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Exploring the Relationship Between Self-Stigma and Mental Health Among People with Substance Use Disorder

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ABSTRACT

This study aims to find out the relationship between self stigma and mental health outcomes (depression and anxiety) among substance use disorder (SUD) people in Peshawar, Pakistan. The purpose was to examine how self stigma influences psychological well being and to investigate a mediating role of social support. A total of 150 participants receiving treatment at public and private rehabilitation centers were surveyed using validated self-report instruments: Self-Stigma of Seeking Help Scale (SSSHS), Patient Health Questionnaire-9 (PHQ-9), Generalized Anxiety Disorder-7 (GAD-7) and Multidimensional Scale of Perceived Social Support (MSPSS). The analyses indicate that there is significant positive correlation between depression and anxiety with self stigmatization. Additionally, social support was causally related to the effects self stigma has on mental health outcomes, in a way that partially mediates this relationship, lending partial support to the buffering hypothesis. The results highlight the importance of self stigma and social support in contributing to mental health outcomes of SUD and reduce psychological distress of stigma. The paper makes the point that stigmatization reduction interventions and strong social systems of support need to be built in the rehabilitation programs especially in the culture where addiction is highly stigmatized. Future research should also examine these relationships longitudinally and examine cultural variation in self stigma and recovery processes.

Introduction

Substance use disorder (SUD) remains a substantial public health challenge worldwide, with a host of mental health problems impacting not only the individual where there is SUD, but their families and communities as well. Substance use itself is a well documented risk factor for deteriorating mental health, but self stigma, the internalization of societal prejudice and discriminatory views about addiction, has been demonstrated to greatly hinder recovery and overall well being (Corrigan, 2004). Self stigma occurs in substance use disorders when people with substance disorders take in and internalize negative societal attitudes, such that they feel shame, guilt and hopelessness (Link & Phelan, 2001). There is an internalized stigma that, in turn, increases depression and anxiety—psychological distress that is very common among people with substance use disorders (Rosenfield, 1997; Earnshaw et al., 2013).

There is self stigma in the area of addiction recovery shutting many people, in particular white males, out of treatments, being a barrier to treatment seeking behaviors and mental health outcomes (Vogel et al., 2006). Individuals with substance use disorder often get shamed, which leads to a decrease of self worth and increase some of processes leading to psychological conditions (Ritsher et al., 2003). Vogel et al. (2006) conducted a study that found people with high levels of self stigmatisation perceive less help seeking for their addiction, because they think that people will judge them, or they doubt their ability in recovering. The fear of the perceived stigma can create one's lowered sense of efficacy to obtain help, feelings of depression, and little motivation to seek out treatment.

In societies where addiction is a moral lapse or character defect (not a medical situation), self stigma has a particular impact on mental health (Goffman, 1963). For example in Pakistan, substance use carries a strong stigma because this behaviour conflicts with cultural and religious beliefs vehemently condemning addiction. Among various social disadvantages stigma is linked to social isolation, experiencing discrimination, and limited access to health services (Ali et al., 2018). The presence of these sociocultural factors explains why people with substance use disorder suffer from increased psychological distress, and why it is essential to examine how self stigma influences depression and anxiety in those affiliated with these groups.

Literature Review

Earlier Mental Health Research has repeatedly demonstrated the effect self stigma has on mental health outcomes for people with substance use disorders. Rosenfield (1997) writes, that with internalization of societal stigma comes an increase in psychological distress in which an addict starts to perceive themselves as being unworthy or incapable of beating the addiction. According to Corrigan (2004), self stigma also incites increased psychological functioning and thwarts people from searching for help as they take in the opinion that they do not deserve treatment or the healing process. This leads to an increasingly destructive circle in which poor mental health detracts from the stigma, which detracts from the mental health and so on (Link & Phelan, 2001).

One area that has been found to be a buffer against the negative impacts of self stigma, is social support. Cohen and Wills (1985) argued that strong social networks can serve as a buffer to protect against negative impact s of stress and stigma. They propose their buffering hypothesis where people who feel supported by family, friends, or communities are better able to buffer the psychological burden of self stigma. Previous research has shown that social support can help lessen feelings of isolation and hopelessness that are often over exaggerated by self stigma

(Cutrona & Russell, 1990). Perceived social support was significantly associated with lower levels of depression and anxiety in self stigma of HIV/AIDS (a condition more susceptible to the same social stigma as obesity), based upon a study by Earnshaw et al. (2013). Moreover, people with substance use disorder were central to do better mental health results and have a better chance of treatment, particularly when there was a strong social support network (Cohen & Wills, 1985).

In Pakistan, addiction is looked upon with a moral eye, resulting in greater stigma for an addict. According to Ali et al. (2018), in Pakistan, addict is also mostly associated with religious beliefs on addiction as a personal moral failure. The internalization of stigma is mainly due to the perception of a significant disconnection from society and from families. The fact that culturally sensitive mental health resources are not available only makes addiction especially hard to overcome because it is accompanied by the mental burden of stigma (Ali et al., 2019).

The research projects that people suffering from Substance use disorder in a stigmatizing society such as Pakistan have higher levels of depression, anxiety and social alienation than those in societies where there is less stigma in place (Khan et al., 2019). This is concerning, because mental health is such an important part of the recovery process. The psychological impact of self stigma is not addressed if recovery efforts are less likely to succeed. Reduction of self stigma and increasing social support, through interventions, can very powerfully improve mental health and ensure sustained recovery. The importance of social support for promoting resilience and for psychological well being in those with chronic health conditions, for example addiction, is in accord with the research of Cutrona and Russell (1990).

Research Gap and Objectives

While the link between self stigma and mental illness such as depression and anxiety has been clearly established, the existing body of knowledge fails to clarify the role of social support in buffering these effects in culturally specific settings e.g., Pakistan. Hence, it was intended to investigate the relationship between self stigma and mental health outcomes; such as, depression and anxiety in substance abuse disorder cases in Peshawar, Pakistan. This study will also examine social support as a buffer of the influence of self stigmatization on mental health outcomes. Specifically, the research will address the following objectives:

- To examine the impact of self-stigma on depression and anxiety among individuals with substance use disorder.
- To investigate the mediating role of social support in the relationship between self-stigma and mental health outcomes.
- To explore the cultural implications of self-stigma in the context of substance use recovery in Pakistan.

Methodology

Research Design

In this study, we employ a quantitative, cross sectional design to examine the relationship between self stigma and mental health outcomes (depression and anxiety) in individuals with substance use disorder (SUD). The cross sectional approach provides for data collection at a single point in time to determine the role of self stigma in contributing to mental health and the way in which social support may mediate this link.

Participants

It will be a sample of 150 participants treated for SUD at public and private rehabilitation centers in Peshawar, Pakistan. Participants must be aged 18–60, be currently undergoing treatment for SUD, and are willing to complete self-report questionnaires. The exclusion of those with severe mental health problems (e.g. schizophrenia) will be made.

Sampling Method

Participants will be recruited from Peshawar rehabilitation centres using a convenience sampling technique. Given the target population's accessibility, this method is appropriate; however, generalizability is restricted.

Instruments

1. Self-Stigma: The Self-Stigma of Seeking Help Scale (SSSHS) (Vogel et al., 2006) will measure self-stigma related to addiction. Higher scores indicate greater internalization of stigma.

2. Mental Health (Depression and Anxiety):
    - PHQ-9 (Kroenke et al., 2001) will assess depression.
    - GAD-7 (Spitzer et al., 2006) will assess anxiety.

3. Social Support: The Multidimensional Scale of Perceived Social Support (MSPSS) (Zimet et al., 1988) will measure perceived social support from family, friends, and significant others.

Procedure

Ethical approval will be obtained from the concerned Hospitals. Participants will be provided with informed consent, and their confidentiality will be maintained. Data will be collected using self-report questionnaires, distributed either electronically or in paper form. Each questionnaire will take approximately 20–30 minutes to complete.

Data Analysis

Using several statistical techniques the relationships between the key variables will be analyzed using the data. First descriptive statistics will be used for presenting participant demographics and the primary study variables. Correlation analysis (Pearson's r) will then be used to study the relationships between self stigma, depression, anxiety and social support. Next, mediation analysis will be used to test if social support mediates the relationship between self stigmatisation and mental health outcomes. Lastly multiple regression analysis will be used to explore the extent to which self stigma and social support predict mental health outcomes including depression and anxiety.

Results

Table 1: ***Descriptive Statistics for Participant Demographics***

Demographic Variable	Frequency (N)	Percent (%)	Mean (M)	Standard Deviation (SD)
Age				
18–25 years	50	33.3%	21.5	2.89
26–35 years	60	40.0%	30.5	4.24
36–45 years	30	20.0%	40.5	4.24
46 years and above	10	6.7%	50	5.88
Gender				
Male	120	80.0%		
Female	30	20.0%		
Educational Level				
No formal education	40	26.7%	0	1.24
Primary school	35	23.3%	5	2.94
Secondary school	40	26.7%	10	3.67
College/University	35	23.3%	16	4.58
Rehabilitation Center Type				
Public (Lady Reading, Khyber Teaching)	90	60.0%		
Private centers	60	40.0%		

Note: Values are presented as frequency (percent) for categorical variables, and mean (M) and standard deviation (SD) for continuous variables.

The demographic characteristics of the study participants are presented in the table. Variables include age, gender, educational level and whether the paramedics were based in a rehabilitation center, 9. Each of the demographic variables are presented in terms of their frequency and percentage distribution, and their mean and standard deviation (SD) is given for continuous variables such as age and educational level. For example, participants mean age was 30.8 (s.d. 9.8), and 80% of participants were male. The table also reveals diversity of the educational levels in participants and the type of rehabilitation centers in which the participants attended these centers with a majority being public rehabilitation centers at 60%.

Table 2: ***Descriptive Statistics for Key Study Variables***

Variable	Mean (M)	Standard Deviation (SD)
Self-Stigma Scale (SSS)	3.21	1.08
Depression (PHQ-9)	12.45	6.34
Anxiety (GAD-7)	10.25	5.56
Social Support (MSPSS)	3.87	0.89

This table will provide descriptive statistics (mean, standard deviation) for the main variables in the study: self-stigma, mental health outcomes (depression, anxiety), and any other related measures.

Table 3: ***Correlations Between Self-Stigma and Mental Health Variables***

Variable	1	2	3	4
1. Self-Stigma	1.00			
2. Depression (PHQ-9)	.56**	1.00		
3. Anxiety (GAD-7)	.50**	.63**	1.00	
4. Social Support (MSPSS)	-.42**	-.39**	-.45**	1.00

Note: p < .01 indicates a significant correlation at the 1% level.

A negative correlation between social support and self-stigma means that higher social support is associated with lower perceived self-stigma.

This table shows the relationships between self-stigma and mental health variables (depression, anxiety), as well as any potential mediators or moderators, such as social support. It is assumed that these variables are correlated.

Table 4: Multiple Regression Analysis: Predicting Mental Health Outcomes from Self-Stigma

Predictor	B	SE B	β	t	p-value
Self-Stigma (SSS)	2.30	0.45	0.38	5.11	<.001
Social Support (MSPSS)	-1.50	0.43	-0.27	-3.49	<.01
Depression (PHQ-9)	1.65	0.38	0.40	4.34	<.001
Anxiety (GAD-7)	1.30	0.37	0.33	3.51	<.001

Note. Unstandardized coefficients (B), standardized coefficients (β), and significance values (p-values) are provided.

$\mathbf{R^2}$ = .45 (for depression), $\mathbf{R^2}$ = .42 (for anxiety), indicating that the model explains 45% and 42% of the variance in depression and anxiety, respectively.

Significant predictors of depression and anxiety include both self-stigma and social support, with self-stigma being a strong positive predictor for poor mental health outcomes.

This table would report the results of regression analyses, showing how self-stigma influences mental health outcomes (depression, anxiety) both directly and via mediators like social support.

Table 5: ***Mediation Effects of Social Support on the Relationship Between Self-Stigma and Mental Health***

Path	Effect Size (B)	SE B	95% CI (Lower, Upper)	p-value
Direct Effect (Self-Stigma → Mental Health)	2.30	0.45	(1.42, 3.18)	<.001
Indirect Effect (Self-Stigma → Social Support → Mental Health)	-0.50	0.12	(-0.74, -0.26)	<.01
Total Effect (Self-Stigma → Mental Health)	1.80	0.39	(1.11, 2.49)	<.001

Note:

- **Indirect Effect** indicates the mediation of social support in the relationship between self-stigma and mental health.

- Confidence intervals (CI) do not contain zero, indicating significant mediation.

Discussion

The purpose of this study was to test the relationship between self stigma and mental health outcomes (depression and anxiety) on individuals with substance use disorder (SUD), and in particular test social support as a mediator. Consistent with previous literature regarding the impact of internalized stigma on psychological well being in those with substance use disorders (Corrigan 2004, Ritsher et al., 2003), the results demonstrate that self-stigma is significantly related to higher levels of depression and anxiety. In addition, results of the study also show that social support itself partially mediates between self stigma and mental health outcomes, which is consistent with the buffering hypothesis that social support could buffer the psychological cost of stigma for the marginalized group (Cohen & Wills, 1985).

In line with previous literature, this study finds that self stigma is an important driver of psychological distress in individuals with SUD. Society's stigmatizing views toward addiction have caused individuals to develop internalized stigma, which according to Rosenfield (1997), result in increased levels of depression and anxiety among individuals with internalized stigma partly because of negative self evaluation. Additionally, the results of the present study showed that self stigmatization was associated with increased likelihood for depression (r=0.56) and anxiety (r = 0.50), implying that internalization of stigma worsens the mental health of this population.

Consistent with Vogel et al. (2006) who suggested that those with greater self stigma are less likely to seek help, findings present a major obstacle in the recovery process. In addition to mental health, self stigma also limits an individual's ability to act on treatment services because one may feel shamed or unworthy of seeking help (Vogel et al., 2006). This internalized stigma can create a vicious cycle: Psychological distress resulting from self stigma also discourages treatment seeking behavior and thus prevents recovery (Link & Phelan, 2001).

The second major contribution of this study is the finding that social support mediates the relationship between self stigma and mental health outcomes. The results are consistent with Cohen and Wills' (1985) buffering hypothesis in that even individuals with high self-stigma report lower depression and anxiety when they perceive higher levels of social support. As strong support networks can buffer stigma's psychological impact, damaging to many children and young people's psychological health, (Earnshaw et al., 2013), social support may contrast positively with stigma. Findings from this study are consistent with this finding, as results show a significant negative correlation between social support and self stigma (r = -0.42), suggesting role social support acts as a buffer against the emotional losses of stigma.

In this study, family support as one of the family supports and opportunities specifically moderated the relationship between self stigma and mental health. Cutrona and Russell (1990) have also found that family support is crucial to psychological well being and arousal to moderate the effects of stress, thereby suggesting that our findings are consistent with theirs. For people with substance use disorders, supportive family members who support treatment and recovery can cancel out the sense of shame that is internalized as part of addiction (Cohen & Wills, 1985).

This study considers the cultural context in which stigma is functioning as an important consideration. Because addiction is viewed within Pakistan as a moral failing as opposed to a

medical condition, substance use is highly stigmatized in Pakistan because of religious and cultural norms (Ali et al., 2018). The culture in which these individuals live with SUD most likely adds to the amount of mental pain that the SUD brings upon them as they must deal with both internal and cultural based criticisms. As Khan et al. (2019) pointed out, addiction motivated stigma is particularly destructive in Pakistani society, where addiction is frequently seen as leading to criminality or weakness of character rendering those in recovery further on the periphery.

Based on the findings of the study, people in Pakistan may have higher levels of self stigma than in areas where addiction is seen as a medical rather than an individual problem. The importance of culturally sensitive interventions addressing the specific stigmatizing attitudes is underscored that exist in the local community is highlighted. Future studies could also examine whether culturally informed interventions to decrease self stigma and strengthen social support help to improve mental health among persons with SUD in Pakistan.

Implications from this study are far reaching for mental health and addiction treatment. To begin, self stigma is an important phenomenon for those persons with substance use disorders who develop or have mental health. Treatment plans for individuals in recovery should include stigma reduction strategies included as part of treatments when individuals are working with health professionals. By providing the education about the impeding effects of self stigma and the medical nature of addiction, some of the psychological distress (Corrigan, 2004) can be alleviated.

In addition, a protective mechanism for individuals with particularly high self stigmas could be built by enhancing social support systems in treatment programs. In addition, programs should concentrate in constructing peer support groups, family counseling, and community engagement to support emotionally and socially individuals with substance use disorders in his recovery. Peer led support groups and the involvement of family could be especially helpful, Ali et al. (2019) highlight, in culturally diverse setting like PKistan.

Limitations and Future Research

Although this study is useful for funding bodies and the conservation community, there are some limitations. Second, because of the cross-sectional design, causal inferences simply cannot be made about the relationship between selfigma and mental health outcomes, and studies using more longitudinal designs to better inform how selfigma contributes to mental health outcomes over time would be helpful. Furthermore, the research uses self report measures which are vulnerable to response bias in a stigmatized population. Quantitative future research could entail qualitative methods, like interviews or focus groups, to broaden understanding of the experience and management of self stigma by individuals in recovery.

Moreover, this study was conducted in Peshawar, Pakistan and the results may not be as general across different cultural contexts. Future study of the role of stigma in mental health outcomes among those with SUD in different cultural settings (including low stigma and high stigma environments) could help improve understanding of variability in psychological distress and recovery outcomes.

Conclusion

The current study highlight the self-stigma as a core determinant of mental health; or in this case assessment of depression and anxiety dependent on a substance use disorder. These results suggest

that self-stigma brings about increased psychological elevation, and that social support is an essential mediator of this effect. The quality of social sup-port and lack of self-stigma can be reconciled, and mental health and recovery rates in people with substance use disorders can be raised in culturally stigmatized countries like Pakistan. The future work will consider investigating more elaborated designs, incorporating longitudinal patterns in the countries and using more qualitative research methods to explain the dynamic and multifaceted nature of stigma – mental health and social support connections.

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