

# INTERNALIZED STIGMA IN SUBSTANCE USE DISORDER: A COMPARATIVE STUDY INTERNALIZED STIGMA IN SUBSTANCE USE DISORDER

MADDE KULLANIM BOZUKLUĞUNDA İÇSELLEŞTİRİLMİŞ DAMGALANMA: KARŞILAŞTIRMALI ÇALIŞMA  
MADDE KULLANIM BOZUKLUĞUNDA İÇSELLEŞTİRİLMİŞ DAMGALANMA

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DOI: 10.52818/cjmr.1657829 E-ISSN: 2791-7061

ARTICLE INFO	ABSTRACT
<b>Article Information</b> <b>Article Type:</b> Research Article <b>Received:</b> 15.03.2025 <b>Accepted:</b> 12.09.2025 <b>Published:</b> 31.12.2025 <b>Keywords:</b> Substance use disorder, Schizophrenia, Bipolar affective disorder, Internalized stigma	<b>Objective:</b> This study aimed to investigate the levels of internalized stigma among patients diagnosed with substance use disorder and to compare these levels with those observed in patients diagnosed with bipolar affective disorder and schizophrenia. <b>Materials and Methods:</b> This cross-sectional study included 167 patients. All participants completed a socio-demographic data form and the Internalized Stigma of Mental Illness (ISMI) scale. <b>Results:</b> Patients diagnosed with schizophrenia (n = 54) and substance use disorder (n = 55) exhibited significantly higher internalized stigma scores compared to those with bipolar affective disorder (n = 58) (p = 0.003 and p = 0.004, respectively). There was no significant difference in stigma levels between patients with substance use disorder and those with schizophrenia (p = 1.000). Among patients with substance use disorder, female participants had significantly higher internalized stigma scores than their male counterparts (p = 0.034). Notably, the level of internalized stigma in patients with substance use disorder was comparable to that observed in schizophrenia. <b>Conclusion:</b> Assessing internalized stigma in patients with substance use disorder is crucial for improving functionality, treatment adherence, and the management of comorbid conditions such as depressive disorders.

MAKALE BİLGİLERİ	ÖZET
<b>Makale Bilgisi</b> <b>Makale Türü:</b> Araştırma Makalesi <b>Geliş Tarihi:</b> 15.03.2025 <b>Kabul Tarihi:</b> 12.09.2025 <b>Yayın Tarihi:</b> 31.12.2025 <b>Anahtar Kelimeler:</b> Madde kullanım bozukluğu, Şizofreni, Bipolar affektif bozukluk, İçselleştirilmiş damgalanma	<b>Amaç:</b> Çalışmanın amacı madde kullanım bozukluğu tanısı almış hastalarda içselleştirilmiş damgalanma düzeylerini araştırmak ve bu düzeyleri bipolar duygudurum bozukluğu ve şizofreni tanısı almış hastalardaki düzeylerle karşılaştırmaktır. <b>Gereç ve Yöntemler:</b> Kesitsel çalışmaya 167 hasta dahil edildi. Tüm hastalara sosyo-demografik veri formu ve Ruhsal Hastalıklarda İçselleştirilmiş Damgalanma Ölçeği uygulandı. <b>Bulgular:</b> Şizofreni (n=54) ve madde kullanım bozukluğu (n=55) tanısı almış hastalarda içselleştirilmiş damgalanma düzeylerinin, bipolar duygudurum bozukluğu (n=58) tanısı almış hastalardan daha yüksek olduğu bulundu (sırasıyla p=0,003, p=0,004). Madde kullanım bozukluğu ve şizofreni hastalarının içselleştirilmiş damgalanma düzeyleri birbirinden anlamlı olarak farklı değildi (p=1,000). Madde kullanım bozukluğu olan kadın hastaların içselleştirilmiş damgalanma puanları erkek hastalara kıyasla anlamlı olarak daha yüksekti (p=0,034). <b>Sonuç:</b> Madde kullanım bozukluğunda içselleştirilmiş damgalanma düzeylerinin şizofreniye benzerliği dikkat çekicidir. İçselleştirilmiş damgalanmanın incelenmesi, madde kullanım bozukluğu tanısı almış hastalarda işlevsellik, tedaviye uyum ve depresif bozukluk gibi ek hastalıkların yönetimi açısından önemlidir.

This study was presented as an oral presentation at the 59th National Psychiatry Congress and its abstract was published in the congress book.

Sen Gokceimam P. Internalized Stigma in Substance Use Disorder: A Comparative Study. CJMR 2025; 5(3):1-13

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**Authorship Contributions:** The formation of the study design, data collection, statistical evaluation and writing stages all belong to P.S.G.

**Conflict of Interest:** There is no conflict of interest in the article.

**Financial Support:** There is no financial support.

**Ethics Approval:** Ethical approval was obtained from the relevant Ethics Committee prior to data collection (Decision No: 49, Approval Date: July 21, 2023).

DOI: 10.52818/cjmr.1657829

## Introduction

**Stigma** is defined as the exclusion and devaluation of an individual, typically stemming from negative societal beliefs about people living with chronic illnesses (1). **Internalized stigma** refers to the process by which individuals adopt and accept these negative societal judgments, leading to social withdrawal and the experience of negative emotions such as shame and worthlessness (2). In the context of mental illness, internalized stigma adversely affects various domains including help-seeking behavior, self-esteem, social acceptance, interpersonal relationships, and treatment adherence (3–6).

Among the various forms of stigma, internalized stigma has been reported to have the most detrimental impact on the individual (7). A recent meta-analysis investigating the relationship between different types of stigma and help-seeking behavior found that internalized stigma and treatment-related stigma were consistently and negatively associated with the likelihood of seeking help (8).

**The perception or experience of stigma** can adversely impact a wide range of psychosocial domains, ultimately contributing to the deterioration of both mental and physical health (9). **Internalized stigma** has been associated with the exacerbation of psychiatric symptoms (10) and diminished access to mental health services (11). Among mental health conditions, **substance use disorders** are widely recognized as highly stigmatized diagnoses (12). Globally, substance use disorders are among the most stigmatized health conditions. Unlike other mental or physical health disorders, these conditions are often misattributed to personal choice, weakness, or moral failing, further reinforcing negative societal perceptions (13).

In recent years, research on internalized stigma in psychiatric illnesses has increased

substantially. Most studies have focused on the degree of internalized stigma in specific disorders such as personality disorders, anxiety disorders, mood disorders, and schizophrenia (14–16). Comparisons of internalized stigma between bipolar disorder and other psychiatric conditions have primarily involved schizophrenia (17,18). However, internalized stigma in individuals with **substance use disorders** remains relatively understudied, and further research is needed to clarify its scope and implications within this population.

The primary aim of this study was to compare the level of internalized stigma in patients diagnosed with **substance use disorder (SUD)** to that in patients diagnosed with other chronic psychiatric disorders—specifically, **bipolar affective disorder** and **schizophrenia**—which, like SUD, are characterized by impaired functionality, disability, recurrent hospitalizations, and acute exacerbations requiring clinical management. By doing so, the study also aimed to draw attention to the significance of internalized stigma in SUD through the insights gained.

A secondary objective was to examine the relationship between **certain sociodemographic variables** and internalized stigma levels across all three diagnostic groups. Based on previous literature and clinical observations, it was hypothesized that **internalized stigma scores would be highest in patients with substance use disorder**, followed by those with schizophrenia, and lowest in patients with bipolar affective disorder.

There is a limited body of research in Türkiye addressing the relationship between addiction and stigma (19–21). One study explored stigma associated with substance use disorders among youth (19), while another examined the association between internalized stigma and individual clinical characteristics, as well as factors influencing treatment motivation (20). A third study focused specifically on how

internalized stigma impacts addiction-related characteristics and perceived social support in women with substance use disorders (21).

Although the presence of internalized stigma is an important issue in individuals with substance use disorders, it remains insufficiently studied and poorly understood. A review of both national and international literature revealed no previous studies directly comparing internalized stigma levels in patients with substance use disorders to those in patients with other chronic psychiatric disorders.

By presenting the findings of this study, we aim to raise awareness of the significance of evaluating and managing internalized stigma in patients diagnosed with substance use disorders—especially given its known associations with various clinical parameters and prognosis. The results are expected to contribute to the literature by emphasizing the need for a more comprehensive understanding of stigma in this patient population.

### Materials and Methods

This study was designed as a cross-sectional investigation, as it involved collecting data from a group of participants at a specific point in time. Ethical approval was obtained from the relevant Ethics Committee prior to data collection (Decision No: 49, Approval Date: July 21, 2023).

A total of **55 consecutive patients** diagnosed with substance use disorder who presented to the outpatient clinic and met the inclusion criteria were recruited by the researcher from the **AMATEM (Alcohol and Substance Addiction Treatment Center) Outpatient Clinic**, where the researcher was actively practicing. For comparison purposes, the researcher also enrolled **58 consecutive patients** diagnosed with bipolar affective disorder in the euthymic phase, and **54 patients** diagnosed with schizophrenia, all of whom met the study cri-

teria. These participants were referred from the **Mood Disorders and Psychotic Disorders outpatient units** of the same hospital on designated days of the week.

During the recruitment process, **23 patients declined to participate**, while **12 were excluded due to acute substance intoxication**, **5 due to an exacerbation of schizophrenia**, and **6 due to acute manic symptoms**.

All participants underwent a DSM-5 axis diagnostic interview conducted by the researcher. Exclusion criteria were as follows: being under 18 or over 65 years of age, illiteracy, refusal to provide informed consent, presence of intellectual disability, comorbid alcohol use disorder and/or other psychiatric illnesses, current substance intoxication or withdrawal, and being in an acute exacerbation phase of bipolar affective disorder or schizophrenia.

Given that the presence of comorbid mood disorders could influence internalized stigma scores, **patients with depressive or anxiety disorders were excluded** based on clinical interviews conducted by the study psychiatrist, utilizing the **SCID-I** (Structured Clinical Interview for DSM-IV Axis I Disorders) diagnostic tool.

All participants provided informed consent and completed the **Socio-demographic Data Form** as well as the **Internalized Stigma in Mental Illness (ISMI) Scale**. Data collection took place between **August 1, 2023, and December 14, 2023**.

### Power analysis

The statistical power of a study is typically defined as  $1 - \beta$ , where  $\beta$  represents the probability of a Type II error. In general, a minimum power of 80% is considered acceptable in scientific research. Based on the power analysis conducted for this study—and assuming a **medium effect size** according to **Cohen's effect size classification** (22)—it was determined that

a total of **165 participants** would be required. This calculation was made to ensure at least **159 valid participants** to achieve **80% power** at a significance level of  $\alpha = 0.05$ , accounting for potential dropouts or exclusions during the study period.

#### *Statistical approach*

A one-way ANOVA power analysis was performed using **G\*Power (v3.1.9)** software to determine the minimum required sample size for each of the three groups, targeting a statistical power of at least 80%. The statistical analyses were carried out using **IBM SPSS Statistics version 21**.

Descriptive statistics—including mean, median, standard deviation, minimum–maximum values, frequencies, and percentages—were used to summarize the data. To assess the normality of distribution for continuous variables, the **Kolmogorov–Smirnov**, **Shapiro–Wilk**, and **Skewness–Kurtosis** tests were applied.

For group comparisons: **One-Way ANOVA** was used when comparing three or more normally distributed groups, followed by **Bonferroni post-hoc tests** for pairwise comparisons. For non-normally distributed variables, the **Kruskal–Wallis test** was employed, with **Bonferroni–Dunn tests** used for post-hoc comparisons.

For categorical data comparisons, **Pearson’s Chi-Square**, **Fisher–Freeman–Halton Exact**, and **Fisher’s Exact Test** were applied, depending on the data structure.

To examine the relationships between variables, **Pearson correlation** analysis was used for normally distributed data and **Spearman correlation** analysis for non-normally distributed data.

All results were interpreted within a **95% confidence interval**, and statistical significance was considered at  $p < 0.05$ .

#### *Data collection tools*

**Socio-Demographic Data Form:** This form was designed by the researcher in accordance with the study objectives and includes a set of questions to collect socio-demographic information from participants (patients), such as age, gender, marital status, education level, employment status, and clinical history.

**Structured Clinical Interview for DSM-IV Axis I Disorders – Clinician Version (SCID-I):** SCID-I is a semi-structured diagnostic interview developed for use by clinicians and researchers to identify major DSM-IV Axis I psychiatric disorders, including depressive disorders, bipolar affective disorder, anxiety disorders, psychotic disorders, and substance use disorders (23). Although it consists of standardized questions, it provides flexibility for clinicians to explore responses in more depth when necessary. It is widely utilized in both clinical and research settings to ensure diagnostic accuracy and standardization. The Turkish validity and reliability of the SCID-I have been previously established (24).

**Internalized Stigma of Mental Illness Scale (ISMI):** Developed in 2003, the ISMI is a self-report scale designed to assess the level of internalized stigma in individuals with mental illness (25). A Turkish adaptation and validation study has also been conducted (26). The scale contains 29 items rated on a 4-point Likert scale (1 = strongly disagree, 4 = strongly agree). It comprises five subscales: **Alienation**, **Stereotype Endorsement**, **Perceived Discrimination**, **Social Withdrawal**, **Stigma Resistance**.

The total score ranges from 29 to 116, with higher scores indicating greater levels of internalized stigma. Subscale scores provide additional insight into specific dimensions of stigma experienced by patients.

## Results

### Demographic features

This study was conducted with a total of 167 patients who presented to the Erenköy Psychiatric and Neurological Diseases Training and Research Hospital, Istanbul University of Health Sciences, by appointment. Among these, 32.9% (n = 55) were diagnosed with substance use disorder (SUD), 34.7% (n = 58) with bipolar affective disorder (BAD), and 32.4% (n = 54) with schizophrenia. The majority of participants were male, accounting for 73.7% (n = 123) of the total sample.

Within the substance use disorder group, substance distribution was as follows: 21 patients used opioids, 10 used cannabis, 11 reported polysubstance use, 8 used methamphetamine, and 5 used synthetic cannabinoids.

The participants' ages ranged from 19 to 65 years, with a mean age of  $37.87 \pm 11.53$  years. Educational attainment varied, with 44.3% (n = 74) having completed primary education, 35.9% (n = 60) high school, and 19.8% (n = 33) university education. Regarding marital status, 26.9% (n = 45) were married, while 73.1% (n = 122) were single.

Scores on the Internalized Stigma of Mental Illness (ISMI) Scale ranged from 29 to 114, with a mean score of  $61.74 \pm 21.13$ . A summary of participants' socio-demographic characteristics is presented in **Table 1**.

**Table 1:** Distribution of Demographic Characteristics and ISMI scores of Patients

		n /score ranges	%
Age (years)	Min-Max (Median); Mean±Ss	19-65 (38)	37.87±11.53
Gender	Male Female	123 44	73.7 26.3
Educational status	Primary School High School University	74 60 33	44.3 35.9 19.8
Marital status	Married Single	45 122	26.9 73.1
Disease groups	Substance use disorder Bipolar affective disorder Schizophrenia	55 58 54	32.9 34.7 32.4
ISMI scores	Min-Max (Median); Mean±Ss	29 - 114 (60)	61.55±20.79

Statistically significant differences were observed in participants' ages across the diagnostic groups ( $p = 0.001$ ). Pairwise comparisons revealed that patients with substance use disorder (SUD) were significantly younger than those diagnosed with bipolar affective disorder (BAD) and schizophrenia ( $p = 0.001$  for both). However, there was no significant age difference between patients with BAD and those with schizophrenia ( $p = 0.467$ ).

A statistically significant difference was also found in gender distribution among the diagnostic groups ( $p = 0.001$ ). Specifically, the proportion of male patients was significantly higher in both the SUD and schizophrenia groups compared to the BAD group ( $p = 0.001$  and  $p = 0.007$ , respectively). No statistically significant difference in male gender distribution was found between the SUD and schizophrenia groups ( $p = 0.059$ ).

In contrast, educational attainment and marital status did not significantly differ among

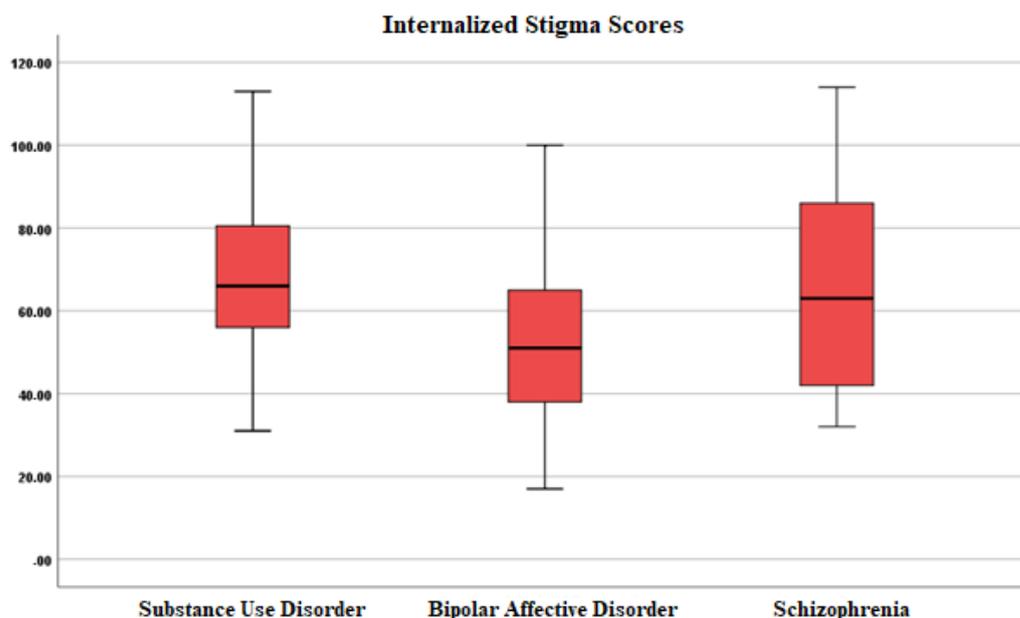
the three diagnostic groups ( $p = 0.176$  and  $p = 0.218$ , respectively). A detailed comparison of demographic variables across the diagnostic groups is presented in **Table 2**.

**Table 2:** Evaluation of Demographic Characteristics and ISMI scores of patients by Disease Groups

		Substance use disorder (n=55)	Bipolar affective disorder (n=58)	Schizophrenia (n=54)	p	IQR + Std.E
Age (years)	Mean± Ss	29.04±9.66	43.33±11.47	40.63±8.53	<sup>a</sup> 0.001**	18 + 11.6830
Gender;n(%)	Male Female	50 (90.9) 5 (9.1)	31 (53.4) 27 (46.6)	42 (77.8) 12 (22.2)	<sup>b</sup> 0.001**	1+0.4369
Educational status;n(%)	Primary School	28 (50.09)	20 (34.5)	26 (48.1)	<sup>b</sup> 0.176	1+0.7663
	High Scholl	21 (38.2) 6 (10.09)	23 (39.7) 15 (25.9)	16 (29.6) 12 (22.2)		
	University					
Marital status;n(%)	Married Single	18 (32.7) 37 (67.3)	17 (29.3) 41 (70.7)	10 (18.5) 44 (81.5)	<sup>b</sup> 0.218	1+0.4435
ISMI	Mean±Ss	66.27±18.00	53.50±19.26	65.96±23.57	<sup>a</sup> 0.001**	

*Comparison of ISMI scores by disease groups*

Statistically significant differences were observed in ISMI scores among the diagnostic groups ( $p = 0.001$ ). Pairwise comparisons demonstrated that patients diagnosed with substance use disorder and schizophrenia had significantly higher internalized stigma scores compared to those with bipolar affective disorder ( $p = 0.003$  and  $p = 0.004$ , respectively). In contrast, no significant difference was found between the ISMI scores of patients with substance use disorder and those with schizophrenia ( $p = 1.000$ ). A comparative distribution of ISMI scores by diagnostic group is illustrated in **Figure 1**.



**Figure 1.** Comparison of patients' ISMI scores by disease groups

*Evaluation of the ISMI score according to demographic characteristics in disease groups*

A statistically significant difference was observed in ISMI scores among patients with substance use disorder based on gender ( $p = 0.034$ ), with male patients exhibiting lower ISMI scores compared to female patients.

Among patients with schizophrenia, ISMI scores also differed significantly according to educational status ( $p = 0.035$ ). Pairwise comparisons revealed that individuals with only primary school education had significantly higher ISMI scores than those with a university-level education ( $p = 0.032$ ).

The evaluation of ISMI scores according to demographic characteristics across the diagnostic groups is summarized in **Table 3**.

**Table 3:** Evaluation of the ISMIS scores According to Demographic Characteristics in Disease Groups

Disease Groups	Demographic Features		ISMI scores			p
			n	Min-Max (Median)	Mean±Ss	
Substance use disorder (n=55)	Gender	Male	50	31-113 (62)	64.80±18.06	<sup>e</sup> 0.034*
		Female	5	69-94 (82)	81.00±9.14	
	Educational status	Primary School	28	31-113 (62)	65.61±19.33	<sup>e</sup> 0.914
		High School	21	32-94 (68)	66.14±16.49	
		University	6	51-103 (61)	69.83±19.41	
	Marital status	Married	18	32-113 (68.5)	70.11±19.27	<sup>d</sup> 0.274
Single		37	31-103 (62)	64.41±17.32		
Bipolar affective disorder (n=58)	Gender	Male	31	29-97 (52)	53.98±20.97	<sup>d</sup> 0.741
		Female	27	29-100 (51)	52.59±16.49	
	Educational status	Primary School	20	29-97 (62)	51.25±20.11	<sup>a</sup> 0.934
		High School	23	29-97(62)	51.25±20.11	
		University	15	29-100 (51)	53.20±20.95	
	Marital status	Married	17	29-92 (66.3)	50.43±19.50	<sup>d</sup> 0.362
Single		41	29-100 (55)	54.88±19.20		
Schizophrenia (n=54)	Gender	Male	42	32-111 (65)	67.98±23.16	<sup>e</sup> 0.212
		Female	12	34-114 (53.5)	58.92±24.66	
	Educational status	Primary School	26	39-111 (68)	71.23±23.94	<sup>c</sup> 0.035*
		High School	16	38-114 (69)	67.56±22.17	
		University	12	32-88 (39.5)	52.42±20.87	
	Marital status	Married	10	36-106 (68.5)	68.50±23.38	<sup>e</sup> 0.632
Single		44	32-114 (63)	65.39±23.85		

## Discussion

This study aimed to compare the levels of internalized stigma among patients diagnosed with substance use disorder, schizophrenia, and bipolar affective disorder, and to examine how these levels relate to socio-demographic characteristics across the three groups. According to the findings, internalized stigma scores were significantly higher in patients with substance use disorder and schizophrenia compared to those with bipolar affective disorder. However, no significant difference was found between the internalized stigma levels of patients with substance use disorder and those with schizophrenia.

Among patients with substance use disorder, female participants exhibited significantly higher internalized stigma scores than their male counterparts.

There were also significant differences in the demographic profiles of the three diagnostic groups in terms of age and gender. These differences likely reflect the epidemiological characteristics of substance use disorders, which tend to occur more frequently in younger male populations. In this study, the proportion of male patients was higher among those with substance use disorder, aligning with typical outpatient clinic demographics for this diagnosis.

Additionally, the proportion of male patients was higher in both the substance use disorder and schizophrenia groups compared to the bipolar affective disorder group. This demographic similarity between the substance use disorder and schizophrenia groups supports the finding that internalized stigma levels did not differ significantly between these two groups. It also strengthens the validity of the comparison by reducing potential gender-related confounding effects.

A review of the literature on internalized stigma reveals that individuals with schizophrenia tend to experience significantly higher levels of internalized stigma compared to those with bipolar disorder (27). In a study conducted in Taiwan, no significant difference was found between the internalized stigma levels of patients with schizophrenia and those with bipolar mood disorder; however, both groups exhibited higher stigma levels than patients diagnosed with anxiety disorders (28).

Another study focusing on individuals with severe mental illnesses—including major depressive disorder, schizophrenia, and bipolar disorder—demonstrated a significant relationship between symptom severity and internalized stigma. However, in that study, ISMI scores did not significantly differ based on psychiatric diagnosis (29). Many other studies also report elevated internalized stigma in patients with schizophrenia compared to those with other psychiatric conditions (30,31). For instance, one study noted that individuals diagnosed with schizophrenia reported more severe stigma experiences than those with depressive disorder (32).

Similarly, numerous studies have confirmed that patients with substance use disorder frequently experience high levels of internalized stigma (33–37).

Despite these findings, to the best of our knowledge, no prior study has directly compared internalized stigma levels between patients with substance use disorder and those with schizophrenia. In the present study, no statistically significant difference was found between the ISMI scores of these two groups, suggesting that both populations experience comparable levels of perceived societal exclusion. However, it is important to consider that stigma levels might be even higher in other populations of individuals with substance use disorder—particularly those using differ-

ent substances or those not currently seeking treatment.

The finding that patients diagnosed with substance use disorder and schizophrenia had significantly higher ISMI scores compared to those with bipolar affective disorder is consistent with the limited existing literature. However, to our knowledge, no previous study has directly compared internalized stigma levels between patients with substance use disorder and those with bipolar affective disorder.

A noteworthy result of this study is the comparable levels of internalized stigma between patients diagnosed with schizophrenia—a chronic, disabling psychiatric illness known for its association with high levels of social stigma—and those diagnosed with substance use disorder, another chronic condition. Both disorders are often perceived by society as dangerous, leading to fear, avoidance, and distrust. These perceptions likely contribute to social exclusion and reinforce internalized stigma in affected individuals.

Functionality is significantly impaired in both disorders, spanning multiple domains such as family life, social interactions, academic achievement, and occupational performance. One study highlighted that individuals with schizophrenia and substance use disorder are often viewed by society as engaging in dangerous and unpredictable behaviors (38), which may further explain the similarity in internalized stigma levels observed in this study.

Importantly, substance use disorder is arguably less accepted as a legitimate medical condition by society—particularly in more traditional cultural contexts—compared to schizophrenia. Many patients with substance use disorder report feelings of guilt, shame, and regret related to their substance use, all of which may amplify internalized stigma beyond the levels seen in other psychiatric conditions.

It is also important to emphasize that this study included only patients who sought treatment voluntarily. Therefore, those with substance use disorder who do not present for treatment—potentially due to even higher levels of internalized stigma—are not represented in this sample. It is plausible that stigma levels could be even more elevated in this untreated population compared to those with schizophrenia.

Previous studies have reported mixed findings regarding the relationship between gender and internalized stigma. One study found that women held more negative attitudes toward mental illness than men (39), while another study concluded that internalized stigma scores were higher among male patients compared to females (40). In contrast, a study investigating stigma experiences among individuals with bipolar disorder identified male gender, comorbid substance use, and longer illness duration as factors associated with increased stigma (41). Research involving patients with schizophrenia has shown that internalized stigma may be more pronounced in female patients (42,43).

In the current study, a significant gender difference was observed in ISMI scores among patients with substance use disorder. Female patients demonstrated significantly higher levels of internalized stigma compared to their male counterparts, a finding that aligns with certain reports in the literature. Despite the predominance of male participants in the substance use disorder group, the elevated stigma levels among female patients underscore the need for gender-sensitive approaches and further research focusing specifically on women.

In traditional societies, substance use among women is often viewed more negatively than among men. Women are frequently blamed or morally condemned, and the additional burden of socially defined roles—such as being a spouse, potential mother, or care-

giver—may intensify feelings of shame and self-stigmatization. These factors may collectively contribute to higher internalized stigma levels in women.

A study on individuals with severe psychiatric illnesses (including major depressive disorder, bipolar disorder, and schizophrenia) found no significant associations between internalized stigma and demographic variables such as age, gender, education, or employment status (29). However, in this study, the mean age of patients with substance use disorder was significantly lower than those in the bipolar affective disorder and schizophrenia groups, whose ages were more comparable. Despite their younger age, patients in the substance use disorder group exhibited ISMI scores similar to those with schizophrenia. It may be hypothesized that internalized stigma increases with illness duration and other accumulated factors. Therefore, future research involving age-matched groups could potentially reveal even higher stigma levels in individuals with substance use disorder.

#### *Clinical and policy implications*

Clinicians—including those working in primary care—should remain aware of the potential for internalized stigma among patients with substance use disorders and should strive to cultivate a nonjudgmental, empathetic, and inclusive treatment environment. Elevated stigma may act as a barrier to both seeking and engaging in treatment and could also complicate patients' interactions with the legal system.

Patients with substance use disorder often face additional stigma-related challenges such as difficulties in obtaining employment or securing housing, which further reinforce negative self-perceptions. These systemic barriers emphasize the need for public policies aimed at reducing stigma and promoting rehabilitation.

Efforts should be made by healthcare systems and policymakers to develop targeted

anti-stigma interventions and social support programs. Encouraging treatment engagement and improving access to legal and social resources may help mitigate the negative consequences of internalized stigma and improve overall clinical outcomes.

#### **Limitation**

As with other studies in the existing literature, this study also has several limitations. First and foremost, due to its **cross-sectional design**, no causal inferences can be made regarding the relationships between the study variables.

#### **Conclusion**

Internalized stigma in individuals with substance use disorder can be at least as profound as that observed in other chronic and severe psychiatric conditions. This phenomenon warrants serious attention due to its established associations with numerous clinical outcomes, including reduced treatment engagement, heightened anxiety and depression symptoms, and increased risk of suicidality.

Importantly, internalized stigma is not a fixed trait; it is modifiable through targeted interventions (44), making it a clinically significant factor that should be actively addressed during patient follow-up. This characteristic presents a unique opportunity for mental health professionals to improve patient outcomes through structured psychosocial support and stigma-reduction strategies.

There is a clear need for further **prospective, descriptive, and comparative studies** involving **larger and more diverse samples** to comprehensively examine internalized stigma in patients with substance use disorder. Future research should explore: Differences in internalized stigma across **specific substance types**, the role of **sociodemographic variables** such as gender, age, education, and marital status, the

impact of **clinical variables** such as duration of illness, comorbid psychiatric conditions, and treatment history.

Such investigations will help inform evidence-based practices and contribute to the development of holistic, stigma-sensitive care models for individuals affected by substance use disorders.

Additionally, **patients with substance use disorder were not stratified according to the specific substances used**. Variations in internalized stigma may occur depending on the type of substance, method of use, and associated sociocultural perceptions. Future research differentiating substance types (e.g., opioids, cannabis, stimulants) may yield more nuanced results.

Another limitation stems from the use of **self-report measures**, which may reduce the objectivity of the data. Although patients in acute illness phases—during which judgment may be impaired—were excluded to mitigate this issue, it is still possible that internalized stigma levels fluctuate depending on insight and disease phase.

Furthermore, **clinical variables such as illness duration and symptom severity** were not evaluated for patients with bipolar affective disorder and schizophrenia, which may have influenced stigma levels. These variables should be included in future studies to better contextualize ISMI scores.

While the **sample size** was statistically adequate, larger and more diverse samples may yield more robust findings. Specifically, the **generalizability** of the results is limited, as all participants with substance use disorder were individuals who voluntarily sought outpatient treatment. Therefore, the findings may not reflect the experiences of those who **avoid or are unable to access treatment**, who may experience even higher levels of internalized stigma.

Additionally, **demographic disparities** between the diagnostic groups—such as differences in age and gender—may have introduced confounding factors. Although the sample size of female patients with substance use disorder was sufficient for statistical comparison, future studies with **balanced demographic representation** across groups will be more informative.

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