



Relationship between Perceived Stigma and Social Support in Treatment Seeking Male Patients with Opioid Dependence

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ABSTRACT:

OBJECTIVE: This study aims to examine how perceived stigma and social support differs in treatment seeking Male patients with Opioid dependence based on socio-demographic and clinical variables, and to what extent internalized stigma is related to perceived social support.

METHODS: Sixty-two male patients with Opioid Use Disorder (OUD) were included. Semi-structured socio-demographic and clinical data proforma, Substance Use Stigma Mechanism Scale (SU-SMS) and Multidimensional Scale of Perceived Social Support were utilized in the study to collect data. Statistical analysis was performed using EZR software (Easy R), which is based on R and R commander) for Windows (Version 1.54). $P < 0.05$ was considered statistically significant at a 95% confidence level.

RESULTS: Perceived stigma was related to family, involvement in illegal activities, participants who hadn't left opioid use or sought help for the same ($p < 0.01$) No significant relationship was found in perceived social support and socio-demographic characteristics. On the other hand, there was no relationship found between stigma score and multidimensional perceived social support scores.

CONCLUSION: To conclude, stigma and social support occupies an important place in the treatment of OUD, which occurs with frequent relapses and is hard to treat. By aiming at reducing this perception and mobilizing people's social support systems, to educate families on the issue and to get in touch with support units exclusive to individuals with Opioid Use Disorder, it may be possible to increase the success of treatment in such patients.

Keywords- Perceived stigma, Social support, Opioid use disorder

I. INTRODUCTION:

Opioid dependence has become a major public health problem in India. Various researches time and again, have shown the disorder substantially interfering with the patients' daily activities; disrupting social life and disturbing

emotional well-being. Based on a recent survey in 2019, about 2.1% of the country's population use opioids, with heroin use being highest followed by pharmaceutical opioids and opium. [1] Amongst these users, majority of them suffer from opioid dependence and seek treatment for the same. However, there is a considerable delay in treatment seeking owing to various barriers such as lack of health coverage, costs of treatment etc. The stigmatization of these patients is also one such barrier which may lead to this delay. [2]

Stigma is a multidimensional construct that can take the form of an attitude, an attribute or characteristic, or a shared belief about behaviour and can manifest itself in a variety of ways. [3] Self-stigma is an internalized negative belief that individuals hold about themselves, while public stigma refers to the public's negative belief about a person or group. [4] Perceived stigma is the internalized negative belief that others have which is a generally held stereotype about the stigmatized group. Perceived stigma is associated with higher internalized shame and may be a barrier for individuals to enter treatment. Stigma can lead to fear and social isolation and can discourage individuals from seeking treatment and/or help and can affect the way treatment providers interact with someone with a substance use disorder. [5,6]

Perceived social support is a cognitive evaluation of a person receiving support. It has a greater beneficial effect on health than actually received social support. People with SUDs tend to have lower perceived social support than people without SUDs. It tends to improve overall well-being and act as a buffer against relapse and positively influence treatment outcomes in people with SUD. As per a research, it was found that perceived social support is related to frequency of substance use in socially stigmatized population. So perceived social support may be one of the key factors in reducing isolation, functions as a coping resource, and reduce the likelihood of relapse in people with SUD. [7]

It has been found that in the treatment of opioid addiction greater social support is associated



with better outcomes, e.g like seeking treatment earlier, less drug use and improved mental health. Thus, strengthening medical treatment with social support services such as counselling, psychiatric care and family therapy also leads to a further decrease in opioid use. [8]

Since most of the research on perceived stigma and social support concerns SUDs, there is paucity of literature regarding opioid dependence in particular. Therefore, this study will identify these modifiable factors which may improve treatment entry and outcomes in these patients.

II. METHODOLOGY:

This study was conducted at Department of Psychiatry, Mahatma Gandhi Medical College and Hospital, Jaipur- a tertiary care hospital. This study had the approval of the Institutional research ethics committee. A cross-sectional design was employed. The sample of convenience was recruited from the outpatient service by screening all the new registrants with opioid-dependence syndrome (as per DSM-V) [9] to see if they fulfilled the inclusion and exclusion criteria. A written informed consent was obtained from the patients taken up for the study.

Assessment Measures:

Socio-demographic and clinical data was collected by using a semi-structured proforma.

Perceived stigma was measured using Substance Use Stigma Mechanism Scale (SU-

SMS), developed for use in a diverse range of substance using populations, including those who are out-of treatment, non-treatment seeking, treatment-seeking, and in-treatment for substance use disorders. It is an 18 item self-rated 5-point Likert-type scale (1-Never to 5-Very often), which is structured to measure enacted, anticipated, and internalized substance use stigma as distinct constructs (6 points each). Higher scores indicate high substance use stigma. SU-SMS and its subscales is a valid and reliable tool with internal consistency across all stigma mechanisms scales ($\alpha = .90 - .93$) and sub-scales ($\alpha = .90 - .95$). [10]

Social support was assessed using Multidimensional Scale of Perceived Social Support which is a valid and reliable ($\alpha = .88$) 12-item measure of perceived adequacy of social support from three sources: family, friends, & significant other; using a 7-point Likert scale (1 = very strongly disagree, 7 = very strongly agree). Scoring is done by calculating the scores across the 12 items, further dividing by 12, to obtain a mean scale score ranging from 1-7. This mean scale scores between 1-2.9 can be considered as low support, 3-5 as moderate support and 5.1-7 as high support. [11]

Statistical analysis was performed using EZR software (Easy R), which is based on R and R commander) for Windows (Version 1.54). $P < 0.05$ was considered statistically significant at a 95% confidence level.

III. RESULTS:

TABLE-1 Socio-demographic and clinical characteristics of the participants and its relationship with stigma and social support

Socio-demographic and clinical characteristics of participants		N=62	SU-SMS		Multidimensional Scale for Perceived social support	
			TOTAL SCORE (Mean \pm SD)	P value [#]	TOTAL SCORE (Mean \pm SD)	P value [#]
			45.90 (14.0)		3.2 (1.5)	
AGE	18-30 years	41 (66.1 %)	47.02 (14.2)	0.313	3.2 (1.49)	0.336
	31-50 years	16 (25.8 %)	46.19 (14.8)		2.9 (1.9)	
	>50 years	05 (08.1 %)	36.80 (6.0)		4.1 (1.1)	
RELATIONSHIP STATUS	Single	24 (38.7%)	48.58 (15.5)	0.266	3.2 (1.3)	0.580
	Married	31 (50.0%)	43.19 (12.7)		3.0 (1.6)	
	Separated /Divorced	05 (08.1%)	53.60 (13.8)		3.9 (2.4)	
	Widow	02 (03.2%)	39.00 (9.8)		3.9 (2.1)	
OCCUPATION	Unemployed/ Student	16 (25.8%)	50.31 (14.4)	0.370	3.5 (1.1)	0.700



	Labourer	13 (21.0%)	44.08 (14.5)		3.3 (2.0)	
	Self-employed	25 (40.3%)	43.16 (13.7)		3.0 (1.6)	
	Professional	08 (12.9 %)	49.25 (13.2)		2.7 (1.2)	
EDUCATION STATUS	Upto primary	11 (17.7 %)	49.36 (15.2)	0.446	3.6 (2.1)	0.613
	Upto matric	27 (43.5 %)	43.52 (14.0)		3.2 (1.4)	
	Above matric	24 (38.7%)	47.21 (13.6)		3.0 (1.4)	
SOCIO-ECONOMIC STATUS	Upper class	13 (21.0%)	46.46 (13.9)	0.081	2.8 (1.2)	0.168
	Upper middle class	21 (33.9%)	42.81 (12.3)		2.9 (1.4)	
	Middle class	18 (29.0 %)	43.33 (14.0)		3.7 (1.6)	
	Lower middle class	06 (09.7 %)	54.17 (14.9)		3.9 (2.4)	
	Lower class	04 (06.5%)	60.75 (13.9)		2.1 (0.8)	
RELIGION	Hindu	42 (67.7%)	46.29 (12.7)	0.779	3.2 (1.5)	0.903
	Muslim	08 (12.9%)	42.75 (16.3)		3.0 (1.6)	
	Others	12 (19.4%)	47.08 (17.5)		3.1 (1.6)	
DOMICILE	Rural	27 (43.5%)	45.41 (15.2)	0.780	3.1 (1.7)	0.805
	Urban	35 (56.5%)	46.43 (13.3)		3.2 (1.4)	
TYPE OF FAMILY	Nuclear	22 (35.5%)	51.27 (12.9)	0.027*	3.6 (1.5)	0.143
	Joint	40 (64.5%)	43.08 (13.9)		2.9 (1.5)	
ROUTE OF ADMINISTRATION	Oral	13 (21.0%)	41.31 (13.4)	0.112	3.1 (1.5)	0.080
	Smoked	33 (53.2%)	44.64 (13.6)		3.5 (1.6)	
	Injectable	01 (01.6%)	64.00		5.5	
	≥ 2 routes	15 (24.2%)	51.80 (13.9)		2.4 (1.2)	
EVER LEFT OPIOID FOR >1 MONTH	No	39 (62.9%)	41.31 (12.7)	<0.001**	3.2 (1.6)	0.794
	Yes	23 (37.1%)	53.91 (12.7)		3.1 (1.5)	
INVOLVEMENT IN ILLEGAL ACTIVITIES IN PREVIOUS MONTH (such as drug peddling, theft, robbery)	No	54 (87.1%)	43.80 (13.5)	0.011*	3.3 (1.6)	0.176
	Yes	08 (12.9%)	60.75 (6.9)		2.5 (1.1)	
DID YOU EVER SEEK HELP IN LEAVING OPIOID?	No	40 (64.5%)	40.23 (12.0)	<0.001**	3.1 (1.6)	0.497
	Yes	22 (35.5%)	56.45 (11.3)		3.4 (1.5)	

#One-Way ANOVA; *p<0.05; Significant; **p<0.001; Highly significant

In this study, amongst the participants (N=62), 66.1% were between 18-30 years of age, 50% were married, 40.3% were self-employed, 43.5% had received education till 10th class, 33.9% belonged to upper middle socio-economic class,

67.7% were Hindu, 56.5% belonged to urban areas, 64.5% lived on joint family. Also, 53.2% consumed opioids in smoked form, 62.9% didn't leave opioid use for >1 month, 64.5% were seeking



help for the first time, however, only 12.9% were involved in illegal activities in previous month. The participants reported stigma in all 3 domains (enacted, anticipated and internalized) with type of family ($p=0.027$) and involved in illegal activities ($p=0.011$) as important factor in perceived stigma.

Also, highly significant results were obtained with those participants who hadn't left opioid use or sought help for the same ($p<0.001$) No significant relationship was found in perceived social support and socio-demographic characteristics. [Table 1]

TABLE- 2 Correlation between Substance Use Stigma (SU-SMS Scale Scores) And Perceived Social Support (Multidimensional Scale For Perceived Social Support Scale Scores)

VARIABLE	Multidimensional Scale for perceived social-support	
	r value	P-value
SU-SMS Score- Total	0.090	0.489
Enacted Stigma Scores	0.058	0.654
Anticipated Stigma Scores	0.150	0.244
Internalized Stigma Scores	0.029	0.820

$p>0.05$; Not significant

In the present study, no significant relationship was found between substance use stigma and perceived social support in the participants. [Table 2]

IV. DISCUSSION:

Individuals with opioid abuse may suffer from severe stigma, however little is known about correlation between stigma and perceived social support. This research examined how these two influences males seeking treatment for opioid use as helping such individuals may be fruitful for combatting the negative impact of stigma and building support for them.

The present study suggests that a high level of stigma exists in various aspects in opioid abusers which is also depicted in previous studies [12, 13]; with type of family, involvement in illegal activities, >1 month of past history of abstinence and help sought in leaving opioid abuse acting as important factors. This is similar to findings from a study done by Ahern et al. [14] Therefore, implementing changes by providing educational platforms, training to healthcare professionals and researchers, elimination of use of pejorative language (e.g., "addict") might help in reducing stigma.

In our study, no significant relationship could be established between perceived stigma (enacted, anticipated and internalized) and social support, contrary to findings from a Turkish study [15] where a negatively significant relationship was found suggesting internalized stigma is expected to decrease as perceived social support increases among opioid users. A possible explanation for the same can be that most of the participants in our study came with caregivers, thus they had social support. Also, studies in past had researched

relationship mainly between internalized stigma and social support, but none had included all the 3 domains. However, it is vital to enlist family support for people with Opioid use disorder and engage other social support systems to reduce internalized stigma and increase treatment adherence.

V. LIMITATIONS

This study is governed by certain limitations. First of all, the study included a modest number of participants, thereby restricting statistical power. Secondly participants were chosen using convenience sampling method at a single centre, which may limit the generalization of these findings because of sampling bias. Thirdly, self-reporting of the stigma and social support by participants was another important limitation as there might be a discrepancy between the actual responses given to the real picture, which could potentially lead to inaccuracies in the information that has been reported.

VI. CONCLUSION:

To conclude, stigma and social support occupies an important place in the treatment of OUD, which occurs with frequent relapses and is hard to treat. By aiming at reducing this perception and mobilizing people's social support systems, to educate families on the issue and to get in touch with support units exclusive to individuals with OUD, it may be possible to increase the success of treatment in such patients.

CONFLICT OF INTEREST- Nil



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