Archives of Psychiatric Nursing 29 (2015) 441–446

Contents lists available at ScienceDirect

Archives of Psychiatric Nursing

journal homepage: www.elsevier.com/locate/apnu

Social Functioning and Internalized Stigma in Individuals Diagnosed with Substance Use Disorder

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A B S T R A C T

The aim of this descriptive study was to determine social functioning and internalized stigma in individuals with substance use disorder. The study sample consisted of 105 patients diagnosed with substance use disorder according to the DSM-IV-TR diagnostic criteria. A Descriptive Information Form, Internalized Stigma of Mental Illness Scale (ISMI) and Social Functioning Scale (SFS) were used for data collection. Average total SFS score of the patients was 103.25 ± 25.09 points, indicating an intermediate level of social functioning. Average total ISMI score of patients was 2.92 ± 0.48 points, reflecting a high level of internalized stigma. A negative significant association was observed between the internalized stigma levels and social functioning of patients. These results suggest that rehabilitation of substance users should include counseling services in order to reduce internal perception of stigma and improve their social functioning.

Substance use disorder, such as alcohol, nicotine, and illicit drugs, is one of the largest public health issues in the world. Figures from the World Health Organization (WHO) show that 3.3 million people die from alcohol use disorder each year (WHO, 2014), and at least 15.3 million people have substance use disorders (SUD) (WHO, 2013). Studies showed that alcohol and substance use disorders which were less threatening for our country in previous years have become so widespread today that many parts of the society are affected (Bulut et al., 2006; Coşkun, 2008; Gürol, 2008; Ögel et al., 2004).

A substance use disorder is an illness which can lead to severe disruptions in family, social, physical, mental and occupational functioning (China National Narcotics Control Commission [CNNCC], 2013; Deng, Tang, Schottenfeld, Hao, & Chawarski, 2012; United Nations Office on Drugs and Crime [UNODC], 2012). Patients suffering from substance use disorders have reported fewer social interactions with their friends and family, lower interest or pleasure in their leisure activities, less autonomy to maintain duties, worse cognitive functioning, inadequate social skills and participation in social activities (Coşkun, 2008; Türkiye Uyuşturucu ve Uyuşturucu Bağımlılığı İzleme Merkezi [TUBIM], 2012). Such symptoms are observed from the beginning of the disease (Güdük, 2010).

Loss of social functioning reduces the quality of life of the patient and leads to problems in social, family, recreational and occupational activities (Addington & Addington, 1999). It is important to determine other related factors that might affect social functioning. The internal perception of stigma has been reported to be a predictor of deterioration in social functioning and treatment adherence (Çam & Bilge, 2007; Corrigan, 2004; Pyne et al., 2004; Zartaloudi & Madianos, 2010). Specifically, greater concerns about stigma have been linked with decreased initial intentions to seek therapy (Vogel, Wade, & Hackler, 2007) and, once in therapy, with decreased compliance with therapeutic interventions (Fung, Tsang, Corrigan, Lam, & Cheng, 2007; Sirey, Bruce, Alexopoulos, Perlick, Friedman, et al., 2001), missed appointments (Vega, Rodriguez, & Ang, 2010), less intention to return for subsequent sessions (Wade, Post, Cornish, Vogel, & Tucker, 2011) and early termination of treatment (Sirey, Bruce, Alexopoulos, Perlick, Raue, et al., 2001)

Stigma is a social phenomenon. In the recent two decades, more attention has been drawn toward stigma and its possible consequences, especially after WHO has launched programs against stigma. (Major & O`Brien, 2004). People with mental disorders and especially substance users are the most common victims of stigmatization in almost every culture (Corrigan, Kuwabara, & O'Shaughnessy, 2009). Stigma, plays a critical role in stigmatized people's health and psychological wellbeing (Ahern, Stuber, & Galea, 2007; Corrigan, 2004). A large body of evidence has shown association between self-stigma and decreased self-esteem, anxiety, depressive symptoms, increased feelings of guilt and shame and lower quality of life in the labeled individuals (Corrigan et al., 2003; Crocker & Quinn, 2003; Simbayi, Kalichman, Strebel, Cloete, & Henda, 2007). Therefore, stigmatization and discrimination were given priority in developing the standards for mental health care all over the world (World Health Report, 2001). National studies on stigmatization show that individuals with mental diseases are stigmatized and exposed to social exclusion in our country as well (Arıkan, Genç, Etik, Aslan, & Parlak, 2004; Arkan, Bademli, & Çetinkaya, 2011; Bahar, 2007; Genişol et al., 2003; Schomerus et al., 2011).

Gaziantep University Psychiatric Nursing Postgraduate Thesis

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http://dx.doi.org/10.1016/j.apnu.2015.07.008
0883-9417/

Alcohol and substance use disorders are among the most highly stigmatized of the psychiatric disorders (Corrigan et al., 2005; Etesam, Assarian, Hosseini, & Ghoreishi, 2014). For example, public perceptions of individuals with alcohol and substance use disorders include negative labels, such as dangerous, immoral, weak character, tendency to criminal acts and blameworthy (Corrigan et al., 2005; Fleming, Bradbeer, & Green, 2001). Individuals who perceive these messages may internalize the stigma and behave accordingly beginning from the childhood. "Internal stigma" – also described as felt, imagined, or self stigma – is the product of the internalization of shame, blame, hopelessness, guilt, and fear of discrimination associated with substance use (Corrigan & Watson, 2002; Herek, 2007; Kranke, Floersch, Kranke, & Munson, 2011; Luoma et al., 2007).

Internalized perception of stigmatization plays a powerful and unique role in attitudes toward mental illness and seeking psychological services. The primary goal of the psychosocial treatment of substance use disorder is to achieve reintegration of the individual into the society (Coşkun, 2008). In this context, we believe that the results of the present study provide important data for interventions directed at eliminating internalized stigmatization, which might be a major obstacle to seeking treatment among substance users and their reintegration into the society. Restoration of normal social functioning is the ultimate goal of treatment. Additionally, the results of the present study are expected to serve as a guide for the patients while they are getting prepared to function in the society. The present study was conducted with the aim of determining the level of social functioning and internal perception of stigma among individuals with substance use disorder.

MATERIALS AND METHODS

This descriptive study was conducted at the Department Psychiatry of Gaziantep University Şahinbey Research and Practice Hospital. The study population consisted of 122 patients who were diagnosed with substance use disorder according to DSM-V diagnostic criteria (American Psychiatric Association [APA], 2013) at this hospital during the study period while patients were receiving inpatient treatment. All patients meeting the study inclusion criteria were enrolled without using any specific sampling method. The final study sample comprised 105 individuals with substance use disorder that met the study inclusion criteria and accepted to participate in the study. Seventeen patients were excluded due the presence of a comorbid psychiatric disorder. After informing the patients about the purpose of the study via personal interviews, data were collected using a "Descriptive Information Form" and the "Internalized Stigma of Mental Illness Scale" which was used to determine the stigmatization level and the "Social Functioning Scale" for assessment of functioning levels. Data were collected in the clinic by the study investigator (GC). Completion of descriptive information forms and questionnaires took approximately 20–25 min. *The study inclusion criteria* included being literate, meeting DSM-V diagnostic criteria for substance use disorder (APA, 2013) having no physical disability (physical disability may cause stigmatization and social isolation), and a history of substance use within the previous 10 days. *The study exclusion criteria* included being in the recovery phase after discontinuation of substance use, intellectual disability, age younger than 18 and older than 65 and diagnosis of a comorbid psychiatric disorder (eg., psychotic disorder, personality disorder, depression).

Instruments

Descriptive Information Form

The Descriptive Information Form was developed by the researcher in the light of literature information (Çavuşoğlu, 2009; Güleç & Köroğlu, 2007) and consisted of a total of 16 questions to collect information on sociodemographic features of the patients including age, gender, education status and the level of income and the characteristics of substance dependence.

Internalized Stigma of Mental Illness Scale (ISMIS)

ISMIS was developed by Ritsher, Otilingam, and Grajales (2003) and its validity and reliability were demonstrated in a national study by Ersoy and Varan (2007). The scale was designed to measure the subjective experience of stigma. The scale is a 29-item paper and pencil questionnaire designed to assess subjective experience of stigma (Ritsher et al., 2003). Based on the national validity-reliability study, the reliability coefficient of the scale was 0.94. In the current study, the reliability coefficient was 0.87. It presents participants with first person statements and asks them to rate on a four-point Likert scale how much they agree or disagree. Items are summed to provide five scale scores: alienation, which reflects feeling devalued as a member of society, stereotype endorsement, which reflects agreement with negative stereotypes of mental disorder, discrimination experience, which reflects current mistreatment attributed to the biases of others, and social withdrawal, which reflects avoidance of others because of mental disorder. The final scale, stigma resistance, asks about participant's perceived ability to deflect stigma. The total item score of ISMIS varies between 1 and 4 points (Ersoy & Varan, 2007). Concerning the intensity of stigma, ISMIS scores are rated as follows: a score of 2 or lower indicates minimum intensity, scores between 2 and 2.49 indicate mild intensity, scores between 2.5 and 3 indicate moderate intensity and scores 3 and higher indicate severe intensity (Keyes et al., 2010). Higher scores of ISMIS signify that the internalized stigma of individual is more severe in the negative direction (Ersoy & Varan, 2007).

Social Functioning Scale (SFS)

This scale was developed by Birchwood, Smith, Cochrane, Wetton, and Copestake (1990) and its validity and reliability were demonstrated in a study by Erakay (2001). In this study Cronbach's coefficient alpha was 0.91. SFS consists of 7 sub-scales including (1) Social withdrawal, (2) Interpersonal functioning, (3) Pro-social activities, (4) Recreational activities, (5) Independence-competence, (6) Independence-performance and (7) Work. Minimum and maximum total scores of this scale range between 0 and 223 points and summed score obtained from each subscale indicates positive progress in the social functioning (Erakay, 2001).

Data Assessment

SPSS (Statistical Package for Social Sciences) for Windows 18.0 was used for statistical analysis of study data. Descriptive statistical data (Mean, Standard deviation) were used for data analysis. Pearson's Correlation analysis was used to analyze associations between scales and sub-scales. The results were interpreted using a confidence interval of 95% and significance level set at $p < 0.05$.

Ethical Considerations

Ethical requirements were met during the conduct of the study. Written permission was obtained from the manager of the hospital to conduct this study. Patients were informed about the purpose of the research and each participant gave informed consent. The participants were assured of their right to refuse to participate or to withdraw from the study at any time. Anonymity and confidentiality of patient data were guaranteed.

RESULTS

Analysis of the socio-demographic characteristics of patients showed that 37.1% were between 18 and 25 years of age and 34.3% between 26 and 35 years of age; 92.4% were male, 43.3% had an educational level of high school or higher education, 46.7% were married, 89.5% were employed, 65.7% had an intermediate level of income, 75.2% did not migrate from another region and 84.8% resided in the city centre.