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Short communication

Internalized stigma as an independent risk factor for substance use problems among primary care patients: Rationale and preliminary support

Magdalena Kulesza, Katherine E. Watkins*, Allison J. Ober, Karen C. Osilla, Brett Ewing

RAND Corporation, 1776 Main Street, Santa Monica, CA 90407, USA

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ABSTRACT

Background: Little is known about internalized stigma among primary care patients, and whether the presence of internalized stigma is related to the severity of substance use problems independent of substance use-related variables. We sought to examine the relationship between internalized stigma and substance use problems among primary care patients with opioid or alcohol use disorders (OAUDs).

Methods: We present baseline data from 393 primary care patients who were enrolled in a study of collaborative care for OAUDs. Regression analyses examined the relationship between internalized stigma and substance use problems, controlling for demographics, psychiatric comorbidity, and quantity/frequency of use.

Results: The majority of participants reported thinking, at least sometimes, that they "have permanently screwed up" their lives (60%), and felt "ashamed" (60%), and "out of place in the world" (51%) as a result of their opioid or alcohol use. Higher internalized stigma was significantly related to more substance use problems ($\beta = 2.68$, $p < 0.01$), even after the effects of covariates were accounted for. Stigma added 22%, out of 51% total variance explained, leading to a significant improvement in prediction of substance use problems.

Conclusions: Among this group of primary care patients with OAUDs, rates of internalized stigma were comparable to those reported in specialty substance use treatment settings. Consistent with extant specialty care literature, our results suggest that internalized stigma may be a unique contributor that is associated with treatment outcomes, such as substance use problems, among primary care patients with OAUDs.

1. Introduction

Substance use disorders affect 8.1% of the United States population aged 12 or older (Lipari et al., 2016), are highly comorbid, and associated with debilitating consequences (Grant et al., 2015, 2016), such as medical complications, financial difficulties (Allensworth-Daviews et al., 2012; Blanchard et al., 2003), and stigma (Room, 2005; Earnshaw et al., 2013, 2015; Smith et al., 2016). While stigma towards substance use and people who use substances is well-documented (Kennedy-Hendricks et al., 2016, 2017; Kulesza et al., 2015; MacCoun, 2013; Pescosolido et al., 2010), its impact on stigmatized persons continues to be understudied and poorly understood (Corrigan et al., 2017; Kulesza et al., 2013; National Academies of Sciences, Engineering, and Medicine, 2016; Smith et al., 2016). We add to the literature by evaluating the relationship between internalized stigma and substance use problems (SUP), defined as negative consequences of substance use such as legal or financial problems (Blanchard et al., 2003).

Internalized stigma is conceptualized as a process whereby stigmatized individuals internalize (i.e., apply to themselves) negative stereotypes about the stigmatized group they belong to, which may lead to feelings of worthlessness and self-devaluation (Corrigan et al., 2006, 2009; Link and Phelan, 2001). In this paper, we specifically focused on the relationship between internalized stigma and SUP among primary care patients with opioid and/or alcohol use disorders (OAUDs) for the following reasons. First, there is preliminary evidence that internalized stigma is significantly related to more SUP and other treatment outcomes such as lower quality of life and greater engagement in HIV high-risk behaviors (Earnshaw et al., 2015; Kulesza et al., 2013, Smith et al., 2016Kulesza et al., 2013, Smith et al., 2016). However, these findings are based predominantly on the data from specialty addiction treatment settings (i.e., hospitals, addiction rehabilitation centers, mental health clinics), which may not accurately reflect experiences of primary care patient population. Second, SUP is a promising predictor of addiction treatment outcome. Specifically, higher SUP at baseline is associated with lower specialty addiction treatment retention, after controlling for readiness to change and frequency of substance use (Kiluk et al., 2013). Third, internalized stigma has been shown to be modifiable through

* Corresponding author.
E-mail addresses: mkulesza@rand.org (M. Kulesza), kwatkins@rand.org (K.E. Watkins), ober@rand.org (A.J. Ober), karenc@rand.org (K.C. Osilla), brettewing@gmail.com (B. Ewing).

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intervention (Luoma et al., 2008, 2012). At the same time, it would be more challenging to address other SUP-related risk factors, such as participant characteristics (Ali et al., 2015; Kiluk et al., 2013), higher quantity/frequency of use (Bennett et al., 2009; Blanchard et al., 2003), and greater psychiatric comorbidity (Ali et al., 2015; Buckner et al., 2007; Gorka et al., 2012).

We sought to examine the relationship between internalized stigma and SUP among a sample of primary care patients diagnosed with OAUDs. We hypothesized that higher internalized stigma would be significantly related to more SUP. To our knowledge, internalized stigma has not yet been evaluated among this patient population. Assessing the relationship between internalized stigma and SUP will help to determine what, if any, additional interventions are needed to adequately address this important clinical target (Donovan et al., 2012; Miller and Miller, 2009).

2. Methods

2.1. Participants and procedures

Participants were 393 adults diagnosed with OAUDs presenting to a large urban, federally qualified health center (FQHC) in Los Angeles for medical care, who completed a baseline assessment as a part of a randomized controlled trial (NCT01810159). Eligible individuals were: 18 or older, screened positive for moderate to severe alcohol or opioid problem (assessed by the Alcohol, Smoking and Substance Involvement Screening Test-3.1; Humeniuk et al., 2008), did not have marked functional mental health impairment (Sheehan Disability Scale; Sheehan, 1986), and were not currently in treatment for OAUDs. Out of 453 eligible participants, 397 consented to the study, and of those 393 completed baseline measures presented in this manuscript. For more information about study procedures, see (Ober et al., 2015). This study was approved by the RAND Corporation's Institutional Review Board.

2.2. Measures

SUP was assessed with the Short Inventory of Problems-Alcohol and Drugs (SIP-AD; Blanchard et al., 2003). Participants rated each of the 15 items (1 = yes or 0 = no), inquiring about physical, social, intrapersonal, and interpersonal problems related to OAUDs in the past 90 days. The sum of the items provided a total score. Higher scores correspond to more severe SUP, which has been validated among primary care patients (Allensworth-Davies et al., 2012). Cronbach's alpha in the current sample was 0.92.

Internalized stigma was measured by the Self-Devaluation Subscale, of the Substance Abuse Stigma Scale (Luoma et al., 2013). Participants rated each of the 8 items, inquiring about the frequency of self-devaluating thoughts and feelings during the past 90 days, on a five-point scale (1 = never to 5 = very often). Higher scores correspond to greater internalized stigma. Cronbach's alpha in the current sample was 0.90.

The Timeline Follow-back Method (Sobell et al., 1979) was used to measure alcohol/opioid use quantity/frequency over the past 30 days. The TLFB has been used extensively in both clinical and research settings and has been shown to have good psychometric properties across a wide variety of substances and diverse populations.

The Comprehensive International Diagnostic Interview (Haro et al., 2006) Version 3.0, sections 11 and 12 were used to diagnose OAUDs.

Psychiatric comorbidity was measured by the Patient Health Questionnaire-4 (PHQ-4; Kroenke et al., 2009), which consists of combined depression (Kroenke et al., 2003) and anxiety screeners (Kroenke et al., 2007). Participants rated each of the 4 items on a 4-point scale (0 = not at all to 3 = nearly every day). Higher scores correspond to greater depression and anxiety symptom severity, with established validity in primary care settings (Kroenke et al., 2003, 2007, 2009). Cronbach's alpha in the current sample was 0.86.

2.3. Analytic plan

Potential covariates, including demographics, OAUD diagnosis, quantity/frequency of use, and psychiatric comorbidity were examined for associations with SUP. Covariates with significant associations ($p < 0.05$) were entered into the first step of a stepwise multiple linear regression model to examine the association between internalized stigma and SUP. Internalized stigma was entered in the second step to evaluate if it accounted for significant variance in SUP, after adjusting for covariates. Goodness of fit tests of all models were assessed using an F-test for the linear model that tests be omnibus impact of all the covariates (including the confounders) on the SUP outcome. All analyses were conducted using SAS version 9.3.

3. Results

The majority of the sample was male (79%), on average 42 years old (SD = 11.97), and predominantly (61%) self-identified as racial/ethnic minority (31% Hispanic/Latino/a, 13% African-American, 17% multiracial/other). Most participants obtained at least high school education (72%), half of them reported living in unstable housing/homeless, and over half (56%) received either AUD (53%) or OUD (3%) diagnosis while 44% were diagnosed with comorbid AUD and OUD disorder. Lastly, sample mean SIP-AD score was 9.34 (SD = 4.83) and mean PHQ-4 score was 5.93 (SD = 3.91).

3.1. Descriptive stigma results

When examining overall internalized stigma, participants reported an average of 2.57 (SD = 1.09) across the items, which corresponds to a "rarely" on the scale (see Table 1). Participants were most likely to report that they "feel ashamed" and think that they "have permanently screwed up" their lives as a result of their opioid or alcohol use.

Table 1
Percent of participants (N = 393) endorsing each of the internalized stigma items.

Internalized Stigma Questions[a]	Never		Rarely		Sometimes		Often		Very Often	
	N	(%)	N	(%)	N	(%)	N	(%)	N	(%)
I have the thought that a major reason for my problems with substances is my own poor character.	126	(32)	71	(18)	98	(25)	59	(15)	39	(10)
I have the thought that I should be ashamed of myself.	94	(24)	67	(17)	114	(29)	67	(17)	51	(13)
I have the thought that I deserve the bad things that have happened to me.	126	(32)	79	(20)	90	(23)	63	(16)	35	(9)
I have the thought that I can't be trusted.	185	(47)	86	(22)	63	(16)	43	(11)	16	(4)
I feel inferior to people who have never had a problem with substances.	173	(44)	67	(17)	75	(19)	35	(9)	43	(11)
I feel out of place in the world because of my problems with substances.	126	(32)	63	(16)	102	(26)	63	(16)	39	(10)
I have the thought that I've permanently screwed up my life by using substances.	110	(28)	51	(13)	102	(26)	63	(16)	67	(17)
I feel ashamed of myself.	110	(28)	51	(13)	106	(27)	67	(17)	59	(15)

[a] Measured by the Substance Abuse Stigma Scale (Luoma et al., 2013).