers. While labeling providers as "stigmatizers" might create additional resistance, not directly naming stigma may facilitate its continued presence within care provision and further embed it within best care practices. Future work should address this issue.

Interactional Discrimination

Through anecdotes used during presentations and providers' descriptions of their work practices, the data highlight instances of interactional discrimination and providers' struggles with reconciling their beliefs, assumptions, and emotions. Many provider interactions with mothers with an SEP occur within the neonatal intensive care unit (NICU), where infants experiencing symptoms of withdrawal receive care, making NICUs frequent sites of interactional discrimination. In the field note below, a presenter discussed how NICU nurses described treating mothers and assumptions they made when infants presented with symptoms of withdrawal:

She said the nurses were very insightful and said that they ignore the mother when she comes in. They told her that they don't greet her when she comes in. They assume she

won't take care of the baby. They don't make an effort to share information on baby or give her the information she needs to care for the baby. They assume if she didn't come it was because she was a bad mother or didn't care. She said the exercise showed them how angry and judgmental they were and how it affects their professional work with the mothers (Opioid Workshop)

While some providers may explicitly express anger at and endorse moral judgment against mothers with an SEP, most of the participants described conflicting feelings. In the excerpt below, a provider grapples with her sense that mothers with an SEP warrant care despite their use of "evil" substances:

It's encouraging to me to see that there are a lot of people out there who...are nonjudgmental and really wanting to advocate for these patients because you know that's what I want to do. I want to treat them as a human being, not look at them as evil because they use substances. I understand that substances are evil, and nobody wakes up one morning and says, "I think I'll be a drug user." (Elizabeth)

By using the phrase *wants to treat them as human* the provider (perhaps unwittingly) implied the default is to see mothers with an SEP as nonhuman. Even as she clarified that it is substances themselves and not the people who use them that she considers "evil," this language underscores the sense that substance use is not only abnormal, but some aspects are also immoral. The imposition of moral values can lead to interactional discrimination based upon feelings of superiority.

Field notes from an opioid workshop highlight another example of how providers may struggle with norms, morals, and feelings of superiority when working with mothers with an SEP. In this excerpt, a provider's pregnancy created tension in her care provision:

She mentioned a psychiatrist they had at [treatment center] who had to stop seeing patients for a while when she herself was pregnant. She had too many conflicting feelings about how careful she was being about what she put in her body and what these women were doing. She recognized that she wasn't helping them and might be hurting them. So, she took some time off and then went back to it. (Opioid Workshop)

At the workshop, this story was shared to emphasize the importance of self-awareness when working with mothers with an SEP. It also demonstrates some of the difficulties providers may experience around hegemonic mothering norms, which are central to the negative characterization of mothers who use substances in pregnancy. The provider struggled because she sensed that she was protecting her unborn child and that the mothers she was caring for were not. These findings are supported by previous studies detailing the co-location of empathy and understanding with negative and stereotypical attributes in providers' perceptions of mothers with an SEP (Benoit et al., 2014; Geraghty et al., 2019).

Interactional discrimination can also manifest as hesitancy, uncertainty, and/or being overly kind (Link & Phelan, 2014) and we found evidence of these forms of social stigma in the data.

Providers' focus on "judgment" over stigma often left them grappling with how best to provide care. Below a provider describes her initial hesitancy in approaching mothers with an SEP:

Honestly, I was fearful when I started seeing that population not because I was afraid of...I didn't want to say the wrong thing. Or I didn't want them to, in the beginning honestly, I didn't want them to feel, I know they ARE very judged, a lot of times,...um they're very judged and I didn't want them to feel like I was judging them or prying them. So, in the beginning I kind of kept my distance. (Janet)

Another provider described anxiety over the possibility that mothers would feel judged by her simply because she offered services. She perceived their eligibility for services being based on drug use could elicit feelings of judgment and shame.

I don't want them to feel judged and so I think that maybe they're like "well you know are you offering this to me just because my baby's going through withdrawal" (Nina)

Concerns that eligibility requirements alone can create feelings of being "judged" by recipients of services create discomfort in the act of offering services, which represent the initial interactions between provider and patient. This discomfort, and potential hesitancy, can create feelings of distance and "otherness" found in interactional discrimination (Sheehan et al., 2017), which can then increase barriers for mothers with an SEP to engage in needed services.

Stigma and Mothering Ability

In addition to exploring the ways stigma can impact and occur within provider-patient interactions, this work also offers insight into the influence and force of hegemonic motherhood within this arena. Judgments around women's ability to mother were central to providers' clinical decision-making, their beliefs and behaviors, and to the meanings they made of mothers' emotions and experiences. The primary emotions attributed to mothers with an SEP were guilt and shame. Providers perceived these emotions as being grounded in mothers' actions; what they "did to" their children, either while pregnant or parenting.

A lot of those parents that are referred to us it is because of substance abuse. And so, it's getting past the shame and the guilt, that that I did this. I caused this [as] a result of my addiction. Surely, I'm not worthy of parenting. (Lola)

Guilt and shame occupied a complicated space within the care provision discourse. There was both an expectation these emotions would be present and a recognition that they can interfere with receiving care. In the example below, a provider explained potential negative outcomes from experiencing shame, or "non-helpful" guilt.

They experience significant guilt and shame. Often, they can't believe they've used for so long. Most don't come in until month 5, 6, 7 of their pregnancy. Guilt and shame can put them at risk for relapse. There is helpful guilt and non-helpful guilt. (Educational Conference)

Though shame and guilt carry different meanings, providers often used them interchangeably. In a recent study on parenting practices and drug use parents reported feelings of guilt but not shame (valentine et al., 2019). This calls into question how assumptions of shame are tied to stigmatizing attitudes. In the quote below, a provider both accepts guilt and shame as normal responses while also suggesting they may be embedded in the provision of care:

Why did she come out of that experience with that feeling? Although that's the base feeling of almost all the women that I dealt with, was the shame and the guilt. But I don't know. Did she not get that positive reinforcement that she needed? or was she getting it and not hearing it? I don't know, but that's obviously critical in providing services.
(Kevin)

While these emotions were situated as a natural consequence for what was perceived as mothers' negative actions, providers also felt guilt and shame needed to be "worked through" in order to achieve ideals of good mothering. In the excerpt below, a provider describes how moving forward is necessary to effectively parent:

...but a lot of guilt, a lot of shame and processing that shame and helping them kind of unload a little bit so that they can move forward, I mean, it doesn't even matter if it is their fault, it's DONE! We've got to move on, we got kids to raise now. But just getting past that far enough that they can actually get to the work of raising the kids sometimes is challenge (Provider Focus Group)

Presenters and audience members provided examples of "bad mothering" during presentations and in conversations, demonstrated in the following field note:

She also gave an example of a mom whose greatest shame was her son going through a glass door while she was high, and she didn't take him to ER for 2 days because of fear they would take him away. The shame was overwhelming but need to focus her on what she's going to do about it now. There are some things you can't change (like FAS) but what can you do to be the best mom now. (Opioid Workshop)

These examples were generally historicized and/or portrayed as events that could be overcome as women became better mothers. However, these kinds of stories also entrenched the narrative of people who use substances as bad mothers. These narratives were further solidified by the use of hypothetical examples during discussions. A question from an audience member in a lecture on marijuana use in pregnancy asked if "*Mom's blowing pot smoke in baby's face. Is this bad for brain development or just lung development?*" At the same lecture another audience member suggested that bad mothering was intergenerational, claiming: "*It's not just tobacco. You have a 15-year-old pregnant mom smoking pot and her 32-year-old mother is smoking with her.*" These anecdotes, assumptions and analogies both arise from and solidify beliefs that substance use is synonymous with "bad" mothering.

Providers expressed a need to endorse examples of "good mothering" with their clients. They frequently mentioned praising mothers for various behaviors—such as visiting their infant in the NICU—in an attempt to help mothers commit to care provision and sometimes to suggest that

“good” care-seeking behaviors were part of becoming a “good” mother. Examples were often tied to recovery-based behaviors, which reinforced treatment as a redemptive act on the path to “good mothering:”

Letting them know that parenting is hard but that they can do it. Look at how much they’ve done already for their baby to get into treatment for their baby and that baby depends on them and that...they can do it. (Janet)

Maternal love was also discussed as a potentially redemptive factor. Providers frequently noted that mothers who used substances loved their children as expressed below:

I think that all women who have issues with substances, they love their children. I don’t think any of them will hurt their children...So, I think a lot of them are remorseful but in denial. But I don’t believe for one second they will intentionally hurt their children (Lisa)

Providers used mother’s love for their children as a means to get them into substance use treatment. Sometimes coercive approaches—often centering on the threat of custody loss—were promoted (“*She said that DSS is one of the best ways to get women into treatment. They will go someplace that they are scared of just to keep their baby.*”).

Substance use during pregnancy violates a key tenet of hegemonic motherhood and thus mothers with an SEP are marked as “bad” mothers (Ettorre, 2015). As others have found (Benoit et al., 2014), this violation appears to intensify anger and frustration expressed toward mothers with an SEP. Our findings illuminate the complexity of hegemonic mothering ideals within provider discourse. Providers expressed judgment of actions they perceived to be “bad mothering” while promoting actions of idealized motherhood. The presentation of good mothering coupled with recovery work as a redemptive process may be effective for getting women into treatment, but it does not help dismantle stigma.

Here we argue the invisibility of the good mothering discourse in service provision, particularly the extent to which it is used as a both condemnation and (often coercive) support, is problematic. Ultimately a focus on hegemonic motherhood ideals serves to distance mothers with an SEP from other mothers and from their providers. Yet the imposition of an idealized motherhood goes unquestioned in practice. Pregnancy makes a woman’s role as a mother visible. Her use of substances, however, can remain invisible unless she chooses to reveal it to her healthcare provider. In this study, good mothering was at once hyper-visible: mothers who used substances violated hegemonic standards, and invisible—providers did not see the ways the archetype of good mothering informs and affects treatment of mothers with an SEP. Therefore, “good mothering” functioned as a mostly invisible agent of stigma.

Intersectional Stigma

As described above, the intersection of gender, particularly dominant norms of motherhood, and substance use were evident in the data. Likewise, providers acceptance of harm reduction practices, like MAT, was variable. Presentations on the history and science of MAT options often evoked side conversations among participants who believed it was “*treating drug addiction*

with another drug.” Data from interviews and focus groups also revealed a mixture of endorsement, ambivalence, and distrust of MAT. One provider’s statement against methadone (*“I’m going to say what I have to say anyway, but I struggle with every single pregnant woman being put on methadone. I just struggle with that”*) elicited a heated discussion of harm reduction practices among the group. While at least one participant defended the appropriateness of MAT in certain cases, the discussion ended with consensus on *“the shadow side”* of methadone. Provider bias against the use of MAT for pregnant women has been documented in the literature (Earnshaw et al., 2013) and may be particularly evident in the addiction treatment arena (Novotna et al., 2013).

Intersectional differences based on race/ethnicity and class did not surface as a stated concern of providers. There were several allusions to bias in screening for drug use (*“some people get tested and some people don’t”*) but specific discussions of race and class were primarily absent in the data. Some differences in class (*not upper-class middle-class families for the most part I would say. So that is an issue I would say*) and geographic location, such as urban and rural areas, were presented yet race was rarely mentioned in conference discussions. This absence within the discussion of care provision was notable due to the complex history of race and class disparities in how perinatal substance use has been treated (Bridges, 2020).

The demographic profile of women who use substances has shifted from primarily Black women in urban areas to white women in suburban and rural areas (Jumah, 2016; Lester et al., 2004). Public narratives around maternal opioid use focus on substance use as a disease and women’s vulnerability, which is in direct contrast to the demonization of Black mothers that occurred in response to the “crack epidemic” of the 1980’s (Daniels et al., 2018; Hansen, 2017). References to media representations of “crack babies” did occur in presentations but were not tied to the race of mothers. This silence allowed providers to address maternal opioid use from a “race blind” perspective and further reinforce hegemonic ideals of white middle-class motherhood. Since race and class disparities exist in the enforcement of punitive policies (Amnesty International, 2017; Kerker et al., 2006; Roberts & Nuru-Jeter, 2012), it is imperative to bring these discussions to the forefront. Future studies should directly assess intersections of race/ethnicity and class in stigma responses to perinatal substance use.

Conclusion

Findings from this study suggest implications for practice and future research. Clinical implications include the use of reflective practices to identify instances of interactional discrimination as well as illuminate the role of hegemonic motherhood in care provision. In order to decrease stigma and humanize the client, we need to acknowledge how the good mothering ideal permeates interactions with and around mothers. Self-reflection and more formal reflective practice are effective tools for providers to increase self-awareness and may decrease one’s culturally influenced natural tendency to negatively judge mothers with an SEP (Donaldson et al., 2016). Investigating one’s own values around good mothering may offer a new evaluative lens for provider practice and help caregivers lean into and improve provider-client interactions. This exploration allows space for providers to explicitly and thoughtfully consider how their approach to caring for mothers with an SEP affects their clients’ engagement in their own care as well as their expectations and experiences of caring for a newborn.

Compassionate and unbiased care cannot occur, however, in the absence of structural support (Crawford et al., 2014). Going forward, we need research that examines institutional practices and policies across systems of care that support interactional discrimination and create barriers to providing unbiased and compassionate care. We need to identify critical leverage points for creating conditions for both reflective practice and compassionate care. With those conditions in place, we can work toward care provision that identifies mothers' strengths and challenges outside of the good mothering ideal and helps them develop non-coercive, collaborative, and individualized goals.

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