Self-stigma in persons with Alcohol Use Disorder: An exploration of its relationships with psychosocial factors.

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Self-stigma is high among individuals with substance use disorders (SUDs). Its presence in individuals with alcohol use disorder (AUD) alone is not well explored. An exploratory study was carried out to examine self-stigma in persons with AUD and its relationships with various psychosocial factors. Sample included 40 persons with AUD accessing treatment under a health care facility. Self-report measures were used to assess self-stigma, psychological distress, loneliness, perceived social support, daily prayer and socio-demographic factors. Data set met assumptions for normality and so Pearson correlation was applied for bivariate correlation and t test and ANOVA for comparison of means. Results showed high levels of self-stigma in the study sample. Self-stigma in AUD was found to have a significant positive correlation with psychological distress and loneliness and a significant negative correlation with perceived social support. Prayer and years of alcohol use were found to have significant effects on self-stigma , particularly on the values disengagement component. Age, gender, education, employment and marital status did not have significant relationship with self-stigma in AUD.

Keywords: Self-stigma, alcohol use disorder, psychological distress, loneliness, perceived social support, prayer.

Alcohol use disorder (AUD) is a common disorder which is defined as "a problematic pattern of alcohol use leading to clinically significant impairment or distress" (The American Psychological Association [APA], 2013. People with AUD can suffer from a set of behavioral and physical symptoms including withdrawal, tolerance and craving (APA, 2013). AUD has severe implications for one's physical health. Prolonged used of alcohol in large amounts can contribute to serious health issues involving the gastrointestinal, cardiovascular, and the peripheral and central nervous systems (APA, 2013). According to the World Health organization[WHO], harmful use of alcohol accounts for more than 200 disease and injury conditions, about 3 million deaths every year and 5.1% of the global burden of disease and injury (WHO,2022). Apart from the ill effects on physical health, AUD can also hamper one's interpersonal, social and occupational prospects. In spite of this overarching impact of harmful alcohol use on a person's life, many remain untreated for the condition. It is estimated that in lower and middle income countries, treatment gap for IUD is about 95% (Rathod et al., 2016). One of the reasons for lack of approach for treatment is the presence of stigma related to alcohol use.

Stigma is considered as a social construction that involves the recognition that an individual is different based on some distinguishing characteristic that may further lead to devaluation of the person (Dovidio, Major & Crocker, 2003). Kilian et al. (2021) described stigma as a process involving the use of a label (for eg., alcoholic) to describe a person who is then subjected to stereotypes (for eg., dangerous), prejudices, and discrimination which may include the desire for social distance, social exclusion, etc. In a review of studies reported over the past one decade, Kilian et al.(2021) noted that stigmatization of persons with AUD is high and that as compared to persons with other mental disorders, persons with AUD are attributed more

negative stereotypes and perceived as more responsible for their conditions. Kilian et al. also documented a greater desire for social distance from people with AUD.

One of the consequences of stigma is its internalization by members of the stigmatized group-self-stigma. According to the functional contextual theory of stigma (Luoma et al., 2013), self-stigma comprises of four components: First, it involves the internalization of negative public stereotypes that leads to self-devaluation. Second, the individual fears being discriminated and rejected by the society- fear of enacted stigma. Third, the individual may attempt to reduce, avoid or escape stigma related emotions, thoughts, or sensations in a maladaptive manner - experiential avoidance, Fourth, the maladaptive pattern of responding leads to disengagement from pursuit of valued goals. Self-stigma, when present, can lower self-esteem, act as barrier to help seeking and make the lives of those afflicted even more difficult.

The limited existing literature on substance use self-stigma suggests that individuals with substance use disorder (SUD) experience high self-stigma (Luoma et al. ,2007; Melchior et al.,2019). Association of substance use self-stigma with socio-demographic variables have so far not been demonstrated as substantial or consistent. Amongst demographic variables, employment status correlated (Brown et al.,2015;Estesam et al., 2014; Silveira et al.,2012) while age and gender did not correlate with substance use self-stigma (Brown et al., 2015; Silveira et al.,2012). Association of education with self-stigma was not consistent across the few studies that examined it (Brown et al.,2015;Estesam et al., 2014; Silveira et al.,2012). With regard to psychological factors, Brown et al.(2015) documented significant associations of substance use self-stigma with depression, anxiety and quality of life. Studies such as these that have examined the psychosocial correlates of substance use self-stigma are limited. Moreover, no such study has been attempted with regard to self-stigma in AUD. It is believed that experiences of self-stigma may not be uniform across groups of different substance users (Chang et al.,2022).

Kilian et al.(2021) has pointed out that the stigmatization of persons with AUD can be distinct from that of other substance related disorders. There are a couple of studies that have highlighted the internalization of stigma amongst persons with AUD(Rathod,Nadkarni,Bhana & Shidhaye,2015; Zewdu, Hanlon, Fekadu, Medhin and Tefura,2019) but no effort has been made to understand its relationships with psychosocial factors . Although the associations of self-stigma with psychosocial variables have been described in previous research with other stigmatized groups, it is not sure whether those findings can be generalized to all stigmatized groups including persons with AUD. As an extension to the limited research in the area, the present study had been conducted with the following objectives:

- To assess the level of self-stigma in persons with AUD.
- To examine the relationships of self-stigma in AUD with various psychosocial factors.

Method

Variables

The study looked at the potential association of self-stigma in AUD with a number of psychological factors namely psychological distress, loneliness, social support and prayer, and a number of socio-demographic factors including age, gender, educational level, employment status, marital status and years of alcohol use.

Sample and procedure

Sample comprised of 40 participants recruited from a hospital at Dimapur in Nagaland. The participants were those who fulfilled the DSM-5 criteria for AUD and accessing treatment for AUD at the hospital facility. The mean age of the participants was 37 (SD=8.8). Participants were administered the questionnaire after giving proper instruction. All participants could understand English and participation was voluntary. Individuals with AUD but with history of poly substance use and having psychotic symptoms and /or intellectual disability were excluded.

Ethics

Ethical approval was obtained from the Institutional Review Board of the Christian Institute of Health Sciences and Research, Dimapur, from where the data was collected. Informed consent was obtained from all the participants.

Tools used

Substance Abuse Self-Stigma Scale (SASSS) by Louma et al., 2013 was used to assess self- stigma. The scale is a forty item scale with four sub-scales- Self Devaluation sub-scale (α=.82); Fear of enacted stigma sub-scale (α=.88); Stigma avoidance sub-scale (α=.86) and Values Disengagement sub-scale (α=.82). The internal consistency for the full scale was .86. Each subscale has five response categories.

The Kessler-10 Scale (Kessler et al., 2002): It is a ten item scale widely used in assessing non-specific psychological distress. Each item has five response options: All of the time, Most of the Time, Some of the time, A little of the time and None of the time that are scored 5,4,3,2,1 respectively. Higher scores on the scale indicate higher distress.

The UCLA Loneliness Scale-Version 3 (Russell,1996): It is a twenty item scale designed to measure subjective feelings of loneliness. Participants rate the items on the scale from 1(Never) to 4(Often). The scale yields a maximum score of 80. Higher scores indicate greater loneliness.

Berlin Social Support Scales (Schwarzer & Schulz,2000): The perceived support subscale which assesses emotional and instrumental social support was used in this study. This sub scale has eight statements on a four-point Likert scale with scores ranging from 1(Strongly Disagree) to 4(Strongly Agree). The sub scale has high internal consistency (α =.83).

Socio-demographic information questionnaire: This consisted of questions pertaining to age, gender, educational qualification, employment status, marital status and years of alcohol use. There was also a question on whether or not one engages in daily private prayer with Yes/No response options.

Statistical analyses

IBM SPSS -21 was used for data analysis. Parametric statistics- t test, ANOVA and Pearson product moment correlation were used as the data set met the assumptions for use of parametric tests.

Results and Discussion

Socio-demographic distribution of the sample. A great majority of the participants were males (95 %). Females constituted only 5% of the sample. Majority were unmarried (65%). Almost half of the participants (47.5%) had education up to Class 12, the remaining(52.5%) had education up to graduation and above. More than half the total participants (57.5%) were in the ages 18 to 35 years , the remaining(42.5%) were above 35 years of age. More than half (57.5%) were employed in some way, the remaining (42.5%) had no employment. In terms of years of alcohol use, 25% reported using alcohol for more than 15 years, 45 % for 10 to 15 years and 30% for less than 10 years. Almost half of them (45%) reported not engaging in daily personal prayer even once a day, the remaining (55%) reported in the affirmative.

Self-stigma in AUD. Mean scores on all the self-stigma sub-scales were found to be high on the study sample- self devaluation (M=25.80, SD=6.11); fear of enacted stigma (M=27.15,SD=6.57); stigma avoidance (M=40.20, SD=5.91) and values disengagement (M=28.32, SD=6.28). The functional contextual model of self-stigma predicts that an individual who identifies with a stigmatized group will internalize derogatory stereotypes which leads to self devaluation and fear of encountering stigmatizing actions from others which in turn leads to avoidance behaviors and disengagement from one's valued goals. The high mean scores on all the four subscales indicate the internalization of stigma in the study sample. While studies on self-stigma of persons with AUD are rare, similar observations had been reported in the couple of studies documented till date. For example, Zewdu et al. (2019) in a population study in rural Ethiopia had observed that amongst persons with AUD, majority had reported high internalized stigma. In another population based cross sectional

study in Madhya Pradesh, India, 16-49 percent of persons with alcohol use problems reported various aspects of stigma internalization (Rathod et al., 2015). Like in other stigmatized groups, self-stigma appears to be an issue that needs attention in persons with AUD.

Psychological distress and self-stigma in AUD. Psychological distress is a broad term that describes mental and emotional states involving depression and anxiety. Pearson bivariate correlation showed a strong positive correlation between SASSS total scale score and psychological distress(r=.67, p<.001). Psychological distress was found to be positively correlated with all components of SASSS- self devaluation(r=.48, p=.002), fear of enacted stigma(r=.53, p<.001), stigma avoidance(r=.63, p<.001) and values disengagement(r=.48, p=.002). Previous research had demonstrated that psychological distress is correlated with mental illness self-stigma (Lin et al.,2016 ; Yanos et al., 2008), weight self-stigma (Farhangi, Emam-Alizadeh,Hamedi & Jahangiry, 2017), HIV/AIDS self-stigma(Herek,Saha & Burack,2013), sex worker self-stigma (Hart,Allen,Aubyn & Mason,2022) and substance use self-stigma (Cheng et al., 2019; Saffari et al., 2022;). Similar to the self-stigma in these other marginalized groups, self-stigma in AUD is also found to be correlated with psychological distress.

Loneliness and self-stigma in AUD. Self-stigma in AUD was also positively correlated with loneliness(r=.56, p<.001). Significant positive correlations were observed between loneliness and the different components of SASSS- self devaluation(r=.52, p=.001), fear of enacted stigma(r=.41, p=.009), stigma avoidance(r=.44, p=.004) and values disengagement(r=.40, p=.011). Previous research with other stigmatized groups, for eg., persons with mental illness (Yildirim and Budak,2019), domestic helpers(Yeung et al., 2021), college students with visual impairments(Kong et al., 2021), people over 65 years(Gonzalez-Dominguez et al.,2018), and sex workers(Hart et al., 2022) have also demonstrated similar relationship between self-stigma and loneliness. Loneliness is an unpleasant subjective state experienced by an individual owing to perceived gap with respect to the level of support or companion

one wishes to have and that which is actually available to them (Blazer,2002 as cited in Golden et al, 2009). Persons with AUD often face social rejection and exclusion and studies have shown that persons with AUD often experience loneliness (Wakabayashi et al., 2022). It is possible that such experiences of loneliness lead to the internalization of stigma or that self-stigma compounds the experiences of loneliness experienced by persons with AUD. Future studies may look into the predictive relationship between the two variables.

Perceived social support and self-stigma in AUD. There was a significant negative correlation between SASSS total score and perceived social support(r=-.41, p=.009) which agrees with findings from research in other stigmatized groups (Karacar & Bademli,2022; Yeung et al., 2021). With respect to the four components of SASSS, perceived social support was found to have significant negative correlations with fear of enacted stigma(r=-.42, p=.006) and values disengagement(r=-.39, p=.014) components. It was not found to be significantly correlated with the two other components- Self devaluation (r= -.22, p=.162) and stigma avoidance(r=-.192, p=.235). Lesser perceived social support is associated with greater fear for stigmatizing actions from others and more disengagement from the pursuit of one's valued goals.

Daily prayer and self-stigma in AUD. Prayer is a religious practice that enables a person to communicate with a higher power. It is reportedly being increasingly used as a coping mechanism (Wachholtz & Sambamoorthi, 2011) but its role in self-stigma had so far not been explored. In the present study, engaging in daily prayer was found to have a significant effect on self-stigma (t=2.05, p=.048). It was noted that significant differences exist between persons with AUD who do daily prayer and who do not in terms of the values disengagement (t=2.36, p=0.024) component. Participants who did not engage in daily prayer reported higher values disengagement (M=30.78, SD=6.74) than those who did daily prayer (M=26.32, SD=5.21). The finding implies the potential positive effect that prayer can have in reducing self-stigma, particularly, values disengagement, among persons with AUD. Future studies may benefit

Table 1. Means, SDs and t/F values for the self-stigma subscales

		Self devaluation		Fear of enacted stigma		Stigma avoidance		Values disengagement	
Grouping	variable	Mean SD	t /F	Mean SD	t /F	Mean SD	t/F	Mean SD	t /F
Gender	Male n=37	25.38 6.02	t=1.56 p=.13	27.49 6.69	t=1.14 p=.26	40.11 5.97	t=0.34 p=.73	27.97 6.37	t=1.25 p=.22
	Female n=3	31 5.57		23 3		41.33 6.11		32.67 2.87	
Age	18-35 n=23	27.04 5.19	t=1.52 p=.14	26.96 6.44	t=.214 p=.83	40 6.18	t=.246 p=.81	27 6.54	t=1.25 p=.22
	>35 n=17	24.12 6.97		27.41 6.92		40.47 5.70		29.76 5.79	
Education	<Cl 12 n=19	25.95 4.97	t=0.14 p=.88	26.84 6.54	t=0.28 p=.78	39.95 6.15	t=0.25 p=.80	29.58 5.93	t=1.21 p=.23
	Grad. n=21	25.67 7.10		27.43 6.75		40.43 5.83		27.19 6.52	
Marital status	Married n=14	23.93 6.85	t=1.44 p=.16	27 6.74	t=0.10 p=.92	40.85 5.47	t=0.51 p=.61	30.14 5.41	t=1.36 p=.18
	Unmarried n=26	26.81 5.54		27.23 6.62		39.85 6.21		27.35 6.60	
Employment	Emp. n=23	25.13 6.21	t=0.80 p=.43	27.52 5.79	t=0.41 p=.68	40.04 6.15	t=0.19 p=.84	28.78 6.91	t=0.53 p=.60
	UnEmp. n=17	26.71 6.02		26.65 7.66		40.41 5.74		27.71 5.47	
Years of alcohol use	<10 n=12	26.75 5.29	F=0.21 p=.81	26.75 5.97	F=1.35 p=.27	40.25 6.11	F=1.58 p=.22	26.75 5.24	F=4.79 p=.014**
	10-15 n=18	25.28 6.44		25.83 5.85		38.72 5.43		26.67 5.48	
	>15 n=10	25.60 6.86		30 8		42.80 6.17		33.20 6.76	
Daily prayer	YES n=22	24.77 6.29	t=1.18 p=.24	25.68 6.27	t=1.59 p=.12	39.04 6.18	t=1.38 p=.17	26.32 5.21	t=2.36 p=.024*
	NO n=18	27.05 5.79		28.94 6.65		41.61 5.39		30.78 6.74	

**P<.01, *P<.05

from studying whether or not frequency or types of prayer will have any effect on self-stigma in AUD.

Demographic factors and self-stigma in AUD. Years of alcohol use was found to have a significant effect on the values disengagement (F= 4.79, p=0.014) component. Participants using alcohol for more than 15 years were found to have significantly more values disengagement from those using for 10 to 15 years (Mean Difference=6.53, p=0.018) as well as from those using for less than 10 years (Mean Difference= 6.45, p=0.033). Age, gender, educational level, employment and marital status did not have significant effect on any of the self-stigma components (Table 1). While there are no studies that have specifically looked at the relationships between such demographic

variables and self-stigma in AUD, results from previous research on the role of demographic variables in substance use self-stigma have not been consistent (Brown et al., 2015; Estesam et al., 2014; Silveira et al ,2012). Although more research is needed in the area, the findings of this study do no imply associations of self-stigma in AUD with demographic variables. One notable observation, however, is that persons with AUD experience more values disengagement with longer duration of alcohol use.

Conclusion

The study was based on a sample of limited size drawn from one hospital in Dimapur, Nagaland, rendering a limited generalizability value. Moreover, self-report measures were used for data collection and so responses may be subject to social desirability bias. In spite of these limitations, the study has provided important insights into our understanding of self-stigma in persons with AUD. Of particular importance are the findings that- a) persons with AUD suffer from high self-stigma and that longer duration of alcohol use may contribute to more values disengagement, b) the experiences of self-stigma in AUD are positively correlated with psychological distress and loneliness, c) perceived social support is associated with lower fear of enacted stigma and values disengagement, and d) daily prayer is helpful particularly for reducing values disengagement. Future studies may be done with larger sample sizes so as to further understand the predictive values of the psychosocial factors examined in this study.

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