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Impact of Perceived Stigma on Help-Seeking Intentions and Social Support among Substance Use Disorder Patients

by

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CERTIFICATE OF APPROVAL

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(Muneeba Siddiqui)

Abstract

The present study aimed to examine the impact of perceived stigma on the help-seeking intentions and social support of patients with Substance Use Disorders (SUDs). A correlational research design was used in this study. Specifically, data were gathered from 220 individuals who were receiving treatment at rehabilitation centers, using a purposive sampling technique. Participants provided data through completion of the Perceived Stigma of Addiction Scale (PSAS), General Help-Seeking Questionnaire (GHSQ), and the Multidimensional Scale of Perceived Social Support (MSPSS). The scales were translated into Urdu using Brislin's (1970) forward and backward translation approach so that the two languages achieved linguistic and conceptual equivalence. Pearson correlation and simple linear regression analyses were employed to test the research hypotheses. Pearson correlation analysis revealed significant positive associations among the research variables; perceived stigma correlated positively with all dimensions of social support, and all social support dimensions (family, friends, and significant others) correlated positively with help-seeking intention, with the strongest link found between support from significant others and help-seeking for suicidal ideation. Regression analysis indicated that while perceived stigma did not significantly predict help-seeking intention for emotional distress or suicidal ideation, it was a significant positive predictor of all dimensions of social support. Finally, gender did not significantly influence help-seeking intentions or perceptions of stigma.These findings contrast with traditional theoretical assumptions, suggesting that higher perceived stigma may drive individuals in rehabilitation to perceive greater support from their immediate social networks as a protective mechanism. The study underscores the need for localized clinical interventions that leverage existing social support systems to mitigate the impact of stigma and enhance recovery outcomes in the Pakistani context.

Keywords: Perceived Stigma, Help seeking intention, Social support, Substance Use Disorders (SUDs), Perceived Stigma of Addiction Scale (PSAS), General Help-Seeking Questionnaire (GHSQ), Multidimensional Scale of Perceived Social Support (MSPSS).

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Abbreviations

GHSQ	General Help-Seeking Questionnaire
MSPSS	Multidimensional Scale of Perceived Social Support
PSAS	Perceived Stigma of Addiction Scale
SUDs	Substance Use Disorders

Chapter 1

Introduction

1.1 Background of the Study

Substance abuse is an issue that requires significant social attention, as statistics and research show that tens of millions of people around the world struggle with substance use disorders (United Nations Office on Drugs and Crime, 2024). Approximately 316 million people worldwide suffer from substance use disorders, with a significant proportion only 1 in 12 individuals receiving the treatment they urgently need (United Nations Office on Drugs and Crime, 2025).

Mental and substance use disorders make up about 7.4% of all disability-adjusted life years (DALYs) globally according to current epidemiological assessments by the Global Mental Health Countdown (Frontiers in Public Health, 2026), making mental health disorders one of the major sources of non-fatal health burden around the world. However, despite this immense burden, there is an immensely inadequate allocation of funds in global healthcare systems in order to deal with substance use and mental health concerns, especially in Low- and Middle-Income Countries, where the treatment gap is more than 90% (Frontiers in Public Health, 2026).

In Pakistan, the prevalence of drug use remains alarmingly high, with recent reports indicating that approximately 7.6 million individuals struggle with drug addiction, primarily involving cannabis, heroin, and prescription opioids (United

Nations Office on Drugs and Crime, 2023). According to the results from the National Survey on Drug Use conducted in Pakistan, the proportion of people who are dependent on drugs stood at 5.8% among those aged 15 to 64 years (United Nations Office on Drugs and Crime, 2023).

According to a national report from the Ministry of Narcotics Control and UNODC, it is evident that there has been an abrupt increase in the consumption of synthetic drugs, especially 'methamphetamine' commonly known as 'ice', amongst young people and university students (United Nations Office on Drugs and Crime (UNODC Country Office Pakistan), 2022).

However, irrespective of the seriousness of their illness, people who suffer from SUDs are bound to face several complex challenges that will prevent them from gaining access to the required assistance and social support (United Nations Office on Drugs and Crime, 2024). People suffering from SUD are faced with a multi-layered web of difficulties, including extreme poverty, non-availability of specific facilities for addictions treatment, and deep-rooted social exclusion (Mehdi et al., 2024).

One of the most critical barriers was perceived stigma, which is defined as an individual's awareness or expectation of public devaluation, rejection, and social discrimination based on their status as a substance user (Luoma et al., 2010).

In today's psychological research, perceived stigma is treated as a separate entity as compared to self-stigma (negative stereotypes that a person experiences inside himself/herself), and structural stigma (institutions that deprive people with stigmas of resources by means of policy decisions) (Isman et al., 2025). Perceived stigma acts as an anticipatory filter for cognition in such a way that when patients believe themselves to be evaluated negatively or discriminated by society, they take precautionary measures (Isman et al., 2025). Researchers found that perceived stigma is extremely high among people with substance use disorders than other diseases due to the fact that society misinterprets addiction as a choice, and not a chronic brain disorder (Shahzadi and Riaz, 2023).

Addiction was viewed as a taboo across in major cultures, Pakistan included, creating a strong sense of social risk when individuals sought formal help or even

openly discussed their addition and given the significant social risk (Ahmad et al., 2023).

Empirical evaluations of a cross-sectional nature carried out in major metropolises of Pakistan, including Karachi, Lahore, Islamabad, Peshawar, Quetta, and Faisalabad, reveal that self-stigma of substance abuse and stigma of substance abuse differ greatly, depending on the extent of addiction and its period, with the highest rates observed for relapsed and chronic patients (Journal of Pakistan Psychiatric Society, 2022; Waseem, 2023).

Research indicate that more than 60% of individuals have SUDs in Pakistan delay or end up not seeking treatment due to fear of ridicule, backlash, or blame from the family and/or community (Khalid et al., 2022). Such stigmas are also culturally reinforced by religious culture where drugs are viewed as sinful (haram) or criminal, compelling many to suffer in silence rather than perceived ostracism (Ali and Kiani, 2023). The recent systematic review on SUD stigma among South Asian settings reveals that the perception by the general public about individuals as either deviant or dangerous reinforces discrimination in healthcare settings, making access to health services even more difficult (Shahid and Asmat, 2023b).

Stigma does not only influence treatment plans, but can have consequences far worse. Research from Pakistan have shown instances of heightened feelings of social isolation, declining mental health, or limited peer or family support experienced by stigmatized individuals (Bukhari et al., 2022). For example, a qualitative study investigating recovered patients in Lahore, stated individuals sought to hide their treatment to not risk losing a job or being rejected by their future spouse (Khan et al., 2024).

Qualitative studies on the subjective experiences of SUD sufferers in Pakistan show that the stigmatization problem greatly prevents social reintegration by causing significant economic difficulties, interpersonal problems, and strong psychological problems (Journal of Ayub Medical College Abbottabad, 2024). Moreover, current cross-sectional studies in the clinical setting show that stigma and experiential avoidance have been found to act as mediators in the process of developing suicidal thoughts among adults undergoing SUD treatment in Pakistan (Saifullah et al.,

2025). When the level of public devaluation is high, people engage in experiential avoidance that isolates them and makes them hopeless (Saifullah et al., 2025).

Such a culture of silence contributes to a cycle of exacerbated addiction where individuals enter into self-medication, or informal and often ineffective remedies when avoiding formal help altogether (United Nations Office on Drugs and Crime, 2024). It is additionally exacerbated by the presence of structural stigma in regular healthcare facilities, where patients often experience being treated with hostility or judgment by medical professionals, thus turning their primary care space into a place of worry instead of relief (Regional Tribune, 2025). It was clear that resolving stigma where people can openly seek help or even ask for help, would fundamentally alter the experience of social supports for individuals with SUDs in Pakistan (Shahzadi and Riaz, 2023).

In many examples, avoidance of treatment pathways was intricately linked to help-seeking intention which refers to the behaviors that individuals engage in to seek help from professionals or assistance systems in a relational context (Rickwood and Thomas, 2012).

Seeking assistance was not an isolated phenomenon; rather, there were various individual and socio-perceived variables affecting help-seeking intention, such as stigma associated with people undergoing therapy, attachment to others, and intention to seek therapeutic assistance (Dagani et al., 2023).

According to the Theory of Planned Behavior, help-seeking intention is the most important immediate variable that influences treatment-seeking behavior. If a person perceives high levels of societal stigma, the subjective norm associated with treatment will be extremely negative and will lower behavioral intention to seek professional help (Isman et al., 2025). There was a strong connection between cultures with high levels of stigma and help-seeking. For instance, in societies with high stigmas, people shy away from seeking help and end up dealing with their own problems, family problems, or societal issues alone (Yu et al., 2023).

As an example, in Karachi a study examined pathways to care for patients with behavioral consequences of substance use disorders (SUD); 68% of patients sought

help for their SUD from religious leaders or traditional healing practices before accessing a clinical setting, indicating that clinical treatment pathways were considered "last resorts" (Bukhari et al., 2022). The latest research on healthcare-seeking intentions among people in Pakistan has identified that supernatural explanations and the use of faith or non-professional healers is considered to be a major mode of coping since people have an intense fear of being publicly disclosed in professional psychiatric institutions (Regional Tribune, 2025). This cycle of avoidance continued to exist, compounding health disparities where untreated SUDs will move into multiple crises (United Nations Office on Drugs and Crime, 2024).

Cultural norms also manifest in help-seeking; in Pakistan, familial honor (izzat) was a strong motivator in making decisions; many individuals worry that by self-disclosing their substance use and subsequently identifying as an addict that they would 'shame' their family household (Ali and Kiani, 2023).

However, in South Asian societies that value collectivism, an individual's act will affect the social status, marital prospects, and reputation of the whole family. Thus, it is the families themselves who will compel silence or denial of a loved one's substance use disorder to safeguard their family's honor at the expense of denying the patient much-needed health care (Regional Tribune, 2025).

Men felt the pressure of making clear to others that they were maintain their providing role, and women were commonly at risk of abandonment/divorce when addressing that they engaged in substance use (Khalid et al., 2022). The gender-based research makes it clear that women substance abusers in Pakistan confront double stigmatization. Women who are suffering from SUDs break not only religious laws but also traditional gender expectations concerning modesty and maternity, which leads to serious social punishments, more family rejections, and almost complete isolation from any rehabilitation programs (Regional Tribune, 2025). Although male patients experience great stress due to financial and role requirements, they have much more freedom to seek special assistance than women patients whose efforts for recovery are constantly hindered to hide family shame (Regional Tribune, 2025). Structural barriers also exist including the cost associated with treatment, geographic access to treatment, and lack of trust imposed by

treatment providers (Zafar and Aslam, 2023). Interventions must address these multi-layered deterrents to foster equitable care access.

However, it is important to note that social support plays an integral part in recovery from substance use disorders. Social support refers to the incorporation of interpersonal relations and support from external sources within one's close social circle including friends and family, with emotional, information, and instrumental support being offered (Taylor, 2022).

Under Social Support Theory, these interactions are believed to act as protective factors which enable individuals to manage stress effectively in relation to substance use problems (Lakey and Orehek, 2023). Social support which includes family members, friends, and significant others is a vital psychological buffer against stress that protects an individual from the adverse effects of stigma in maintaining treatment adherence and psychological resilience (Frontiers in Public Health, 2026).

The more patients experience a high level of emotional and instrumental support from their social environment, the less detrimental effect does public stigma have on their help-seeking intentions (Regional Tribune, 2025). Despite its significance in recovery, addiction stigma continues to pose a barrier to the formation of social ties due to fear of stigmatization or discrimination (Livingston et al., 2023). Pakistan is characterized by a paradoxical milieu in which collectivism is a norm that would form the basis of strong supportive environments, but when individuals experience addiction stigma, these supportive networks collapse (Batool and Manzoor, 2023). The latest research continues to point to the devastating social implications of addiction; for example, according to recent studies, more than 60% of people diagnosed with an SUD have experienced being rejected by their families when they disclosed their addiction (Shahzadi and Riaz, 2023). Moreover, recent statistics in Khyber Pakhtunkhwa show that almost 80% of individuals experience intense social isolation and lose all their friends immediately after revealing their SUD (Ali and Anwar, 2024a). Family and social networks for women evaporated from stigma to a greater extent than male and the family reporting was 85% fully isolated from social support in Punjab (Ali et al., 2023). New ways of addressing

these intersectionality challenges are emerging in culturally relevant ways. The "Sober Ummah" Mosque recovery program in Lahore has a resistance rate of retention that is forty per cent higher than clinical programs (Rahman and Tareen, 2022), and evidence indicates that psychoeducation introduced by Agha Khan University Hospital has fifty per cent improved referral support in the household (Malik et al., 2023a).

According to the recent programmatic evaluations, there is potential for reducing community stigma and encouraging formal help-seeking paths through task shifting of mental health interventions to primary health care workers, such as Lady Health Workers, and involving faith leaders in anti-stigma campaigns (Regional Tribune, 2025).

Although stigma clearly disrupts support connections, specifically designed interventions that take a cultural framework into account, would be successful in restoring support connections and social recovery (Javed and et al., 2024). Despite the high prevalence of substance use disorders (SUDs) in Pakistan, treatment gaps remain due to stigma barriers that have yet to be sufficiently studied (Khan et al., 2023).

Whereas international literature provides ample evidence on how stigmatization causes early termination of treatment (Isman et al., 2025), empirical data in Pakistan, with its honor-based collectivism, is limited and scattered. Current stigma-related research does not have localized evidence to illustrate how perceived stigma disrupts help-seeking and distress related social support among SUD individuals in an honor-based society such as Pakistan (United Nations Office on Drugs and Crime, 2024).

Understanding the complex interactions between perceived stigma, multidimensional social support (family, friends, and significant others), and help-seeking intentions is essential for designing evidence-based, culturally congruent psychological interventions and public policy frameworks in Pakistan. This study seeks to understand the impact of perceived stigma on help-seeking behavior and social support among substance use disorder individuals suffering in Pakistan.

1.2 Gap Analysis

While there is an extensive knowledge base concerning the mechanisms of SUDs, the psychological and social factors behind these clinical conditions have yet to be well-studied, especially in relation to Low-and Middle-Income Countries such as Pakistan (Hanif et al., 2025; Thompson and Saleem, 2024). The absence of evidence from the region has caused dependency on global statistics, which do not account for certain causes such as the influence of family honor or social stigma on behavior outcomes in South Asia (Awan and Malik, 2024). Among the most prominent lacunae in SUD recovery literature, there is the lack of empirical research linking perceived stigma to help-seeking behaviors and social support in SUDs in South Asia (Hassan et al., 2022; Rao et al., 2023; Shahid and Asmat, 2023b). Despite the universally recognized role of perceived stigma in SUD recovery, contemporary literature on the topic has yet to conduct a significant body of work with a specific focus on the unique experience of stigmatizing attitudes toward patients with substance disorders in Low-and Middle-Income Countries (United Nations Office on Drugs and Crime, 2024; Corrigan et al., 2024).

Furthermore, the existing literature on the subject has treated help-seeking intention and social support as two distinct constructs, with limited studies having explored the interrelation between the two constructs within the context of perceived stigma (Xu et al., 2022). Though recent studies have taken into consideration the gender differences in the perception of stigma and help-seeking intention, the studies were conducted on a limited sample and a non-clinical population and were based on attitudes rather than actual treatment-seeking intention (Rao et al., 2023; Hanif et al., 2025).

Another important limitation of the existing literature is the lack of empirical research on individuals who are currently undergoing treatment for their substance use disorder. The vast majority of the existing research is still limited to community-based individuals or those who are resistant to seeking help (Ali and Anwar, 2024a; Khan et al., 2024). The present study attempts to bridge this important research gap by examining individuals currently undergoing rehabilitation

for their drug use disorder in drug rehabilitation centers in Pakistan. The study offers important cultural nuances on how perceived stigma can affect help-seeking and support systems during the treatment phase of the disorder.

In essence, the current study adds value to existing literature through the analysis of such dynamics in an unusual and culturally unique setting. The previous body of research demonstrates the strong influence of such sociocultural stigmas on preventing recovery processes through isolation and use of drugs (Ali and Anwar, 2024a; Batool and Manzoor, 2023; Khan et al., 2024). Identifying such barriers helps to prove the need for implementing community awareness interventions. The initial stage of such interventions would include informing families and the community about the medical dimension of the phenomenon (Malik et al., 2023a). Such strategies would help to eliminate stigmatization in Pakistani culture, which is critical when developing psychosocial interventions in this context (Hanif et al., 2025; Thompson and Saleem, 2024).

1.3 Problem Statement

Substance Use Disorders (SUDs) have been increasingly acknowledged as chronic and relapsing disorders that require comprehensive biopsychosocial interventions (Corrigan et al., 2024). The urgency of this issue is underscored by recent global data indicating that approximately 316 million people worldwide suffer from substance use disorders, with a significant proportion only 1 in 12 individuals receiving the treatment they urgently need (United Nations Office on Drugs and Crime, 2025). Psychologically, SUDs patients tend to be characterized by internalized stigma, low self-worth, and an overwhelming sense of fear and anxiety about their conditions (Shahzadi and Riaz, 2023). On a social front, the impacts of the aforementioned conditions may be even more devastating, involving familial ostracism, marriage breakdown, and social isolation among peers (Ali and Anwar, 2024a). The pattern of clinical abandonment and social alienation is most pronounced in South Asia, as the failure to develop a culturally sensitive support system results

in the absence of any effective route to rehabilitation for the growing number of people affected by SUDs (Khan et al., 2024).

The severity of this issue tends to escalate tremendously within resource-limited collectivist countries like Pakistan (Batool and Manzoor, 2023). Within such a specified target group, one's identity and social status are highly contingent upon family reputation; thus, addiction stigma not only affects the individual but rather the whole household (Khan et al., 2024). Such social realities create numerous psychosocial impediments to seeking treatment (Thompson and Saleem, 2024). Being afraid to cause family shame, along with the absence of any form of cultural psychosocial framework, is one of the key barriers to seeking assistance; hence, making treatment inaccessible (Javed and et al., 2024; Zafar and Aslam, 2023).

In low- and middle-income countries such as Pakistan, the problems of addressing Substance Use Disorders have been compounded by the lack of mental health infrastructure and psychosocial services and the stigma of substance use (Sarkar et al., 2021; Thompson and Saleem, 2024). In such culturally conservative environments, addictions are commonly explained as consequences of moral failings or individual weaknesses and not as potentially curable health issues (Abbas et al., 2025). People with substance use disorders therefore tend to face significant levels of "perceived stigma", which is defined as an individual's awareness or expectation of public devaluation, rejection, and social discrimination based on their status as a substance user (Luoma et al., 2010).

With the immense fear of being shunned by society, people with SUDs tend to hide their problems and refrain from accessing any form of treatment in order to save their reputation both socially and in their families (Ali and Anwar, 2024a). The problem with stigma in this regard is that the fear of being discriminated against is enough to dissuade an individual from making contact with the medical establishment (Malik et al., 2023a). In any case, it is important to remember that proper medical care and social networks of support are universally acknowledged as the only protective factors for recovery from addiction (Zafar and Aslam, 2023).

Yet another, though not so well-explored, aspect in this context is the role of gender in differentiating stigmatization, help-seeking, and social support among

SUD (Shahid and Asmat, 2023b; Rao et al., 2023). There is a growing body of evidence that gender influences health-related behaviors (Hanif et al., 2025). For instance, men may not seek help due to gender roles and expectations of being more self-sufficient. Women suffering from SUD are likely to experience greater levels of stigmatization and social marginalization, thus limiting their access to help and support (Shahid and Asmat, 2023b; Rao et al., 2023; Hanif et al., 2025).

The persistence of SUDs, despite available treatments, highlights an important knowledge gap in the psychological literature, particularly within clinical and social psychology, in relation to the interpersonal and social factors that facilitate SUD recovery (Rao et al., 2023; Shahzadi and Riaz, 2023).

There is an urgent need for quantitative studies that assess perceived stigma, help-seeking, social support within culturally relevant models to improve our understanding of SUD recovery processes in this population (Khan et al., 2024; Shahid and Asmat, 2023b).

This focus is critical because individuals with SUDs in Pakistan exist within a massive "treatment gap," where systemic resource scarcity and a lack of specialized psychiatric facilities mean that less than 10% of those needing help actually receive it (Zafar and Aslam, 2023).

The present study, therefore, aims to assess the impact of perceived stigma on help-seeking intention and social support in SUD samples from a quantitative perspective.

This study, therefore, addresses an important knowledge gap in SUD research in low- and middle-income countries, while informing culturally sensitive clinical practices, and intervention approaches, in this population (Hanif et al., 2025; Thompson and Saleem, 2024).

1.4 Research Questions

This research answers the following questions:

1.4.1 Research Question 1

What is the relationship between perceived stigma, help seeking intention and social support among individuals with Substance Use Disorder (SUDs)?

1.4.2 Research Question 2

To what extent does perceived stigma have the impact on help seeking intention and social support among individuals with SUDs?

1.4.3 Research Question 3

How does gender influence perceived stigma, help seeking intention and social support among individuals with Substance Use Disorders (SUDs)?

1.5 Research Objectives for This Study

Objectives of the study are as follows:

1.5.1 Research Objective 1

To examine the relationship between perceived stigma, help seeking intention and social support among individuals with Substance Use Disorders (SUDs).

1.5.2 Research Objective 2

To investigate the impact of perceived stigma on help seeking intention and social support among individuals with SUDs

1.5.3 Research Objective 3

To examine gender differences in perceived stigma, help seeking intention and social support among individuals with Substance Use Disorders (SUDs).

1.6 Hypotheses

H1: There is a negative relationship between perceived stigma, help seeking intention and social support among individuals with SUDs.

H2: Perceived stigma negatively impacts both help seeking intention and social support among individuals with SUDs.

H3: There is a significant gender difference in perceived stigma, help seeking intention and social support among individuals with SUDs.

Chapter 2

Literature Review

2.1 Perceived Stigma and Help-Seeking Intention

Discrimination on the basis of ethnicity, race, and substance use has been part of the social fabric and has been responsible for the persistent gap in care and treatment outcomes (Room et al., 2021; Rao et al., 2023). Perceived stigma is defined as an individual's awareness or expectation of public devaluation, rejection, and social discrimination based on their status as a substance user (Luoma et al., 2010). In clinical and health psychology, stigma perception is the main cognitive barrier that changes the risk-benefit ratio in favor of avoiding professional help (Isman et al., 2025). In cases when people foresee strong societal condemnation, the potential social costs of going to therapy become higher than the medical benefits of getting well (Vogel et al., 2021). People living with SUDs avoid seeking professional help because of the negative social consequences they may have to endure if they seek help, such as being stigmatized and having their social identity compromised (Hanif et al., 2025). The empirical research also shows that individuals who have to endure high levels of perceived stigma have lower probabilities of accessing formal treatment services because of their fear of being marginalized and excluded from society (Ali and Anwar, 2024b; Shahzadi and Riaz, 2023). In recent times, studies conducted in low and middle income countries have stressed

that such a delay in seeking this treatment results in an added health crisis in which patients only seek treatment for their problems at tertiary hospitals when the stage of dependency is very serious or even when there is a medical emergency (Frontiers in Public Health, 2026).

A study by Ali and Anwar (2024b) related to addiction in Pakistan pointed out that individuals with SUDs are often perpetuated to have strong societal stigma, because drug use as a behaviour was socially viewed as morally unacceptable. The results are consistent with studies done elsewhere, like (Yu et al., 2023), which explored how attitudinal stereotypes could act as mediators between perceived stigma and its consequences on accessing care. Attitudinal stereotypes can be seen as directly relevant to the present research because these constitute the particular cognitive tags, for instance, "moral inadequacy" or "poor self-control," which form the basis of the stigma attached (Yu et al., 2023; Shahzadi and Riaz, 2023). According to cognitive attribution theories, the view that society holds of addiction is that of a behavior that can be controlled by an individual, and hence does not regard addiction as a complicated neurobiological condition; therefore, empathy becomes minimal leading to punishment within society (**?**). Also consistent with Zahid et al. (2022) findings from Pakistan, perceived stigma was found to be the most potent predictor of delayed or avoided help-seeking while fearing a loss of family honour and compromising social standing.

More recently, several studies began to expand on these dimensions of perceived stigma in various perceived contexts. For example, Khan et al. (2023) found that perceived stigma was most pronounced in collectivist contexts, like Pakistan, where family reputation and social norms shape behavior. The authors also reported that perceived stigma was often internalized to self-stigmatization, which further decreases the likelihood of help-seeking. The change from stigmatization in terms of public stigma to self-stigma results in an erosion of self-efficacy, wherein individuals feel that they are inherently not worth getting better or receiving clinical attention (Isman et al., 2025). Similarly, a review by Rao et al. (2023) identified perceived stigma as a global barrier to treatment and noted that it was amplified in cultures with fixed moral and social standards, like South Asia.

Several studies have published results in which they have described cultural and religious characteristics/interpretations in Muslim-majority countries that amplify substance use stigma (Ahmed and Mahmood, 2023; Farooq et al., 2024). For instance, (Husain et al., 2023), used cross-sectional data collected in Pakistan and found that 78% of people with SUD's felt that the community viewed addiction as haram (forbidden), which was highly correlated with treatment avoidance.

In a different study conducted in Iran, (Amin-Esmaeili et al., 2022), described the religious condemnation toward substance use led to internalized shame or stigma, especially for women. In Saudi Arabia, (Alasmari and Almutairi, 2024), documented that a majority of imams (65%) believed that substance use disorders are a moral failing versus a medical condition preventing due access to evidence-based care.

However, modern scholars argue that Islamic jurisprudence clearly draws a distinction between voluntary sinning and coerced treatment, implying that religious platforms can be used not to promote but rather to combat stigma through psychoeducation (Regional Tribune, 2025).

The relationship between stigma and treatment delay has been quantified in multiple settings. A longitudinal study in India Subramanian and Varma (2024) revealed that each 1-point increase on the Substance Use Stigma Scale corresponded to a 23-day delay in treatment initiation (95% CI: 15–31 days). In Pakistan specifically, a mixed-methods study Khalid et al. (2022) identified three primary stigma-related barriers: fear of marriage prospects being damaged (reported by 62% of participants), job discrimination concerns (55%), and anticipated family shame (89%).

These quantitative findings were supported by qualitative interviews where participants described being called "charsi" (addict) as a primary reason for avoiding clinics. In addition to that, recent cross-sectional studies conducted at clinical centers in Punjab and Khyber Pakhtunkhwa show that structural stigma, such as the fear of rough handling by health care providers at hospitals, is a strong secondary determinant of treatment refusal and accounts for more than 28% variance in treatment avoidance (Frontiers in Psychiatry, 2025; Saifullah et al., 2025).

2.2 Perceived Stigma and Social Support

In addition to impacting help-seeking, perceived stigma also interferes with access to social support services by people suffering from (Rao et al., 2023). Social support refers to the incorporation of interpersonal relations and support from external sources within one's close social circle including friends and family, with emotional, information, and instrumental support being offered (Taylor, 2022). Social Support Theory perceives such interactions as essential socio-emotional buffers which prevent psychological problems, encourage treatment compliance, and improve recovery capacity (Lakey and Orehek, 2023). If they work properly, good family and peer support systems offer not only material aid (for example, by financing therapy and providing transport) but also emotional support (Journal of Pakistan Medical Association, 2023). However, perceived stigma could be seen as a major obstacle on the road to social support. People who perceive themselves as under severe stigma will feel reluctant to rely on the help of their loved ones out of fear of being judged or ridiculed (Livingston et al., 2023; Yu et al., 2023).

Studies have found that individuals diagnosed with SUDs and perceived as stigmatized face discouragement in seeking help because of a lack of encouragement from their social networks, leading to a decline in their health status (Martínez, 2025). This trend conforms to the Social Support Detriment Model, which suggests that constant stress factors together with strong societal stigma cause social connections to deteriorate, thus making the person socially vulnerable when support is most required (Ghosh et al., 2024). In Pakistan, where family honor and social standing are paramount, there is an impetus for individuals to avoid discussing the issue of playing with drugs due to fears of shaming their families (Khan et al., 2024). Subsequently, Ali and Anwar (2024b) noted that perceived stigma usually leads to social isolation as a person with a SUD fears shaming their family. They may not receive check in's, talk their story and cut themselves off completely to stop bringing shame to their family and avoid the stigma. The resulting social isolation forms a vicious cycle because these patients isolate themselves from their support system to avoid family embarrassment; this isolation, in turn, makes their

condition worse and contributes to further problems (Journal of Ayub Medical College Abbottabad, 2024).

In addition, perceived stigma may trigger a cycle of silence and avoidance. In a study by Memon and Tariq (2024) in Pakistan, individuals with SUDs indicated that they prefer external, non-family supports from places like peer groups or online communities due to fear of perceived risk of judgment from their social networks. Unfortunately, these external supports often lack the ability to provide treatment and systems assistance for recovery. Whereas online forums and social peer groups provide extremely important and much-needed judgment-free zones for emotional release, they seldom have the requisite structures necessary to deal with clinical recovery, detoxification, or psychiatric follow-through (Regional Tribune, 2025).

The effect of perceived stigma on the social support of people with SUD is evident cross-culturally. Stigma has numerous pathways that effectively isolate or dissolve social support networks. For example, a longitudinal study by Subramanian and Varma (2024) in India found that perceived stigma was associated with a 42% decrease in perceived social support over a period of 12 months among individuals with opioid use disorder, mediated by self-isolation. The results also supported the conclusion that people anticipate stigma and, as a result, withdraw from social settings to prevent rejection, as proposed by identity threat models of stigma-related social withdrawal (Loreth and Simon, 2025).

The erosion of family support due to stigma appears particularly pronounced in collectivist cultures. A comparative study in Pakistan and China Zhang et al. (2022) revealed that 68% of Pakistani participants with SUDs reported decreased family contact following disclosure of their condition, compared to 52% in China. Qualitative interviews identified cultural mechanisms for this disparity, including Pakistan's stronger emphasis on family honor ("izzat") and the moral framing of addiction in Islamic contexts (Ali and Anwar, 2024b; Farooq et al., 2024). These results provide an extension to Goffman's initial theoretical framework on stigma by showing how culture influences stigma outcomes through its value orientation and showing how cultural value orientations can affect the degree of stigma's social

outcomes (Agrali et al., 2024). In collective cultures, stigma seldom affects an individual alone; rather, it acts as a "courtesy stigma" or "associative stigma," affecting the whole family, compelling the family members to avoid or hide their patients due to the need for social respectability (Regional Tribune, 2025).

Recent interventions have attempted to address this stigma-support paradox. Aslam et al. (2023) has shown that family-based anti-stigma programs in Pakistan have shown promise, increasing perceived support by 31% through psychoeducation about SUDs as medical conditions. Similarly, mosque-based support groups in Karachi demonstrated 40% better retention than clinical programs by providing culturally-sanctioned support (Malik et al., 2023b). These methods are founded on the theory of social support deterioration, which indicates that interventions like community connection, psychoeducation, and social interaction-based counter-stigma interventions can be used to restore eroded support networks due to stigma and enhance the prognosis of people living with substance use disorders (Ghosh et al., 2024). Community leaders, family psychoeducation, and peer support counselors form an integrated framework for healing the breach and reconstructing the patient's social shield through standard clinical protocols (Regional Tribune, 2025).

2.3 Gender Differences in Perceived Stigma, Social Support and Help-Seeking Intention

Gender emerges as one of the significant factor through which individuals with SUDs interpret their social environment, thus affecting the process of internalizing stigma and activating social support mechanisms (Ali et al., 2023; Khan and Abbas, 2023a). In the sociocultural context of South Asia, the phenomenon of addiction is not gender-neutral; it is highly influenced by the cultural values associated with honor, domesticity, and masculinity. The cultural values not only determine the degree of stigma associated with addiction but also influence the impediments to seeking mental health services (Bukhari et al., 2022; Zahid et al., 2022). Intersectionality-based research shows that the intersection between gender

and socio-economic class and marital status determines entirely dissimilar experiences of stigmatization, social isolation, and access to healthcare services for men and women with SUDs (Mehdi et al., 2024).

2.3.1 Gender Differences in Perceived Stigma

Perceived stigma varies widely between males and females due to varying cultural expectations. For instance, the socialization process for men within the Pakistani culture requires one to portray oneself as someone who is stoic, autonomous, and emotionally restrained. In situations where there is drug addiction, the perceived stigma is a direct attack on one's masculinity (Rahman and Tareen, 2022). In instances where males become addicted to drugs, society tends to perceive it as their inability to play their gender role as providers and protectors of the family and becomes shamed for their failure to produce economically (Mehdi et al., 2024). In the case of women, the perception of stigma results from a violation of their basic moral values. Since the identity of a woman in the Pakistani culture revolves around their roles as caregivers and nurturers, drug abuse represents a violation of gender behaviors (Coppel and Perrin, 2024). As a result, such women are subjected to moral policing, with 89% of women living in urban areas being branded as "bad mothers" or unfaithful (Memon and Tariq, 2024). This form of social disapproval imposes a 'double stigma' upon women, in that they are penalized not only for the criminal and spiritual offense of taking drugs, but also for their violation of the set norms of female decency and motherhood (Regional Tribune, 2025).

2.3.2 Gender Differences in Social Support

Consequently, there will be notable dissimilarities in how social support is provided and sustained in such cases.The social support that would be provided to an addicted male, for example, would center on recovery with the intention of rejoining the workforce, but it will still be inconsistent if the addicted individual stops providing the major financial support to the household (Rahman and

Tareen, 2021; Üzümçeker, 2025). Notwithstanding this point, however, addicted men are always urged to undergo recovery and "rejoin the workforce."

In addition, women suffer from extreme social exclusion and lack of social support systems. For instance, the woman addicted will be forced into isolation due to the fact that addiction brings shame to her, as she brings shame to "family honor" (Ghayrat) (Ali et al., 2023). While families of male addicts tend to search for ways of getting help for their loved ones through rehabilitation centers or finances, the families of female addicts tend to cover up her situation within the family or completely cut off from her to avoid a scandal. This social exclusion faced by the addicted women is further worsened by the fact that they will not receive any formal support since 63 percent of addicted women have experienced various obstacles to recovery, including lack of gendered rehabilitation facilities (Ali et al., 2023).

2.3.3 Gender Differences in Help Seeking Intention

In conclusion, there are comparative disparities between men and women in relation to help-seeking because of the gendered nature of stigma and social support (Zahid et al., 2022; Zaidi et al., 2023). Help avoidance among the Pakistani community is a complex psychological phenomenon associated with gender roles. There is evidence indicating that the primary reason why men refrain from seeking any kind of clinical help is because of the loss of self-competence; males refuse to seek help from professionals in order to preserve their masculinity and not appear as "less of a man" (Mostoller and Mickelson, 2024; Qureshi et al., 2023).

At the same time, females usually refrain from seeking formal help for fear of rejection by their close family members (Zahid et al., 2022; Khan and Abbas, 2023b). However, seeking help professionally exposes women to serious social repercussions such as domestic abuse, being divorced against their wishes, losing custody of children and ultimately being rejected by the entire family (Regional Tribune, 2025). It is essential to note that the underlying problem of gender role strain negatively impacts the help-seeking behaviors of both sexes, but the

reasoning behind this disparity is different (Malik and Hassan, 2024; Smith and et al., 2025). Such deep-rooted gender differences need a gender-specific approach to policy-making in the form of gender-specific rehabilitation centers for women with an inbuilt childcare facility along with a campaign to rebrand addiction as a treatable health condition among both genders (Regional Tribune, 2025).

2.4 Theoretical Framework

The current research is based on Social Support Theory (Thoits, 2011), which explains the relationship between social connections, resources, psychological well-being, coping, and health-related behavior especially for individuals who are under chronic stress and vulnerable (Rao et al., 2023). According to recent research, social support appears to be a vital factor in behavioral reactions to stress, particularly in cases involving clinical samples like those with substance use disorders, which require different approaches to achieving success, including medical assistance and environmental considerations (Ali and Anwar, 2024b; Hanif et al., 2025).

Social Support Theory was developed based on sociological and psychological theories that highlight the protective effects of having a supportive network of individuals to help cope with stressful situations and to perform adaptive behavior under adverse conditions (Thoits, 2011; Rao et al., 2023). Recent studies have applied this framework to addiction studies, where social support is a key determinant of recovery outcomes, treatment compliance, and relapse prevention for individuals with Substance Use Disorders (Rao et al., 2023). People with a support network have been found to exhibit greater help-seeking behavior and better recovery outcomes from their addictions than those without such a network (Ali and Anwar, 2024b; Hanif et al., 2025).

Under this conceptualization, social support is seen as having three dimensions: emotional support, informational support, and instrumental support, each contributing uniquely to recovery processes (Ali and Anwar, 2024b). Emotional support includes receiving empathy, care, and reassurance from family members, friends, and significant others, thus providing stability to mental well-being and

reducing levels of psychological distress during recovery (Rao et al., 2023). Informational support includes receiving advice and information regarding available options and coping strategies, thus aiding in decision-making and service access (Hanif et al., 2025). Instrumental support includes receiving actual help in the form of financial support and logistical assistance, thus aiding in treatment engagement (Khan et al., 2024)

Empirical research findings suggest that having strong social support networks is positively related to levels of treatment engagement, psychological well-being, abstinence, and decreased relapse rates in individuals suffering from substance use disorders (SUDs) (Rao et al., 2023). On the other hand, social support withdrawal and lack thereof are positively related to psychological distress, treatment evasion, and continued SUDs (Ali and Anwar, 2024b).

Moreover, Social Support Theory argues that access to and use of support are further influenced by general social processes, with perceived stigma being one of the critical factors in this regard (Khan et al., 2024). Perceived stigma is defined as an individual's awareness or expectation of public devaluation, rejection, and social discrimination based on their status as a substance user (Luoma et al., 2010). In relation to substance use, perceived stigma has been argued to create a moral problem with individuals being addicted to substances, thus leading to shame and fear of being rejected by society, which in turn affects disclosure and access to support (Memon and Tariq, 2024).

In this theoretical context, perceived stigma has been argued to be one of the psychosocial barriers to building and maintaining social relationships, thus creating barriers to access to support (Ali and Anwar, 2024b). For example, when there is stigma attached to an individual, it becomes difficult for him to avail professional help as well as help available from support groups because of the fear of discrimination (ElHayek et al., 2024).

In the context of Pakistan, perceived stigma is particularly salient in terms of substance use due to factors such as family honor, moral values, and social reputation (Khan et al., 2023; Thompson and Saleem, 2024). Individuals suffering from substance use disorders often tend to deny or hide their condition to avoid being

labeled or bringing shame to their families (Ali and Anwar, 2024b). This further increases feeling of loneliness and decreases access to support systems (Hanif et al., 2025).

Perceived stigma can affect all three aspects of social support. It can affect emotional support by discouraging positive reinforcement, leading to feelings of loneliness and lower self-esteem among affected individuals (Rao et al., 2023). It can affect informational support by limiting communication regarding treatment and recovery, resulting in a lack of proper knowledge and awareness about available support systems (Hanif et al., 2025). Moreover, perceived stigma can affect instrumental support in terms of financial support from families due to factors such as social reputation (Khan et al., 2024). These disruptions significantly affect help-seeking behavior, which is a significant factor in recovery from substance use disorders. Stigma-related emotions, such as shame, denial, and fear, reduce individuals' willingness and self-confidence in seeking help, thus prolonging substance use and recovery (Rao et al., 2023). Therefore, in addition to being a mental barrier, perceived stigma also acts as a social control in limiting access to recovery opportunities. Based on Social Support Theory, this study defines perceived stigma as an independent variable that affects help-seeking intention and social support. Help-seeking intention (assessed via GHSQ) and perceived social support (evaluated through MSPSS) are regarded as outcome variables. This framework offers a systematic comprehension of how stigma undermines social support systems and affects treatment-related behaviors in individuals with substance use disorders (SUDs).

This study employs Social Support Theory within a culturally specific Pakistani framework, providing an extensive elucidation of the interplay among psychological, social factors that affect substance use treatment and recovery outcomes. The findings aim to promote culturally-sensitive clinical practice by determining the cultural standards that affect treatment compliance (Shahid and Asmat, 2023b).

Having determined the clinical baseline, the data can then be used to develop policies that can deal with the system failures that have led to exclusion of marginalized communities from receiving treatment (Zubair et al., 2024).

Indeed, the policy-oriented approach based on scientific research is expected to enhance the intervention strategy among under-researched communities within developing countries (Riaz and Batool, 2024).

2.5 Conceptual Framework

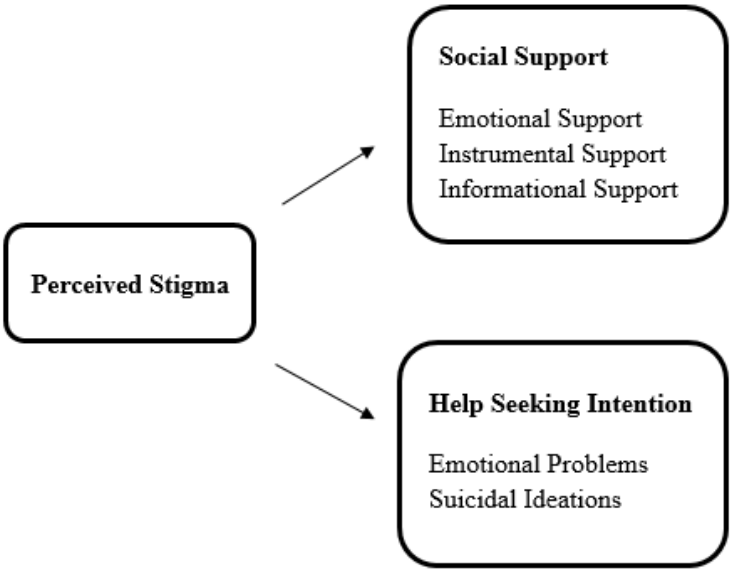

FIGURE 2.1: Conceptual Framework

Perceived stigma appears to be a special type of barrier that affects people's willingness to seek help and use social support, as it induces fear of negative public judgment and makes people refrain from seeking help, depriving them of reliable information regarding their chances of recovery (Isman et al., 2025). Additionally, perceived stigma has the ability to eliminate all forms of social support as families and communities may withdraw assistance to safeguard their own social reputation (Awan and Malik, 2024). It leads to a profound barrier, in which individuals who face extreme stigmatization have dual deficits; they lack both personal initiative and social motivation that is needed to seek help (Farooq et al., 2024).

2.6 Rationale

Substance use disorders (SUDs) are a serious public health issue in Pakistan, where social and religious cultural norms contribute significantly to stigmatizing addiction (Ali and Anwar, 2024b). Although the prevalence of drug use among adults is stated to be about 7.6%, help-seeking intention continue to be relatively rare, largely due to the stigma associated with drug addiction (Khan et al., 2024). The stigma fear instilled within oneself is also a significant barrier, since most people are of the opinion that seeking any help will bring down their family's prestige or izzat (Shahid and Asmat, 2023a). In both rural and urban communities in Pakistan, these stigmas take place in extreme ways, such as family disinheritance and even sudden joblessness, making it difficult to access services for rehabilitation (Awan and Malik, 2024). In turn, these stigmas contribute to a vicious circle of delayed treatment, with individuals opting for help only after experiencing extremely severe symptoms (Zafar and Aslam, 2023). This is especially problematic because of the well-established connection between delayed clinical treatment and lower chances of successful recovery, evidenced by an increased tendency towards relapses (Farooq et al., 2024).

Apart from avoiding professional assistance, stigmatization undermines the social networks that are crucial for achieving sustained recovery (Hassan et al., 2025). Although the social support system is recognised as an essential factor in overcoming addiction successfully, the presence of stigma made the social support system lose its importance for the addicted people in Pakistan (Ali and Anwar, 2024b). According to studies, substance abuse disorder related stigmatization hinders the process of treatment and recovery by diminishing social support and making relapse more likely (Shahid and Asmat, 2023a). Many people with SUDs wind up with a smaller social circle as friends and family distance themselves out of shame or disapproval (Ali et al., 2023). People thus become socially isolated, making their addiction and recovery process even harder because of a lack of social capital for them (ElHayek et al., 2024). This is especially problematic given that the lack of social support and lack of help-seeking create an untenable level of risk for recovery; however, little research has explicitly focused on their connection in

the Pakistani context. Research on stigma regarding SUDs has primarily been conducted in Western contexts. A gap in this literature is its lack in understanding the stigma of SUDs and potentially harmful implications surrounding stigma in the context of Pakistan (Rahman and Tareen, 2021). Family reputation and community acceptance in a collectivist culture such as Pakistan imply that there are special challenges associated with stigma that cannot be fully described using studies from individualistic cultures (Mustaqeem et al., 2025). It is important to note that although social support had already been established to be one of the integral components of treatment globally (Hanif et al., 2025), there was not much known about how the impact of perceived stigma could affect the provision and access to such social support by Pakistani patients who have SUD problems because societal rejection usually results in the loss of family and community support entirely (Awan and Malik, 2024; Shahid and Asmat, 2023b). In the pursuit to address such limitations, this paper will analyze the role of perceived stigma on how it may affect access to social support and help-seeking intention in Pakistan quantitively (Ali and Anwar, 2024b; Khan et al., 2024).

Implications of this research will be significant for clinical practice and public health interventions in Pakistan. By illuminating distinct ways in which perceived stigma hinders help-seeking behavior and and reduces the overall availability of supportive resources, this study offers critical insights into the development of future intervention strategies (Hassan et al., 2025). Ultimately, these findings may help inform the development of more culturally relevant and effective interventions to target these social initiation and support considerations. Possible implementations involve stigma-reduction tactics aimed at families and communities and adapting current treatments to reduce stigma or be more available to those who may be deterred due to community stigma. At a policy level, this research can guide the development of public health campaigns that challenge harmful stereotypes while respecting cultural values. Ultimately, this study represents an important step toward improving treatment outcomes and quality of life for individuals with SUDs in Pakistan, while also contributing valuable insights to the global understanding of addiction stigma in collectivist societies.

Chapter 3

Research Methodology

3.1 Research Design

For the present study, a correlational research design was used to examine the impact of perceived stigma on help seeking intention and social support among individuals suffering from SUDs. The correlational research design is especially suitable for exploring complex psychological and social behaviors, in which the natural variables involved cannot be manipulated in an experimental setting, due to ethical and practical considerations. The use of a correlational design allows this study to assess the direction, magnitude, and structure of the relationships between the independent variable, perceived stigma and the dependent variables, help seeking intentions and social support.

3.1.1 Type of the Study

A non-experimental, cross-sectional, quantitative design was used to examine the impact of perceived stigma on help seeking intention and social support among individuals with Substance Use Disorders (SUDs). The design was cross-sectional and non-experimental, focusing on the relationship among psychosocial variables, all assessed using standardized self-report measures. A quantitative methodology was chosen so that empirical hypotheses could be tested, along with the creation

of standardized statistical models and the ability to generalize results to similar populations of clinical patients in Pakistan.

The cross-sectional method entails collecting information on subjects at one single, defined point in time throughout their rehabilitation process. This research design is highly beneficial when conducting research in a clinical setting, particularly in the field of addiction research, because it reduces patient burden and does not require longitudinal follow-up, which results in higher attrition rates due to stigma associated with being in a stigmatized population. Cross-sectional studies, although do not provide evidence of causal relationships between variables, still give empirical basis for finding statistically significant predictors.

3.1.2 Sampling Procedure

A purposive sampling procedure was used to include participants already admitted to rehabilitation centers in urban settings within Pakistan that met eligibility for the study and inclusion criteria. The purposive sampling method, a type of non-probability sampling technique, was purposely used as it was meant for a special clinical group whose members had a known substance abuse problem, were under or looking for treatment, and who would be hard to sample using random sampling because of their social concealment and sensitivity of the issue.

The inclusion criteria required the participants to be aged 18–45 years, diagnosed with a substance use disorder, and to have an ability to understand and respond in either Urdu or English. Participants with acute drug-induced psychosis, significant cognitive problems, or delirium from medically assisted withdrawal during the data collection process were excluded to ensure informed consent and reliable self-reporting.

Ultimately, 220 participants agreed to participate in the study, after voluntarily consenting for study. The sample size was determined based on the power analyses conducted using G power software.

3.2 Time Horizon, Study Setting and Data Collection Procedure

The current study utilized a cross-sectional time frame, as data were gathered from participants at a singular moment. A cross-sectional design was deemed suitable as the study sought to investigate the relationships among perceived stigma, help-seeking intention and social support without altering variables or monitoring temporal changes. The cross-sectional design was suitable due to the clinical environment and the availability of participants receiving treatment during the data collection phase.

The research was carried out in accredited rehabilitation centers and substance use treatment facilities in Rawalpindi/Islamabad. These centers offer organized treatment plans for people with Substance Use Disorders. These plans include detox services, psychological counseling, group therapy, and programs to help people avoid relapsing. Participants were drawn from clinical populations presently engaged in treatment programs at these facilities. The chosen settings were suitable for the study as they facilitated direct access to individuals with clinically diagnosed substance use disorders who were actively participating in recovery processes. Doing the study in rehabilitation centers made sure that the people who took part met the requirements and had relevant life experiences with stigma, seeking help, and getting social support while getting treatment for substance use.

Before collecting data, the administrative authorities of the chosen rehabilitation centers gave their official permission. Ethical standards were strictly followed, such as voluntary participation, informed consent, privacy, and the right to leave the study at any time. Individuals who satisfied the inclusion criteria (e.g., diagnosed with SUD, presently undergoing treatment, and consenting to participate) were approached individually and informed about the study's objectives.

After getting written informed consent, participants were given a structured questionnaire with standardized scales that measured perceived stigma, help-seeking behavior, and social support, as well as a form for demographic information.

The questionnaires were given in a quiet, private place in the rehabilitation centers to protect privacy and reduce the effects of social desirability bias. Participants were urged to answer truthfully and were guaranteed that their responses would be kept confidential and utilized exclusively for research objectives.

Participants who needed help understanding things because they couldn't read or write were given help. As soon as the questionnaires were finished, they were collected right away to keep the data safe. After that, the data was coded and put into SPSS for statistical analysis.

3.3 Sample Characteristics

The final sample included 220 individuals diagnosed with SUDs. Participants ranged in age from 18 to 45 years (Shahzad et al., 2022), with the majority falling between 26–35 years. Males represented 60.4% of the sample, while females accounted for 39.6%. Educational levels varied, with most participants having completed high school or intermediate education.

Employment status was diverse, including full-time and part-time workers, freelancers, students, and unemployed individuals. Marital status included unmarried, married, divorced, and widowed participants.

Participants reported varied levels of family and personal monthly income, and the substances used included cannabis, amphetamines, heroin, cocaine, and others, with a significant number reporting polysubstance use. The majority had been using substances for 1–5 years. Reasons for substance use were primarily peer pressure, followed by educational stress, financial difficulties, and family or marital issues.

3.4 Selection Criteria

3.4.1 Inclusion Criteria

i. Participants who are diagnosed with Substance Use Disorders (SUDs).

ii. Individuals within the age range of 18–45 years. iii. Participants who are actively engaged in treatment or recovery or who have had previous experience with formal or informal support systems for SUDs.

3.4.2 Exclusion Criteria

i. Participants with any mental or physical impairments that may interfere with their ability to provide informed consent or complete the study questionnaires (e.g., severe cognitive impairments, psychotic disorders).

3.4.3 Measures

3.4.3.1 Demographic Sheet

A comprehensive demographic information sheet was distributed to all participants in Urdu to collect essential background data. The sheet captured key variables including age, gender, nationality, city of residence, parental occupation, family structure, educational attainment, employment and marital status, income levels, and detailed history of substance use (type of substance, duration of use, previous treatment and related health complications). This demographic profiling enabled crucial subgroup analyses while ensuring cultural appropriateness through native language administration.

3.4.3.2 General Help Seeking Questionnaire

The General Help Seeking Questionnaire (GHSQ) was used to examine help-seeking intentions of people with Substance Use Disorders (SUDs). The GHSQ comprises 20 items, organized into 2 separate areas: the first 10 items focused on help-seeking intention towards personal or emotional problems, while the last 10 items asked about help-seeking intentions regarding suicidality. All items are to be completed using a 7 point Likert scale from (1) “extremely unlikely,” to (7) “extremely likely,” with more positive scores related to more willingness to seek help. The total score is converted by summing the responses across all items

(range: 20–140), with two subscale scores composed of emotional distress (items 1–10) and suicidality (items 11–20). Wilson et al. (2005) original study confirmed the GHSQ to have high internal reliability: Cronbach's alpha = 0.88.

3.4.3.3 Multidimensional Scale for Perceived Social Support

The translated version of Multidimensional Scale of Perceived Social Support (MSPSS) was used to evaluate perceptions of available social support in three areas of interest, namely: family (items 3, 4, 8, 11), friends (items 6, 7, 9, 12) and significant others (items 1, 2, 5, 10).

This scale comprises 12 items, and responses are evaluated on a 7-point Likert scale level of agreement from 1 = very strongly disagree to 7 = very strongly agree.

The MSPSS total scores are summed from a range of 12–84 (higher scores indicate greater perceived support). The scale is psychometrically sound, and the original validation reported Cronbach's alpha of 0.91, confirming high internal consistency (Zimet et al., 1988).

3.4.3.4 The Perceived Stigma of Substance Abuse Scale

The Perceived Stigma of Substance Use Scale (PSAS) was used to measure the stigma that people with Substance Use Disorders (SUDs) experience.

The PSAS includes eight questions about the feelings (e.g., shame, fear of being judged) and cognitions (e.g., beliefs about how others think about substance use), the stigma of substance use may decrease people's motivation to seek treatment or maintain their social network.

Respondents rated how much they agreed with each statement on a 5-point Likert scale, from 1 ("strongly disagree") to 5 ("strongly agree"). Higher total scores (range = 8–40) correspond to more perceived stigma. The PSAS has strong reliability (Cronbach's alpha = 0.91) in its initial validation Luoma et al. (2010) and will be a powerful tool for assessing stigma in clinical populations.

Translation Procedure of Research Instruments

Since the Perceived Stigma of Substance Use Scale (PSUSS) and the General Help-Seeking Questionnaire (GHSQ) were initially developed in English, a methodical translation process was implemented to guarantee linguistic and cultural suitability for the intended Pakistani audience. In order to preserve semantic and conceptual equivalency, the translation procedure adhered to Brislin (1970) forward-backward translation model, which is generally advised for cross-cultural research.

i. Step 1: Forward Translation

The General Help-Seeking Questionnaire and the Perceived Stigma of Substance Use Scale were first translated into Urdu by bilingual specialists who were fluent in both Urdu and English. Instead of using a literal translation, the translators made sure that each item's conceptual meaning was maintained by being conversant with psychological terminology.

ii. Step 2: Backward Translation

Following the forward translation, the Urdu versions of the scales were translated back into English by a separate bilingual translator who had not seen the original versions. In order to find discrepancies, meaning distortions, or a loss of conceptual clarity between the original and translated versions, this backward translation was carried out.

iii. Step 3: Expert Review and Reconciliation

University academic members with competence in clinical psychology and psychometrics then evaluated the original English versions, the forward-translated Urdu versions, and the backward-translated English versions. The faculty assessed the translated items for clarity, cultural relevance, conceptual accuracy, and semantic equivalency. In order to improve language and make sure that the things were easily understood within the Pakistani cultural context, minor adjustments were made as needed. The final Urdu versions of both instruments were authorized after integrating expert feedback.

iv. Step 4: Pilot Testing

A pilot research was carried out on a sample of 50 individuals selected from the target group after the translated scales were finalized.

The pilot testing was conducted to evaluate the instruments' initial dependability, understanding level, cultural appropriateness, and item clarity. Any ambiguity or trouble understanding the items was urged to be reported by the participants.

Duration of Translation Process

It took about a month to finish the entire translation and adaption process, which included forward and backward translation, expert evaluation, modifications, and pilot testing. The instruments' linguistic accuracy, cultural sensitivity, and psychometric fitness for application in the Pakistani clinical population were guaranteed by this methodical and exacting procedure.

3.5 Procedure

Following ethical approval and formal permissions from the appropriate rehabilitation centers, purposive sampling was used to recruit participants who had been diagnosed with Substance Use Disorders (SUDs).

The study purpose was explained, and informed consent was received with assurances of participant confidentiality, anonymity, and voluntary participation. Standardized questionnaires, the General Help-Seeking Questionnaire (GHSQ), Multidimensional Scale of Perceived Social Support (MSPSS), and Perceived Stigma of Addiction Scale (PSAS) were translated into Urdu using the forward and backward translation method.

A pilot study was conducted on a small sample (N = 50) to assess reliability and clarity, confirming the instruments were suitable for the main study.

Data were then collected in a paper-pencil format from 220 participants in clinical settings, with the researcher or staff available for assistance. Responses were entered and analyzed using SPSS version 26 to perform descriptive, correlational, and inferential statistical analyses.

3.6 Ethical Considerations

Ethical considerations for the study prioritized the protection and well-being of participants. Conducting research among clinical populations with Substance Use Disorders (SUDs) involves navigating heightened socio-legal vulnerabilities, deep-seated social stigma, and delicate psychological states. Consent forms were provided in Urdu to guarantee full comprehension, with a clear explanation of the study's purpose, procedures, potential risks, and benefits. For participants who possessed limited literacy, the consent document was read aloud verbatim by researcher in a private setting, and witnessed verbal consent were secured. Participants were assured that their participation was voluntary, and they have the right to withdraw from the study at any point without facing any negative consequences, including no disruption or impairment to their ongoing clinical care, medical treatment, or length of stay at the rehabilitation facility.

Confidentiality was guaranteed, and all personal information and responses were kept anonymous, with data reported only in aggregate form. To preserve anonymity, no direct personal identifiers (such as national ID numbers, full names, or residential addresses) were recorded on the questionnaire booklets. Participants were also assured that their data were stored securely and were only accessible to the research team. Furthermore, in the event that participants may feel distress from sharing sensitive information about substance use, support and resources for counseling or treatment were provided. Because reflecting on past societal discrimination, rejection, and personal addiction history can trigger emotional vulnerability or psychological distress, on-site clinical psychologists and facility counselors were placed on standby during all administration sessions to offer immediate debriefing and therapeutic support if requested.

Ethical approval was obtained from the institutional review boards (IRBs) or ethics committees to ensure all procedures were consistent with the highest standards of ethics in research. The administrative authorities and medical directors of each participating rehabilitation center also granted permission prior to conducting data collection on their premises.

Chapter 4

Results

4.1 Pilot Study

The scales were translated into Urdu, respectively, using a forward-backward process (e.g., from source language to target language and then back to source language) to ensure cultural and translational equivalence, and decision accuracy. The pilot study, used to evaluate potential participant bias, clarity, and understanding was analyzed using SPSS so psychometric properties could be explored. Reliability analysis was conducted to assess internal consistency, and correlation was used to explore relationships between variables. The results provided preliminary support for the use of the measures. Below are the reliability and correlation results obtained from the pilot study.

Using the data from the pilot study, Cronbach's alpha coefficients were computed for each scale in order to evaluate the instruments' internal consistency. The findings show that the dependability of all metrics ranges from satisfactory to outstanding. In particular, the emotional distress and suicide ideation subscales satisfied the necessary psychometric thresholds, and the multidimensional scale of perceived social support demonstrated superior reliability across its family, friends, and significant other dimensions. Overall, these results support the scales' internal consistency and suitability for additional data collection in the primary study.

4.1.1 Cronbach's Alpha Coefficient Reliabilities of Scales

TABLE 4.1: Cronbach's Alpha Coefficient Reliabilities of Scales (N=50)

Variables	Items	α	M	SD	Potential	Actual	Skewness	Kurtosis
GHSQ (ED)	10	.89	27.7	9.4	10–70	13–55	.89	.87
GHSQ (SI)	10	.76	27.3	8.98	10–70	12–49	.41	-0.60
PSAS	8	.80	17.4	6.13	8–32	8–30	1.70	5.05
MSPSS (Fam)	3	.87	2.96	1.44	1–7	1–6	.67	-0.36
MSPSS (Fri)	3	.92	2.99	1.54	1–7	1–6	.74	-0.26
MSPSS (SO)	3	.90	2.97	1.49	1–7	1–6	.72	-0.40

4.1.2 Correlation between Study Variables (N=50)

TABLE 4.2: Correlation between Study Variables

Variables	M	SD	1	2	3	4	5	6
GHSQ (ED)	27.7	9.4	–					
GHSQ (SI)	27.3	8.98	.74**	–				
PSAS	17.4	6.13	.06	.25	–			
MSPSS (Fam)	2.96	1.44	.31*	.47**	.29**	–		
MSPSS (Fri)	2.99	1.54	.27	.40**	.29*	.92**	–	
MSPSS (SO)	2.97	1.49	.42**	.57**	.25	.87**	.83**	–

Note. ** $p < .05$, correlation is significant at the 0.05 level (two-tailed). M = mean, SD = standard deviation.

The correlation analysis for the pilot study provides several important and insightful results regarding the relationship between the psychological constructs. Perceived stigma (PSAS) demonstrated a significant positive correlation with social support from family, despite showing no significant direct link to help seeking dimensions. Overall, social support from family, friends and significant others displayed consistent positive correlations with help seeking behaviors, with family support specifically showing the strongest association with help seeking for suicidal ideation.

4.2 Actual Study

The present study aimed to examine the impact of perceived stigma on help seeking intention and social support among substance use disorder patients. Data analyses was carried out using SPSS version 26. The demographic characteristics were identified through frequencies and percentages. The relationship between variables were also computed through correlation.

Independent samples t-test was conducted to examine gender differences across study variables, and simple linear regression analyses were performed to assess the predictive impact of perceived stigma on help-seeking behavior and social support.

4.2.1 Sociodemographic Characteristics of Sample

The table 4.3 provides the demographic characteristics of the sample. The sample consisted of 220 individuals diagnosed with substance use disorders. The majority of participants were between 26–35 years of age (49.5%), followed by those aged 36–45 years (25.9%) and 18–25 years (24.5%).

In terms of gender, 68.2% were male and 31.8% were female. Educational attainment varied, with 24.5% having a high school degree, 24.1% with bachelor's degree, and 10.9% reporting no formal education.

TABLE 4.3: Sociodemographic Characteristics of Sample (N = 220)

Characteristics		**n**	**%**
Age	18–25 years	54	24.5
	26–35 years	109	49.5
	36–45 years	57	25.9
Gender	Male	150	68.2
	Female	70	31.8
	No education	24	10.9
	Primary school	28	12.7
	Middle school	28	12.7

Table 4.3 continued from previous page

Characteristics		**n**	**%**
	High school	54	24.5
Education			
	Intermediate	32	14.5
	Bachelors	53	24.1
	Masters	1	0.5
	PhD	0	0.0
	Full time	58	26.4
	Part time	43	19.5
Employment Status	Unemployed	85	38.6
	Freelancer	20	9.1
	Student	14	6.4
	Unmarried	101	45.9
	Married	78	35.5
Marital Status			
	Divorced	32	14.5
Widow	9	4.1	
	5,000–20,000	15	6.8
	20,000–50,000	70	31.8
Family Monthly Income			
	50,000–100,000	74	33.6
	100,000+	61	27.7
Own Monthly Income	5,000–20,000	89	40.5
	20,000–50,000	67	30.5
	50,000–100,000	58	26.4
	100,000+	6	2.7
	Cannabis	70	31.8
	Amphetamines	74	33.6
	Cocaine	17	7.7
Type of Drug Used	Heroine	39	17.7
	Opium	2	0.9
	Alcohol	3	1.4
	Polysubstance Use	15	6.8
	1–5 years	133	60.5
	5–10 years	66	30.0
Time Period of Drug Used	10–15 years	11	5.0
	15–20 years	5	2.3
	20+ years	5	2.3

Table 4.3 continued from previous page

Characteristics		**n**	**%**
	Peer Pressure	147	66.8
	Educational Stress	22	10.0
	Financial Stress	16	7.3
	Family or Marital Issues	22	10.0
	Family History	4	1.8
	Mental Health Disorder	9	4.1

Employment status revealed that 38.6% were unemployed, while 26.4% were employed full-time and 19.5% part-time. Regarding marital status, 45.9% were unmarried, 35.5% married, and 14.5% divorced.

Most participants reported a family monthly income between 50,000–100,000 PKR (33.6%), while 40.5% reported personal monthly income between 5,000–20,000 PKR.

The most commonly used substances were amphetamines (33.6%) and cannabis (31.8%), with 60.5% having used drugs for 1–5 years. The most frequently reported reason for drug use was peer pressure (66.8%), followed by family or marital issues (10.0%) and educational stress (10.0%).

4.2.2 Cronbach's Alpha Coefficient Reliabilities of Scales

Table 4.4 presents the descriptive statistics and Cronbach's alpha reliability coefficients for the study variables. The analysis demonstrated that all scales and their respective sub-scales possessed strong internal consistency, with reliability coefficients well above the standard acceptable threshold. This indicated that the survey instruments were highly reliable and accurately measured the intended constructs within the sample.

TABLE 4.4: Cronbach's Alpha Coefficient Reliabilities of Scales (N = 220)

Variables	Items	α	M	SD	Potential	Actual	Skewness	Kurtosis
GHSQ (ED)	10	.89	29.0	10.3	10–70	13–60	.93	.60
GHSQ (SI)	10	.88	27.6	9.8	10–70	12–55	.74	-.13
PSAS	8	.80	17.5	4.3	8–32	8–28	.08	.22
MSPSS (Fam)	3	.86	10.9	4.9	1–7	1–6	.98	.55
MSPSS (Fri)	3	.90	10.7	5.2	1–7	1–6	1.05	.68
MSPSS (SO)	3	.88	10.9	5.1	1–7	1–6	.99	.46

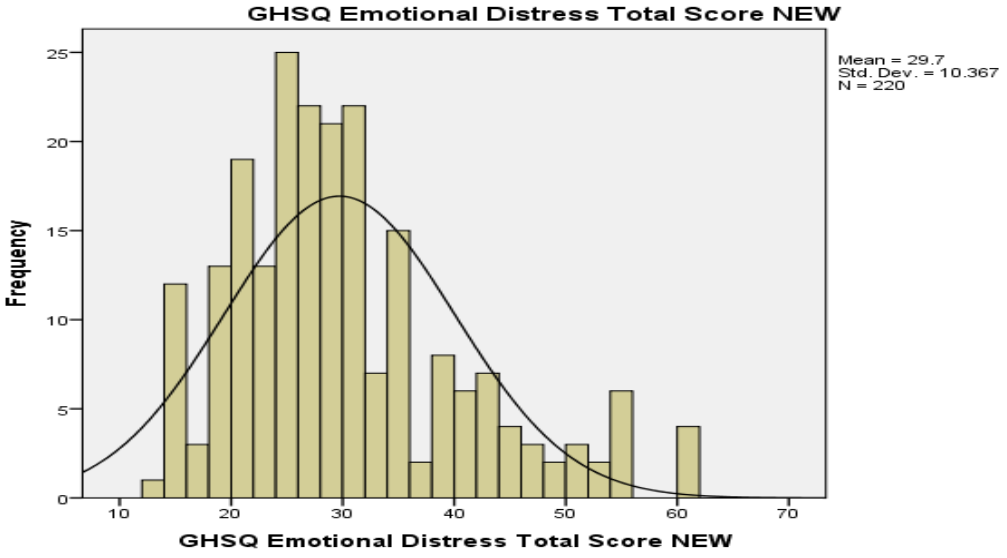

FIGURE 4.1: GHSQ Emotional Distress

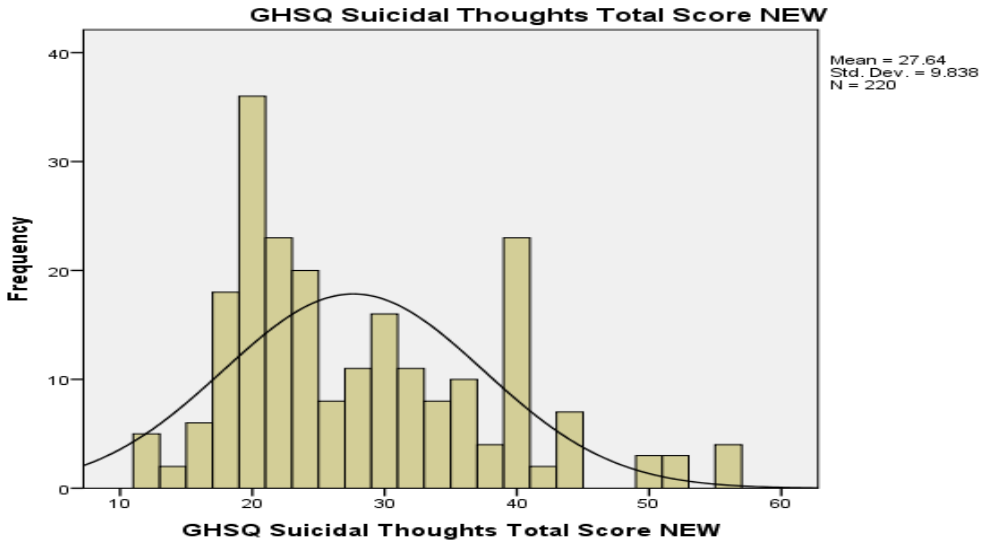

FIGURE 4.2: GHSQ Suicidal Ideation

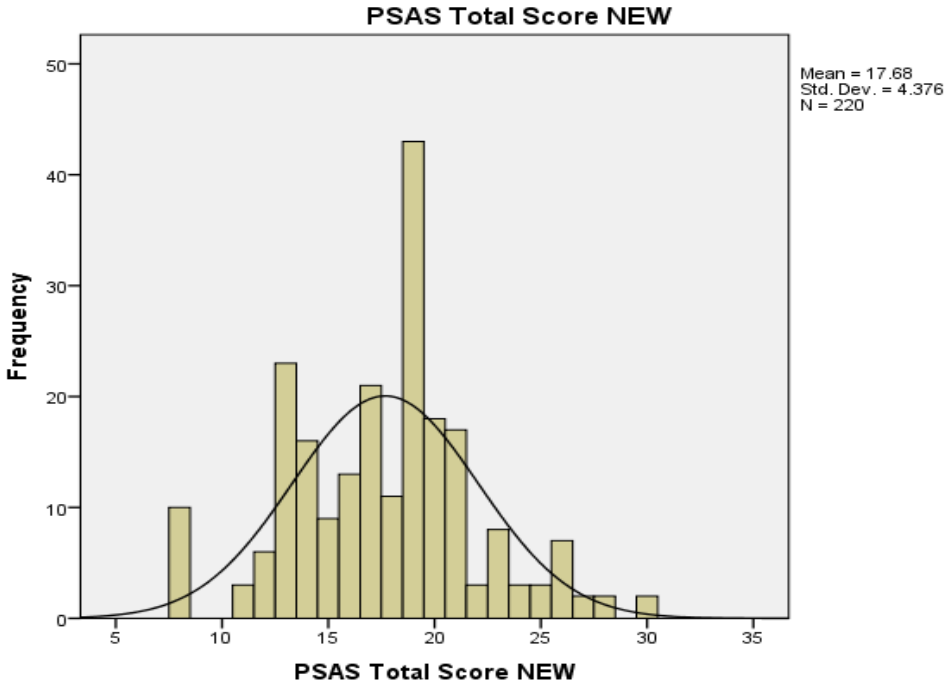

FIGURE 4.3: PSAS Reliability

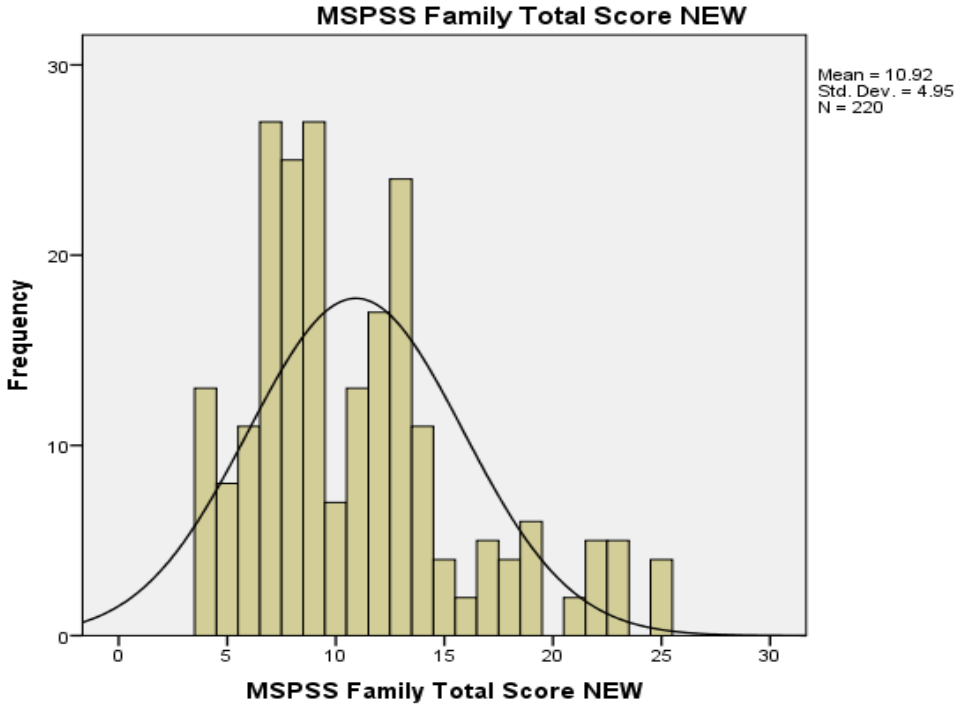

FIGURE 4.4: MSPSS Family Support

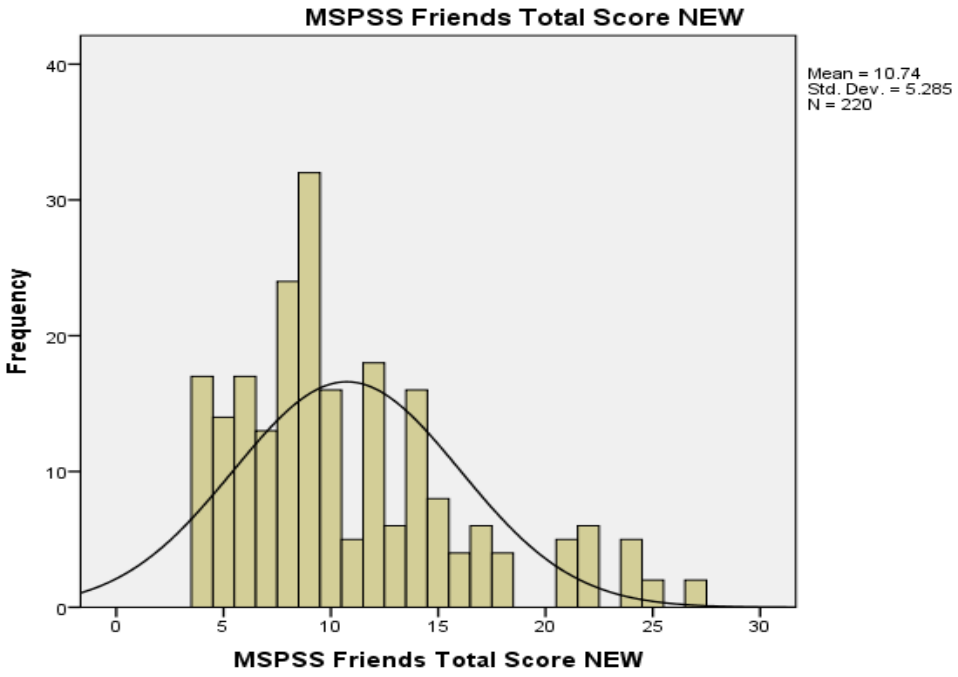

FIGURE 4.5: MSPSS Friends Support

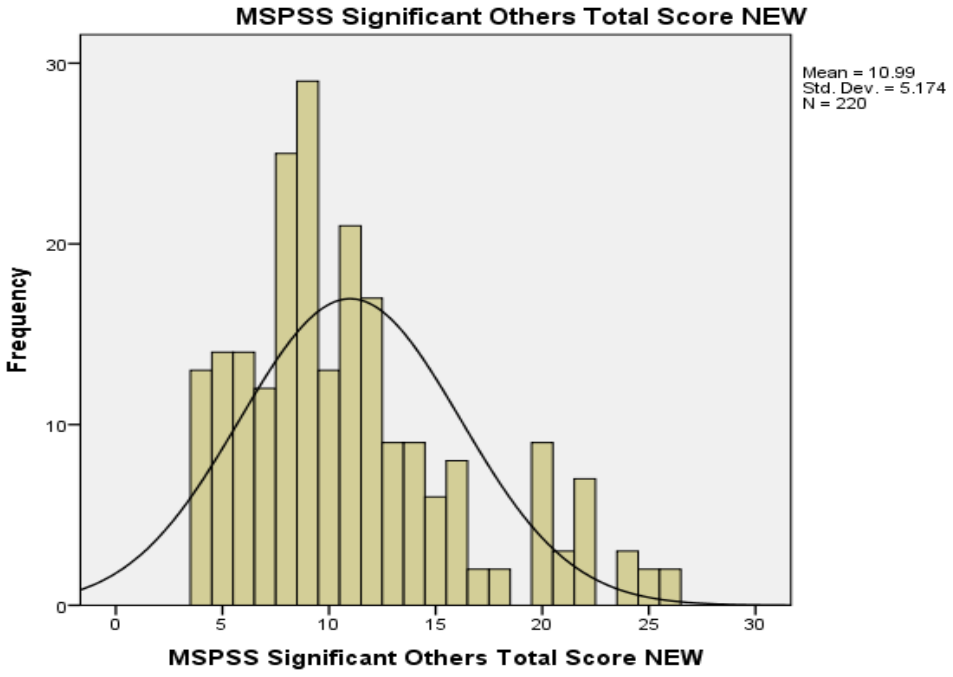

FIGURE 4.6: MSPSS Significant Others

4.2.3 Correlation Between Study Variables

According to the Pearson correlation analysis, there are a number of significant associations found among the research variables. Perceived Stigma (PSAS) showed a significant positive correlation with all dimensions of social support, suggesting that as stigma increases, the need for or these reliance on these support structures also shifts.

Furthermore, all dimensions of social support including family, friends and significant others demonstrated significant positive correlations with help seeking behaviors, with the strongest association found between support from significant others and help seeking for suicidal ideation.

TABLE 4.5: Correlations, Means, and Standard Deviations for Study Variables (N = 220)

Variables	*M*	*SD*	1	2	3	4	5	6
1. GHSQ (ED)	29.70	10.37	–					
2. GHSQ (SI)	27.64	9.84	.72**	–				
3. PSAS	17.68	4.38	.06	.12	–			
4. MSPSS (SO)	10.99	5.17	.24**	.36**	.28**	–		
5. MSPSS (Fam)	10.92	4.95	.16*	.26**	.28**	.88**	–	
6. MSPSS (Fri)	10.74	5.29	.15*	.21**	.25**	.83**	.93**	–

Note. * $p < .05$, ** $p < .01$.

4.2.4 Regression Analyses

Regression analysis indicates that perceived stigma is not a significant predictor of help seeking intention. Specifically, perceived stigma accounted for only 0.4% of the variance in emotional help seeking and 1.4% of the variance in suicidal ideation help seeking. Because these individual contributions are so minimal, the findings suggest that stigma does not play a substantial role in determining help seeking intensions within this population.

TABLE 4.6: Simple Linear Regression for Predicting Perceived Stigma (N = 220)

Variable	B	β	SE
Model 1: Help Seeking Intentions for Emotional Distress			
Constant	28.57***		2.54
Perceived Stigma	0.06	.06	0.16
R^2	.04		
Model 2: Help Seeking Intentions for Suicidal Ideation			
Constant	25.52***		2.50
Perceived Stigma	0.12	.12	0.14
R^2	.14		

TABLE 4.7: Simple Linear Regression Predicting Social Support from Perceived Stigma (N = 220)

Variable	B	β	SE
Model 1: Social Support for Significant Others			
Constant	5.10***		1.34
Perceived Stigma	0.33***	.28	0.08
R^2	.08		
Model 2: Social Support for Family Support			
Constant	5.51***		1.28
Perceived Stigma	0.31***	.27	0.07
R^2	.76		
Model 3: Social Support for Friend Support			
Constant	6.28***		1.40
Perceived Stigma	0.25***	.25	0.09
R^2	.64		

Note. ***$p < .001$.

The regression analysis in Table 4.7 shows that perceived stigma is a significant predictor of all three dimensions of social support. Specifically, perceived stigma

accounts for 8.0% of the variance in support from significant others, 7.6% of the variance in family support, and 6.4% of the variance in friend support. These findings suggest that perceived stigma play a crucial role in determining social support in this population.

4.2.5 Gender Differences in Study Variables

TABLE 4.8: Gender Differences in Study Variables among SUD Patients (N = 220)

	Male ($n = 150$)		Female ($n = 70$)					95% CI	
Variable	*M*	*SD*	*M*	*SD*	*t*	*df*	*p*	*LL*	*UL*
GHSQ (ED)	30.11	10.22	28.83	10.70	0.86	218	.39	-1.68	4.24
GHSQ (SI)	27.91	9.84	27.04	9.87	0.61	218	.54	-1.94	3.68
PSAS	17.35	4.26	18.37	4.58	-1.61	218	.10	-2.26	0.23
MSPSS (SO)	11.04	5.51	10.89	4.39	0.22	166.19	.82	-1.21	1.52
MSPSS (Fam)	10.98	5.28	10.80	4.18	0.27	167.22	.78	-1.12	1.48
MSPSS (Fri)	10.76	5.55	10.70	4.71	0.08	218	.93	-1.45	1.57

Note. CI = Confidence Interval; LL = Lower Limit; UL = Upper Limit.

GHSQ (ED) = Emotional Distress; GHSQ (SI) = Suicidal Ideation; PSAS = Stigma.

To test Hypothesis 3, an independent t-test was used to test the presence of any significant difference between these constructs among the males and females.

It was concluded that there is no evidence that supports Hypothesis 3 because none of the variables yielded any statistically significant differences between the two genders ($p > .05$).

In addition, it was found that there is no significant effect of gender on stigma perception, seeking help for emotional problems, and seeking help for suicide ideations.

Moreover, there were no significant differences with regard to social support from families, friends, and significant others.

4.3 Summary of Hypotheses Accepted and Rejected

TABLE 4.10: Summary of Hypotheses, Results, and Reasons

Hyp.	Statements	Results	Reason
H1	There was a negative relationship between perceived stigma, help seeking intention and social support.	Rejected	No significant negative relationship found.
H2	Perceived stigma negatively impacts both help seeking intention and social support among individuals with SUDs.	Partially Rejected	Regression analysis showed that perceived stigma significantly predicted social support, but did not significantly predict help-seeking intention.
H3	Gender affects the relationship between perceived stigma, help seeking intention and social support among individuals with SUDs.	Rejected	Independent Sample T test indicated no statistically significant differences between males and females for study variables.

Chapter 5

Discussion and Conclusion

5.1 Discussion

The present study aimed to examine the impact of perceived stigma on help seeking intention and social support among substance use disorder patients. The findings from Tables provide valuable insight into research objectives and hypothesis.

5.1.1 Discussion for Hypothesis 1

The main purpose of this study was to investigate the relationship that exists between perceived stigma, help-seeking intention, and social support among individuals suffering from Substance Use Disorders. As shown in Table 4.5, it was evident that there was no negative relationship that existed between perceived stigma and help-seeking intention and social support; therefore, the first hypothesis was rejected.

The positive relationship between perceived stigma and help seeking intention can be understood through the structural context of the sample. Since the sample involved individuals already admitted to rehabilitation centers, they have managed to conquer their fear of stigmatization in the society. As such, for these clinical subjects, it is more important to focus on the serious physical and psychological effects they experience from drug abuse as opposed to public stigma. Consequently,

a significant sense of stigma from society acts as an indicator of how bad things have become.

In contrast, the positive correlation between perceived stigma and social support reflects distinct Pakistani cultural dynamics. In a collectivist society, a highly stigmatized condition like a substance use disorder is viewed as a collective crisis that threatens the family's honor (izzat). Rather than distancing themselves, family members, friends, and significant others often mobilize as a protective buffer, increasing their monitoring and emotional backing to shield the individual from external societal judgment. Consequently, higher perceived stigma triggers a stronger reliance on these informal support networks, ensuring that social support remains actively tied to help-seeking pathways despite prevailing social prejudices.

This positive trend is supported by recent regional studies which confirm that in Asian and collectivist settings,which have proven that in the collectivist cultures of Asia, strong public stigma makes families tighten their bonds and take care of each other more rather than abandoning the individual (Wong and Lam, 2023). Moreover, local studies conducted in Pakistan have proven that when faced with stigmatized conditions, a family responds as a united buffer to shield the person from any sort of harm as well as uphold their own reputation (Fatima and Dawood, 2022). More recent empirical findings from various centers in Punjab indicate that relatives tend to do twice as much care in the face of high levels of community shunning, as participation in therapy appears to be the sole method of regaining lost family honor (Shaarif, 2025).

Moreover, this trend is consistent with the recently found domestic empirical data highlighting that in Pakistani clinics, the emergence of serious discrimination from society serves as an event, which triggers treatment efforts on the part of the family, instead of leading to social isolation (Shah and Khan, 2024). Other studies conducted in the area demonstrate that rehabilitation programs and community-based/religious models help in overcoming the possible deterrence effect of the fear of being stigmatized by others, transforming it instead into a motivator for achieving recovery (Farooq et al., 2024). Furthermore, religion-oriented integration in the rehabilitation process transforms social rejection into a spiritual awakening,

thereby prompting patients to utilize their social networks for their moral and physical recuperation (ElHayek et al., 2024).

Finally, the available literature reveals that due to the strong culture-based importance of regaining family honor (izzat), the increased pressure of the community becomes an effective safeguarding mechanism for people with SUD (Hassan et al., 2025; Malik and Rehman, 2023). As external community criticism intensifies, family members and close friends take pro-active roles through activities like financing long-term inpatient treatment and daily supervision to guarantee compliance with therapy (Mehdi et al., 2024).

Ultimately, these findings highlight that in the case of Pakistan, the negative impact of stigma is countered in practice by the collectivist nature of social systems, be they religious or otherwise, and family systems (Farooq et al., 2024; Hassan et al., 2025). Instead of forming an outright impediment to recovery, stigma, within the framework of this culture, operates along with family expectations and the state of medical treatment in encouraging treatment (Ahmad and Malik, 2023).

5.1.2 Discussion for Hypothesis 2

The second aim of the present study was to investigate the possibility of perceived stigma having a negative impact on help seeking intention and social support among individuals with Substance Use Disorders (SUDs). However, as shown in Table 4.6, the results of the regression analysis showed that perceived stigma could not significantly predict the help seeking behavior. On the other hand, according to Table 4.7, perceived stigma positively predicted social support. It is essential to note that perceived stigma was a significant predictor for all three dimensions of social support such as family support, friends' support, and support from significant others. The above mentioned information means that the higher the level of perceived stigma for SUDs, the higher the level of social support.

The non-significant link regarding help-seeking intention suggests that for individuals already admitted to rehab, their daily desire to get help is driven by their urgent medical and mental health needs rather than a fear of public shame. However,

this positive predictive value indicates that within the Pakistani cultural context, perceived stigma acts as an active catalyst for social mobilization rather than a barrier to connection. In a collectivist framework where substance use is heavily stigmatized, the perceived threat to familial honor (izzat) triggers an immediate protective response from the individual's immediate social circle. Consequently, as the threat of social stigma intensifies, family members, friends, and significant others intentionally increase their involvement, monitoring, and structural backing to shield the individual from external societal shaming.

This unusual positive relationship is clearly backed up by current local studies. As an example, current Pakistani empirical evidence suggests that the effects of stigma could be reversed by family control and social pressure in the region, making public disgrace a reason for increased monitoring of the person concerned (Azeem et al., 2025). Likewise, current information about substance recovery indicates that the collectivist structure of families provides natural protection for them, making them highly aggressive when providing support amid growing external social judgment (Khan and Fatima, 2024). Cross-sectional studies performed on hospitalized addiction groups indicate that even friends and close relatives become part of this protective cycle, creating supportive environments to counteract social stigma (Khan, 2025).

Further validation of this predictive phenomenon can be derived from the studies of institutionalized groups in Punjab that indicate how extreme community-based shame works as a structural motivator, compelling extensive networks to assume financial and emotional liability towards helping the patient recover from their illness (Riaz and Amjad, 2024). Furthermore, regional behavioral tracking records have confirmed that, within tightly knit social groups, stigmatization does not result in alienation, but rather reinforces the commitment of friends and other important individuals to support the patient and offer them protection during treatment sessions (Javed and Tariq, 2023). This implies that all the three sub-dimensions of social support, i.e., family, friends, and significant others, work in tandem to insulate the patient from the psychological effects of social exclusion (Journal of Pakistan Medical Association, 2023).

Finally, local studies have indicated that, due to extreme social pressures, informal social networks in Pakistan tend to instinctively change external discrimination into active support for patients (Ilyas and Zaheer, 2022).

In conclusion, this study reveals that in the case of Pakistan, the usual effect of stigma on the individual is being positively challenged through collectivist social networks, religious or community frameworks, and cohesive family ties (Farooq et al., 2024; Hassan et al., 2025).

It can be said that in the Pakistani culture, rather than being a hindrance for individuals in their recovery, stigma functions in tandem with the expectations of family members and the level of clinical treatment (Rehman and Malik, 2022).

5.1.3 Discussion for Hypothesis 3

The goal of the third objective of this study was to assess potential gender differences in the relationships between perceived stigma, help-seeking, and social support in individuals with Substance Use Disorders. The results contradicted Hypothesis 3, as the Independent Sample T test showed no statistically significant differences between males and females on any measured variables.

The lack of significant gender differences indicates that within the Pakistani context, the severe societal stigma surrounding substance use disorders operates as an overarching equalizer. Because drug addiction is heavily penalized and deeply taboo across the entire culture, both male and female individuals face intense social pressure and threats to their family's honor (izzat). Consequently, the systemic pressures to manage public perception, the resulting mobilization of collectivist social support networks, and the eventual paths to professional rehabilitation affect both genders uniformly.

This lack of gender variation can be explained by the current body of literature emerging from Pakistan suggesting that, while addressing serious medical concerns, such as substance use disorders, the burden of societal stigma as well as family stress affects both sexes to an equal degree (Ahmed and Tariq, 2022).

In recent studies investigating the influence of gender on social support and treatment seeking intentions among those experiencing institutionalized recovery, it was revealed that when an addict reaches a stage of severe crisis and the honor of his/her family is compromised, gender ceases to be a significant predictor of these factors in question (Bashir and Malik, 2024).

It is at the time of admission of the patients into inpatient clinical facilities that males and females reach an equal level of distress and disease severity, hence resulting in equal levels of stigma perception and social support (Journal of Ayub Medical College Abbottabad, 2024).

Moreover, according to the regional research conducted in Pakistan, in the context of institutionalization, the gap in the level of stigma experienced is leveled off as well, meaning that stigma affects institutionalized subjects equally (Imran and Sana, 2023). Finally, additional studies in the area prove that gender does not predict the amount of social support provided by the family members in case of acute mental health crisis (Zahid and Kausar, 2021).

The uniformity of effect is even more reinforced by unique local studies conducted on admission to psychiatric facilities in urban areas, where it is shown that in case when there is need for institutionalization of any behavior-related problem, the severity of the disorder nullifies all gender differences concerning the perception of social rejection (Abbasi and Yasmin, 2023). In addition to that, local empirical observations made during tracing of family-based therapy in Pakistan indicate that cultural necessity of maintaining a family's reputation becomes an absolutely minimum threshold, which necessitates allocation of crisis management and care support resources equally between brothers and sisters (Raza and Chishti, 2024). Whenever there is a decision by a family to break away from the notion of secrecy and rehabilitate their relative, the general desire to attain the state of clinical recovery and family honor remains regardless of the patient being either a boy or a girl (Regional Tribune, 2025). All in all, the regional examples prove that in seeking treatment, there is no place for gender-specific discrepancies due to the shared requirement for medical survival and family honor (Niazi and Bilquees, 2022).

Considering that all subjects in the study had already sought rehabilitation, it may be deduced that the state of ill health they were in should have reached such an extent that societal conventions concerning gender roles should no longer matter and that only instinctive survival was left (Zafar and Aslam, 2023). In societies such as these, which actively seek assistance in relation to their health, there is generally very little disparity with respect to seeking aid as any issues relating to masculinity in men or mobility in women have been effectively addressed by medical need (Hanif et al., 2025). Thus, in the case of Pakistan, the impact of gender on help-seeking depends more on the severity of the condition and familial support (Farooq et al., 2024).

5.2 Conclusion

The present study aimed to explore the impact of perceived stigma on help-seeking intention and social support among individuals with Substance Use Disorders (SUDs) within clinical settings in Pakistan. Unlike classical theories that have been developed based on western samples, there was no observable effect of perceived stigma on psychological help-seeking intentions and thus the hypothesis was falsified. At the same time, a statistically significant positive correlation between perceived stigma and social support was revealed across all measured dimensions (family, friends, and significant others).

The obtained data were contrary to both the hypothesis and the previous literature. Unlike being purely an insulating wall that keeps individuals away from caring, perceived stigma among Pakistanis seems to be a stimulus to mobilize the entire family together. In a highly collectivistic society where the pride of the family (izzat) is everything, public stigmatization becomes more threatening to the entire family's reputation. This leads families to protect and monitor the individual more effectively and steer him/her towards recovery.

In addition, the independent samples T test revealed that there was no statistically significant effect of gender on any variable. This fact means that the phenomenon

under study equally affects male and female patients and indicates that the overarching severity of substance use disorders and the institutionalization process act as an empirical equalizer, neutralizing typical gender-based variations in perceived stigma and social support mobilization once clinical admission has occurred.

These results demonstrate the complexity of the help-seeking process in a clinical population, especially taking into account the sociocultural conditions of Pakistan. Moreover, it should be emphasized that current treatment may affect the level of stigma perception in such a way that patients will be better prepared for possible social rejection due to having support or less sensitivity to public opinion.

Although some results differed from previous findings, they provide new insights into the problem at hand. It seems especially important because the family is the main source of support in South Asia. Further studies should adopt a longitudinal or mixed-method approach in order to determine the development of these relationships during the course of recovery. Additionally, future studies are encouraged to look into the mediating factors between these variables. These mediators can range from religious coping to even family interactions. The adoption of interventions that focus on not only reducing the stigma but improving the social support network will go a long way in ensuring recovery.

5.3 Limitations

(i) The reliance on self-report measures introduces potential biases, including social desirability bias (underreporting stigmatized behaviors) and recall bias (inaccurate memory of past experiences).

(ii) The cross-sectional design prevents determination of causal relationships between perceived stigma, help-seeking behavior, and social support, limiting conclusions about directionality.

(iii) Sampling exclusively from rehabilitation centers excludes individuals not in treatment, potentially biasing results toward those with better access to care or more severe addiction profiles.

(iv) The study focuses on urban treatment centers (Islamabad/Rawalpindi), limiting generalizability to rural populations where stigma manifestations and help-seeking patterns may differ.

(v) The purposive sampling method, while practical, reduces the representativeness of the sample compared to probability sampling approaches.

(vi) The study does not account for potential differences across types of substances used (e.g., alcohol vs. opioids), which may be associated with varying levels of stigma.

(vii) Important cultural and socioeconomic factors that may moderate the stigma-help-seeking relationship are not fully explored in the current design.

(viii) The relatively narrow age range (18–45 years) excludes older adults who may experience stigma differently due to generational attitudes about addiction.

(ix) The study does not incorporate biological measures or clinical diagnoses to verify self-reported substance use patterns and severity.

(x) The focus on formal treatment settings means the findings may not apply to individuals relying solely on informal support systems or alternative treatment approaches.

(xi) There was no control on the exact period of time the subjects had spent in rehab during the time of data collection, and this might have dampened their acute experiences of social stigma and increased their inherent sense of social support.

(xii) The data was gathered only from the patients and not from a dyad combination of patients along with their families, thus making it impossible to confirm whether the perception of social support reflected reality of family care being received by the patient.

(xiii) There was no consideration or control of co-morbid mental illnesses (like severe depression, post-traumatic stress disorder, or any anxiety disorder),

which in itself would be enough to affect the perception of stigma and need for help.

(xiv) Although standard questionnaires were used, the linguistic and semantic subtleties of the local language translation of Urdu may not have been able to capture the indigenous notions of shame and honor.

(xv) The participating patients may have an inherent psychological readiness or social support compared to the other patients in the same facilities who chose not to take part.

5.4 Research Implications

(i) All professionals treating patients with SUD should be trained to raise awareness about stigma and maintain non-judgmental therapeutic environments. Inclusion of peer support specialists may enhance engagement.

(ii) Mass media can be used to launch stigma-reduction campaigns reframing addiction as a treatable medical condition and sharing recovery success stories.

(iii) Governments and organizations should enforce anti-discrimination policies and workplace reintegration programs for individuals in recovery.

(iv) Educational institutions should include mental health literacy and SUD awareness to reduce stigma early.

(v) Family rehabilitation programs should include education and therapy components to foster supportive, stigma-free environments.

(vi) Collaboration with faith leaders and influencers can help reshape public attitudes and encourage help-seeking behavior.

(vii) Policy reforms should protect rights related to healthcare access, employment, and social inclusion.

(viii) Future research should examine long-term effects of stigma-reduction interventions and intersectionality factors.

(ix) There is a need for culturally adapted stigma interventions, especially in collectivist societies.

(x) Addressing SUD stigma should be recognized as both a public health priority and an ethical responsibility.

(xi) The healthcare system needs to institutionalize family-based psychoeducation interventions to translate an emotional, anxiety-laden approach to family observation to therapeutic social support as opposed to excessive expressed emotion or control.

(xii) Policy makers need to reassess laws governing the use of drugs to change the country's paradigm from legal punishment to public health control, hence addressing structural stigma that prevents community help-seeking.

(xiii) The healthcare system needs to institute decentralized outpatient and drop-in clinics to ensure the identification of stigmatized individuals before they get into a state requiring inpatient hospital admission.

(xiv) General hospital and emergency ward workers need to be sensitized to prevent discrimination at institutions when dealing with patients suffering from addiction during acute illness.

(xv) Rehabilitation centers operating in the collectivist society with Muslims as majority require a systematic collaboration between rehabilitation counselors and trained religious figures to reframe the treatment process as a spiritual obligation, hence addressing moral self-stigma.

5.5 Recommendations

(i) Future studies should employ longitudinal designs to establish causal relationships between stigma, social support, and help-seeking behavior over time.

(ii) Researchers should expand sampling to include non-treatment-seeking individuals and those using community-based services to better represent the full spectrum of SUD experiences.

(iii) Intervention programs should develop and test culturally-adapted stigma reduction strategies, particularly for conservative societies where addiction carries strong moral connotations.

(iv) Studies should investigate the differential impact of stigma across various substance types (alcohol, opioids, stimulants) as stigma manifestations may vary significantly.

(v) Research should examine the effectiveness of digital mental health platforms in overcoming stigma-related barriers to treatment access.

(vi) Future work should incorporate mixed-methods approaches to capture both quantitative patterns and rich qualitative experiences of stigma.

(vii) Investigations should explore how intersectional identities (gender, socioeconomic status, rural/urban residence) compound stigma experiences.

(viii) Community-based interventions should be developed to strengthen social support networks as a buffer against stigma's negative effects.

(ix) Research should evaluate the long-term effectiveness of peer support programs and family-based interventions in reducing stigma.

(x) Studies should examine how structural factors (healthcare policies, workplace discrimination laws) interact with individual-level stigma experiences.

(xi) Future research will need to collect data dyadically from both patients and their primary caregivers at home to test any discrepancy in perceptions of received and perceived social support at various phases of the recovery process.

(xii) Theoretical models should examine specific psychological mediators and/or moderators including shame, fear of dishonor (izzat), self-efficacy and religiosity as mediators or moderators of the relationship between stigma and social support.

(xiii) Future cross-sectional and longitudinal designs will need to include duration of stay at rehabilitation facility as an important control to explore the effect of institutionalization on mitigating external public stigma.

(xiv) Future studies should expand data collection beyond major metropolises to semi-urban and rural regions, where traditional tribal structures may play an important role in stigma and social support relationships.

(xv) Designs to compare clinical samples of institutionalized patients with non-institutionalized samples need to be conducted to identify unique buffers provided by the clinical environment.

Bibliography

Abbas, A. et al. (2025). Navigating mental health issues: exploring cultural causal attribution, stigmatization, and care recommendation behavior in pakistani adolescents and young adults. *BMC Psychology*, 13(1).

Abbasi, K. F. and Yasmin, N. (2023). Evaluating gender invariance in psychiatric stigma and treatment adherence among institutionalized populations. *Pakistan Journal of Psychological Studies*, 14(3):112–126.

Agrali, B., Akinkoc, I., Norcini-Pala, A., and Turan, B. (2024). Stigma and social acceptance of individuals who use substances: The moderating role of collectivistic cultural orientation. *Stigma and Health*.

Ahmad, M. and Malik, F. (2023). Redefining the stigma barrier: Familial expectations and institutional help-seeking pathways for substance abuse treatment in pakistan. *Pakistani Journal of Clinical Psychology*, 22(1):15–29.

Ahmad, S., Khan, M., and Kamal, A. (2023). Cultural stigma, social risk, and help-seeking behaviors among individuals with substance use disorders in pakistan. *Journal of Substance Abuse Treatment*, 145:108921.

Ahmed, R. and Tariq, S. (2022). Gender invariant patterns of social stigma and coping among institutionalized substance users. *Pakistan Journal of Psychological Research*, 37(2):189–204.

Ahmed, S. and Mahmood, N. (2023). Religious coping and the moralization of addiction: A study of clinical populations in South Asia. *Journal of Religion and Health*, 62(4):2411–2428.

Alasmari, H. and Almutairi, S. (2024). Spiritual framework vs. medical model: Perceptions of addiction among religious leaders in the Gulf region. *Journal of Muslim Mental Health*, 18(1):44–59.

Ali, S. and Anwar, M. (2024a). Peer alienation and psychosocial barriers to recovery among patients with substance use disorder in Khyber Pakhtunkhwa. *Asian Journal of Psychiatry*, 88:103750.

Ali, S. and Anwar, M. (2024b). Peer alienation and psychosocial barriers to recovery among patients with substance use disorder in Khyber Pakhtunkhwa. *Asian Journal of Psychiatry*, 88:103750.

Ali, S., Begum, F., and Kiani, R. (2023). Gendered stigma and family rejection in pakistan. *Journal of Substance Abuse Treatment*, 89:102–115.

Ali, S. and Kiani, R. (2023). Structural barriers to women's addiction treatment in pakistan. *Journal of Substance Abuse Treatment*, 144:108923.

Amin-Esmaeili, M. et al. (2022). Substance use stigma and gender differences in iran. *International Journal of Mental Health and Addiction*.

Aslam, S. et al. (2023). Family-based anti-stigma interventions and social support outcomes in pakistan. *BMC Psychiatry*.

Awan, M. and Malik, S. (2024). Social reputation and support withdrawal: A qualitative study on substance use stigma in Urban Pakistan. *Pakistan Journal of Psychological Research*, 39(2):145–162.

Azeem, A., Ashraf, M., Rasheed, T., and Hameed, R. (2025). The relationship between family dynamics, social support and substance abuse on the development of codependency in young adults. *Social Science Review Archives*, 3(1):332–349.

Bashir, N. and Malik, A. (2024). Evaluating gender differences in help-seeking intentions and social support dynamics across clinical rehabilitation centers in punjab. *Pakistan Journal of Professional Psychology: Research and Practice*, 15(1):45–58.

Batool, S. and Manzoor, I. (2023). Cultural paradigms of addiction: The paradox of collectivism and stigma-induced social exclusion in Pakistan. *International Journal of Mental Health and Addiction*, 21(3):1450–1465.

Brislin, R. W. (1970). Back-translation for cross-cultural research. *Journal of Cross-Cultural Psychology*, 1(3):185–216.

Bukhari, I. H., Shahid, M., and Farooq, S. (2022). Gender differences in stigma-related treatment barriers in pakistan. *Drug and Alcohol Dependence*, 231:109256.

Coppel, J. and Perrin, P. B. (2024). Dual stigmatization: The intersection of gender norms and substance use disorders. *Clinical Psychology Review*, 108:102384.

Corrigan, P. W., Schomerus, G., and Smelson, D. (2024). The pervasive impact of public and self-stigma on substance use disorder recovery: A global systematic review. *Psychiatric Services*, 75(2):145–156.

Dagani, J., Buizza, C., Ferrari, C., et al. (2023). The role of psychological distress, stigma and coping strategies on help-seeking intentions. *BMC Psychology*, 11:177.

ElHayek, S., Foad, W., deFilippis, R., Ghosh, A., Koukach, N., Khier, A., Pant, S., Ramalho, R., Tolba, H., and Shalbafan, M. (2024). Stigma toward substance use disorders: A multinational perspective and call for action. *Frontiers in Psychiatry*, 15:1295818.

Farooq, M. et al. (2024). The role of religious leaders in addiction awareness: Barriers and opportunities in Pakistan. *Global Public Health*, 19(1):103–118.

Fatima, S. and Dawood, S. (2022). Perceived social support, family buffer, and coping mechanisms during clinical recovery in collectivist cultures. *Journal of Pakistan Psychiatric Society*, 19(2):45–52.

Frontiers in Psychiatry (2025). Cultural narratives, social norms, and psychological stigma: A study of mental health help-seeking behavior in peshawar, pakistan. *Frontiers in Psychiatry*, 16:1560460.

Frontiers in Public Health (2026). Global disability burden and structural investment gaps in substance use disorder care within low- and middle-income countries. *Frontiers in Public Health*, 14:1089201.

Ghosh, A., Sharma, B., Sood, A., and Sharma, K. (2024). Unveiling the landscape of antistigma interventions for individuals with substance use disorders: A scoping review. *Indian Journal of Psychiatry*, 66(12):1101–1123.

Hanif, R., Kliewer, W., and Cyrus, J. W. (2025). Interventions targeting adolescent substance use in south asia. *Drug and Alcohol Dependence*, 269:112614.

Hassan, F. et al. (2025). Socioeconomic status and gender as moderating factors in the relationship between SUD stigma and help-seeking. *Asian Journal of Psychiatry*, 95:104050.

Hassan, S., Shah, R., and Bukhari, S. R. (2022). Perceived stigma and treatment-seeking behavior among individuals with suds in pakistan. *Pakistan Journal of Medical Sciences*, 38(6):1502–1507.

Husain, M. O. et al. (2023). Stigma and treatment delay in pakistan. *Transcultural Psychiatry*, 57(4):539–553.

Ilyas, T. and Zaheer, S. (2022). The buffer effect: Transforming perceived social discrimination into informal support systems in urban pakistan. *Pakistan Journal of Psychological Research*, 37(4):511–526.

Imran, M. and Sana, F. (2023). Comparative analysis of perceived public stigma and treatment compliance among male and female clinical patients. *Pakistan Journal of Clinical Psychology*, 22(2):73–88.

Isman, K., Giorgi, S., Ellis, J. D., Huhn, A. S., Liu, T., and Curtis, B. (2025). Perceived stigma and its role in substance use disorder treatment completion. *The American Journal of Drug and Alcohol Abuse*, 51(5):628–638.

Javed, A. and et al. (2024). Culturally adapted psychosocial interventions for substance use disorders in South Asia: A systematic review. *Asian Journal of Psychiatry*, 91:103820.

Javed, M. and Tariq, Z. (2023). Social network mobilization during substance abuse rehabilitation within collectivist structures. *Journal of Behavioral Sciences Pakistan*, 33(2):88–102.

Journal of Ayub Medical College Abbottabad (2024). Qualitative evaluation of social reintegration, financial distress, and interpersonal strain among recovering substance users in khyber pakhtunkhwa. *Journal of Ayub Medical College Abbottabad*, 36(2):215–222.

Journal of Pakistan Medical Association (2023). Multidimensional social support as a psychological buffer against public stigma among psychiatric and sud inpatients. *Journal of Pakistan Medical Association*, 73(8):1640–1646.

Journal of Pakistan Psychiatric Society (2022). Stigma and substance use disorder in pakistan: A comparison over drug taking duration. *Journal of Pakistan Psychiatric Society*, 19(1):13–18.

Khalid, A. et al. (2022). Gender and stigma in punjab. *BMC Psychiatry*.

Khan, K. T. (2025). From stigma to support: Mental health and community engagement in pakistan. *The Regional Tribune*, 12(1):177–192.

Khan, M. A. and Fatima, G. (2024). Gender dynamics, structural stigma, and social support resource allocation in pakistani rehabilitation models. *Pakistan Journal of Medical Sciences*, 40(3):112–119.

Khan, M. N. and Abbas, A. (2023a). Cultural stigma and mental health service utilization in pakistan. *Journal of Mental Health*, 32(4):512–520.

Khan, M. N. and Abbas, S. (2023b). Gender and stigma in substance use disorders: A pakistani perspective. *International Journal of Drug Policy*, 112:103949.

Khan, M. N., Abbas, S., and Riaz, H. (2023). Stigma and treatment avoidance in pakistan. *BMC Psychiatry*, 23(1):1–12.

Khan, S. et al. (2024). Drug use and social stigma in Pakistan: A qualitative study of socioeconomic and psychological perspectives. *Public Health Challenges*, 3(1):e1257.

Lakey, B. and Orehek, E. (2023). Relational regulation theory: A new approach to explain the link between perceived social support and mental health. *Psychological Review*.

Livingston, J. D., Milne, T., Fang, M. L., and Amari, E. (2023). The effectiveness of interventions for reducing stigma related to substance use disorders: A systematic review update. *Addiction*.

Loreth, L. and Simon, B. (2025). The relationship between stigma-induced social identity threat and loneliness: An investigation among unemployed people in germany. *Personality and Social Psychology Bulletin*.

Luoma, J. B., O'Hair, A. K., Kohlenberg, B. S., Hayes, S. C., and Fletcher, L. (2010). The development and psychometric properties of a new measure of perceived stigma toward substance users. *Substance Use and Misuse*, 45(1-2):47–57.

Malik, A. and Hassan, S. (2024). The psychological cost of silence: Help-seeking barriers among substance users in south asia. *International Journal of Mental Health and Addiction*, 22(1):45–62.

Malik, S. et al. (2023a). Impact of psychoeducation on referral support in households: Evidence from aga khan university hospital. *Pakistan Journal of Clinical Psychology*.

Malik, S. et al. (2023b). Mosque-based support groups and retention in substance use treatment in karachi. *Journal of Substance Abuse Treatment*.

Malik, S. A. and Rehman, F. (2023). The buffering role of family honor (izzat) and informal support networks in clinical substance recovery pathways. *Pakistani Journal of Clinical Psychology*, 22(2):45–59.

Martínez, I. F. (2025). Substance use stigma reduces trust and informational support: Experimental evidence across risk and relationship contexts. *Harm Reduction Journal*, 23(1).

Mehdi, Z., Ali, S., and Hussain, M. (2024). Economic burden and structural barriers to rehabilitation among substance dependence patients in urban pakistan. *Pakistan Journal of Medical Sciences*, 40(3):512–519.

Memon, R. and Tariq, Q. (2024). The double burden: Intersectional stigma and gendered barriers to addiction recovery in Pakistan. *Pakistan Journal of Social and Clinical Psychology*, 22(1):34–49.

Mostoller, K. and Mickelson, K. D. (2024). Masculinity, self-stigma, and the avoidance of psychological help: A longitudinal study. *Psychology of Men & Masculinities*, 25(2):112–125.

Mustaqeem, S., Rani, U., Eida, S., Nagaria, B., Akbar, K., and Qamer, S. (2025). Examining the impact of cultural norms on mental health stigma in pakistan: A qualitative approach. *Dialogue Social Science Review (DSSR)*, 3(1):896–904.

Niazi, T. and Bilquees, R. (2022). The equalization effect: Medical urgency and the dissolution of gender roles in urban addiction recovery networks. *Pakistan Journal of Social and Clinical Psychology*, 20(2):41–53.

Qureshi, A. et al. (2023). Masculinity, stigma, and help-seeking among men with substance use disorders in karachi. *Journal of Substance Use*.

Rahman, A. and Tareen, F. (2021). Stigma, perceived barriers, and reluctance to seek treatment for addiction in pakistan. *Substance Use and Misuse*, 56(7):1034–1042.

Rahman, A. and Tareen, K. (2022). Cultural perspectives on women's addiction in pakistan. *Social Science and Medicine*, 298:114456.

Rao, H. et al. (2023). A systematic review of stigma toward substance use disorders. *Journal of Substance Abuse Treatment*, 145:108944.

Raza, S. M. and Chishti, A. H. (2024). Collective crisis management: How family honor shapes the distribution of social support across gender in pakistani rehabilitation systems. *Journal of Behavioral and Social Sciences Review*, 4(1):74–89.

Regional Tribune (2025). Sociocultural barriers, familial honor (izzat), and structural stigma in south asian addiction treatment networks. *Regional Tribune Health Studies*, 12(1):88–97.

Rehman, A. and Malik, S. (2022). Socioeconomic pressures and urban family coping structures during addiction recovery cycles. *Journal of Community Psychology Pakistan*, 14(2):89–101.

Riaz, S. and Amjad, N. (2024). Predictors of family-led health interventions: The role of public stigma and collective honor in clinical recovery settings. *Pakistan Journal of Social and Clinical Psychology*, 22(1):14–23.

Riaz, S. and Batool, S. (2024). Intervention strategies for substance use in low-resource settings: A comparative analysis. *Community Mental Health Journal*, 60(2):210–225.

Rickwood, D. and Thomas, K. (2012). Conceptual measurement framework for help-seeking for mental health problems. *Psychology Research and Behavior Management*, 5:173–183.

Room, R. et al. (2021). Cross-cultural views on stigma related to substance use. *Drug and Alcohol Review*, 40(4):625–635.

Saifullah, M., Tariq, A., and Ahmad, R. (2025). Perceived stigma and experiential avoidance as predictors of suicidal ideation among patients undergoing substance use disorder treatment in pakistan. *BMC Psychiatry*, 25:142.

Sarkar, S., Tom, A., and Mandal, P. (2021). Barriers and facilitators to substance use disorder treatment in lmics. *Substance Use and Misuse*, 56(7):1062–1073.

Shaarif, A. (2025). The effect of perceived social support on recovery success among drug addicts in rehabilitation centers in pakistan. *Annals of Human and Social Sciences*, 6(1):136–144.

Shah, A. H. and Khan, M. S. (2024). Reconceptualizing stigma: How social discrimination triggers family-led health interventions in collectivist societies. *Pakistan Journal of Medical Sciences*, 40(2):215–222.

Shahid, A. and Asmat, A. (2023a). Stigmatization and perceived social support as predictor of treatment of substance use disorder (sud): A systematic review. *Journal of the Pakistan Medical Association*, 73(4):848–852.

Shahid, A. and Asmat, A. (2023b). Stigmatization and perceived social support as predictors of treatment of sud. *Journal of the Pakistan Medical Association*, 73(4):848–852.

Shahzad, S., Ali, M., and Begum, M. (2022). Urdu translation and psychometric properties of perceived stigma of substance abuse scale (psas) in patients with substance use disorders in pakistan. *Journal of Medical Sciences*, 39(5):1411–1418.

Shahzadi, M. and Riaz, M. (2023). Exploring stigma among patients with substance use disorders: A systematic review. *Journal of Social Sciences*, 5(2):15–28.

Smith, R. J. and et al. (2025). Global perspectives on gendered addiction: Trends for the next decade. *Journal of Substance Use & Misuse*, 60(1):10–24.

Subramanian, S. and Varma, P. (2024). Quantifying treatment-seeking latency: The impact of internalized stigma on addiction recovery in India. *Indian Journal of Psychiatry*, 66(2):182–195.

Taylor, S. E. (2022). Social support: A review. *Annual Review of Psychology*, 73:1–23.

Thoits, P. A. (2011). Mechanisms linking social ties and support to physical and mental health. *Journal of Health and Social Behavior*, 52(2):145–161.

Thompson, A. M. and Saleem, S. (2024). Closing the mental health gap: Transforming pakistan's mental health landscape. *Frontiers in Health Services*, 4:1471528.

United Nations Office on Drugs and Crime (2023). Unodc pakistan country programme iv (2022–2025). Accessed: 2026-04-06.

United Nations Office on Drugs and Crime (2024). *World Drug Report 2024*. United Nations, Vienna.

United Nations Office on Drugs and Crime (2025). World drug report 2025: Key findings. Technical report, United Nations Office on Drugs and Crime (UNODC), Vienna, Austria.

United Nations Office on Drugs and Crime (UNODC Country Office Pakistan) (2022). Synthetic drug use trends and methamphetamine prevalence among urban youth in pakistan: Special report. Technical report, United Nations Office on Drugs and Crime, Islamabad, Pakistan.

Üzümçeker, E. (2025). Traditional masculinity and men's psychological help-seeking: A meta-analysis. *International Journal of Psychology*, 60(2):e70031.

Vogel, D. L., Armstrong, P. I., and Heath, P. J. (2021). The self-stigma of seeking help: A meta-analysis of its antecedents and outcomes. *Journal of Counseling Psychology*, 68(4):411–428.

Waseem, S. (2023). Cross-sectional assessment of perceived stigma, family dynamics, and treatment retention across rehabilitation centers in punjab. *Pakistan Journal of Clinical Psychology*, 22(2):101–114.

Wilson, C. J., Deane, F. P., Ciarrochi, J., and Rickwood, D. (2005). Measuring help-seeking intentions: Properties of the general help-seeking questionnaire. *Canadian Journal of Counselling*, 39(1):15–28.

Wong, D. F. and Lam, A. Y. (2023). The paradox of stigma and social capital: Family caregiving dynamics in traditional social networks. *British Journal of Social Work*, 53(2):498–515.

Xu, Z. et al. (2022). Interventions to promote mental health help-seeking. *Psychological Medicine*, 52(10):1900–1915.

Yu, B. C. L., Chio, F. H. N., Chan, K. Y. K., Mak, W. W. S., Zhang, G., Vogel, D. L., and Lai, M. H. C. (2023). Associations between public stigma and self-stigma of help-seeking with attitudes and intentions. *Journal of Counseling Psychology*, 70(1):90–102.

Zafar, H. and Aslam, F. (2023). Structural barriers to substance use disorder treatment in Pakistan: Cost, accessibility, and healthcare trust. *Journal of Substance Use*, 28(3):415–422.

Zahid, A., Hussain, M., and Sarfraz, M. (2022). Gendered manifestations of addiction stigma in urban pakistan. *Social Science and Medicine*, 298:114876.

Zahid, A. and Kausar, R. (2021). Predictors of institutionalized recovery: Assessing the invariant role of gender and family support in urban rehabilitation centers. *Journal of Behavioral Sciences*, 31(1):102–118.

Zaidi, S. et al. (2023). Intersectional stigma among young adults with substance use disorders and hiv in lahore. *BMC Psychiatry*.

Zhang, Y. et al. (2022). Family support and stigma in collectivist cultures: A comparative study of pakistan and china. *International Journal of Social Psychiatry*.

Zimet, G. D., Dahlem, N. W., Zimet, S. G., and Farley, G. K. (1988). The multidimensional scale of perceived social support. *Journal of Personality Assessment*, 52(1):30–41.

Zubair, M. et al. (2024). Health policy and substance use: Addressing systemic gaps in Pakistan's healthcare framework. *International Journal of Drug Policy*, 112:104102.

Appendix A

رضامندی فارم

السلام علیکم، میں منیبہ صدیقی ہوں، کیپیٹل یونیورسٹی آف سائنس اینڈ ٹیکنالوجی کی طالبہ، جو ایک تحقیق کر رہی ہوں کہ منشیات کے عادی افراد میں محسوس شدہ بدنامی مدد حاصل کرنے کے رویے اور سماجی مدد کو کیسے متاثر کرتی ہے۔ اس تحقیق کا مقصد یہ سمجھنا ہے کہ افراد کو مدد حاصل کرنے میں کن چیلنجز کا سامنا کرنا پڑتا ہے اور ان کے سماجی تعاون کے تجربات کیسے ہوتے ہیں۔ اس تحقیق میں آپ کی شرکت مکمل طور پر رضاکارانہ ہے۔ آپ کی فراہم کردہ تمام معلومات کو مکمل رازداری کے ساتھ رکھا جائے گا اور صرف تعلیمی مقاصد کے لیے استعمال کیا جائے گا۔ آپ کو کسی بھی وقت اس تحقیق سے دستبردار ہونے کا مکمل حق حاصل ہے، اور اس کا آپ پر کوئی منفی اثر نہیں پڑے گا۔ اگر آپ شرکت پر رضامند ہیں تو براہ کرم نیچے دستخط کریں۔ اگر آپ کو اس تحقیق کے حوالے سے کوئی سوالات ہیں تو بلا جھجک مجھ سے رابطہ کریں۔ آپ کے وقت اور تعاون کا شکریہ۔

شرکت کنندہ کے دستخط: _____

تاریخ: _____

محقق کے دستخط: _____

تاریخ: _____

Appendix B

آبادیاتی شیٹ:

ذاتی معلومات:

عمر: _____

جنس: ☐ مرد ☐ عورت ☐ دیگر: _____

قومیت: _____

رہائشی شہر: _____

والد کا پیشہ: _____

والدہ کا پیشہ: _____

کل خاندانی افراد: _____

بہن بھائیوں کی تعداد: _____

پیدائشی ترتیب (مثلاً سب سے بڑا، درمیان والا، سب سے چھوٹا): _____

تعلیمی پس منظر:

☐ کوئی رسمی تعلیم نہیں

☐ پرائمری اسکول

☐ مڈل اسکول

☐ ہائی اسکول

☐ اعلیٰ ثانوی (انٹرمیڈیٹ)

☐ بیچلر ڈگری

☐ ماسٹرز ڈگری

☐ ڈاکٹریٹ (پی ایچ ڈی)

☐ دیگر: _____

ملازمت کی حیثیت:

☐ کل وقتی ملازم

☐ جز وقتی ملازم

☐ بے روزگار

☐ فری لانسر

☐ طالب علم

☐ دیگر: _____

ازدواجی حیثیت:

☐ غیر شادی شدہ
☐ شادی شدہ
☐ طلاق یافتہ
☐ بیوہ/رمل
☐ دیگر: _____

گھر کی ماہانہ آمدنی:

☐ 5,000 – 20,000
☐ 20,000 – 50,000
☐ 50,000 – 100,000
☐ 100,000 سے زیادہ

آپ کی ذاتی ماہانہ آمدنی:

☐ 5,000 - 20,000
☐ 20,000 - 50,000
☐ 50,000 - 100,000
☐ 100,000 سے زیادہ

منشیات کے استعمال کی تاریخ:

استعمال شدہ منشیات کی قسم: _____

استعمال کی مدت: _____

پچھلا علاج :☐ ہاں ☐ نہیں:

استعمال سے متعلق نفسیاتی یا جسمانی مسائل: _____

استعمال کی وجہ: _____

Appendix C

Scale 1

اگر آپ کو کوئی ذاتی مسئلہ درپیش ہو تو آپ کے خیال میں یہ کتنا ممکن ہے کہ آپ درج ذیل لوگوں سے مدد طلب کریں گے؟ براہ کرم جواب پر نشاندہی کریں جو آپ کے مدد لینے کے ارادے کو ظاہر کرتا ہو۔

1=انتہائی نا ممکن

3= نا ممکن

5= ممکن

7= انتہائی ممکن

نمبر	فردیاذریع	1	2	3	4	5	6	7
a	قریبی ساتھی(مثلاً:گرلفرینڈ،بوائےفرینڈ،شوہر،بیوی)	○	○	○	○	○	○	○
b	دوست(جوآپ کےرشتہ دارنہ ہوں)	○	○	○	○	○	○	○
c	والدین	○	○	○	○	○	○	○
d	دیگررشتہ دار/خاندان کافرد	○	○	○	○	○	○	○
e	ذہنی صحت کےماہرین (مثلاً ماہرنفسیات، سماجی کارکنیا کونسلر)	○	○	○	○	○	○	○
f	فون ہیلپ لائن(مثلاً:لائف لائن)	○	○	○	○	○	○	○
g	جنرل پریکٹیشنر/ڈاکٹر	○	○	○	○	○	○	○
h	مذہبی رہنما(مثلاً پادری،ربی،چیلن ،مولوی)	○	○	○	○	○	○	○
i	میں کسی سے مددطلب نہیں کروں گا	○	○	○	○	○	○	○
j	میں کسی اور سے مدد لونگا جو درج فہرست میں نہیں (براہ کرم جگہ پر لکھیں مثال کے طور پر: کام کا ساتھی(colleagues)، اگر نہیں تو خالی چھوڑ دیں	○	○	○	○	○	○	○

اگر آپ خودکشی کرنے کے خیال کا سامنا ہو تو آپ کے خیال میں یہ کتنا ممکن ہے کہ آپ درج ذیل لوگوں سے مدد طلب کریں گے؟ براہ کرم جواب پر نشاندہی کریں جو آپ کے مدد لینے کے ارادے کو ظاہر کرتا ہو۔

1=انتہائی نا ممکن

3= نا ممکن

5= ممکن

7= انتہائی ممکن

نمبر	فردیاذریع	1	2	3	4	5	6	7
a	قریبی ساتھی(مثلاً:گرلفرینڈ،بوائےفرینڈ،شوہر،بیوی)	○	○	○	○	○	○	○
b	دوست(جو آپ کے رشتہ دار نہ ہوں)	○	○	○	○	○	○	○
c	والدین	○	○	○	○	○	○	○
d	دیگر رشتہ دار/خاندان کافرد	○	○	○	○	○	○	○
e	ذہنی صحت کےماہرین (مثلاً ماہرنفسیات، سماجی کارکنا کونسلر)	○	○	○	○	○	○	○
f	فون ہیلپ لائن(مثلاً:لائف لائن)	○	○	○	○	○	○	○
g	جنرل پریکٹیشنر/ڈاکٹر	○	○	○	○	○	○	○
h	مذہبی رہنما(مثلاً :پادری،ربی،چیپلن ،مولوی)	○	○	○	○	○	○	○
i	میں کسی سے مددطلب نہیں کروں گا	○	○	○	○	○	○	○
j	میں کسی اور سے مدد لونگا جو درج فہرست میں نہیں (براہ کرم جگہ پر لکھیں مثال کے طور پر: کام کا ساتھی(colleagues)، اگر نہیں تو خالی چھوڑ دیں							

Scale 2

براہ کرم ہرسوال کوغورسے پڑھیں اور ہرسوال کے نیچےدی گئے نمبر پر دائرہ لگائیں جو اس بات کوظاہرکرے گا کہ آپ اس سوال سے کس حد تک اتفاق یا اختلاف رکھتے ہیں۔ براہ کرم نیچےدیےگئےپیمانے کااستعمال کریں اورکوئی سوال نہ چھوڑیں

1 = مکمل اختلاف 2= اختلاف 3= اتفاق 4= مکمل اتفاق

نمبر	بیان	1 مکمل اختلاف	2 اختلاف	3 اتفاق	4 مکمل اتفاق
1	جو انسان نشے کا علاج کروا چکا ہو، ایسے فرد کو زیادہ تر لوگ اپنی مرضی سے قریبی دوست بنا لیتے ہیں	o	o	o	o
2	زیادہ تر لوگ سمجھتے ہیں کہ وہ فرد جو نشہ کےعلاج کروا چکا ہو، عام شہری کی طرح قابل اعتبارہوتاہے۔	o	o	o	o
3	جو انسان نشے کا علاج کروا چکا ہو، ایسے فرد کو زیادہ تر لوگ عوامی سکول میں بچوں کااستادتسلیم کرینگے	o	o	o	o
4	جو انسان نشے کا علاج کروا چکا ہو، ایسے فرد کو زیادہ تر لوگ اپنےبچوں کی دیکھ بھال کےلیےملازمت پر رکھ لینگے	o	o	o	o
5	زیادہ تر لوگ ایسےفرد کو کمترسمجھتے ھیں جو نشے کا علاج کروا چکا ہو	o	o	o	o
6	اگرکوئی فردنشہ کےعلاج کروا چکاہواورملازمت کےلیےاہل ہوتوزیادہ تر لوگےسےملازمت پر رکھ لینگے	o	o	o	o
7	زیادہ تر لوگ ملازمت کےلیے ایسےفرد کی درخواست کورد کردیں گے جو نشے کا علاج کروا چکا ہواور کسی اوراسیدوارکوترجیح دینگے۔	o	o	o	o
8	زیادہ تر لوگ ایسےفرد کے ساتھ رومانوی ملاقات(date) کرنےپرآمادہ ہونگے جو نشے کا علاج کروا چکا ہو	o	o	o	o

Scale 3

ہدایات:
مندرجہ ذیل بیانات کو غور سے پڑھیں اور بتائیں کہ آپ ان سے کس حد تک متفق یا غیر متفق ہیں۔ ہر بیان کے آگے دیئے گئے جوابات میں سے کسی ایک پر (√) کا نشان لگائیں۔

		بہت زیادہ غیر متفق	زیادہ غیر متفق	معمولی سا غیر متفق	درمیانہ	معمولی سا متفق	زیادہ متفق	بہت زیادہ متفق
.1	ایک خاص شخص ہے جو ضرورت کے وقت میرے ارد گرد موجود ہے۔							
.2	ایک خاص شخص ہے جس کے ساتھ میں اپنی خوشیاں اور غم بانٹ سکتا/سکتی ہوں۔							
.3	میرا خاندان واقعی میری مدد کرنے کی کوشش کرتا ہے۔							
.4	میں جذباتی مدد اور حمایت ضرورت کے وقت اپنے خاندان سے حاصل کرتا/کرتی ہوں۔							
.5	ایک خاص شخص ہے جو درحقیقت میرے لئے سکون کا ذریعہ ہے۔							
.6	میرے دوست واقعی میری مدد کرنے کی کوشش کرتے ہیں۔							
.7	میں اپنے دوستوں پر انحصار کر سکتا/سکتی ہوں جب چیزیں غلط ہوں۔							
.8	میں اپنے مسائل کے متعلق اپنے خاندان سے بات کر سکتا/سکتی ہوں۔							
.9	میرے دوست ہیں جن کے ساتھ میں اپنی خوشیاں اور غم بانٹ سکتا/سکتی ہوں۔							
.10	میری زندگی میں ایک خاص شخص ہے جو میرے احساسات کا خیال رکھتا ہے۔							
.11	میرا خاندان فیصلہ کرنے میں میری مدد کے لئے رضامند ہے۔							
.12	میں اپنے مسائل کے متعلق اپنے دوستوں سے بات کر سکتا/سکتی ہوں۔							

Appendix D

Capital University of Science & Technology
Your Journey Awaits

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W www.cust.edu.pk

Ref: CUST/FMSS/REC/2025-07

May 19, 2025

RESEARCH ETHICS COMMITTEE CERTIFICATE OF REVIEW AND SUPPORT

This is to certify that Project titled: "***Impact of Perceived Stigma on Help Seeking Behavior and Social Support among Substance Use Disorder Patients***" submitted by Scholar: **Muneeba Siddiqui MSP233024** and supervised by: **Ms. Sadafa Zeb** reviewed by the Research Ethics Committee of Faculty of Management and Social Science, meets the requirements of the American Psychological Association's Ethical guidelines for Human Research and is **REVIEWED** and **APPROVED** by Research Ethics Committee of Faculty of Management and Social Sciences.

It is the Scholar's responsibility to ensure that all researchers associated with this project are aware of the conditions of approval and which documents have been approved.

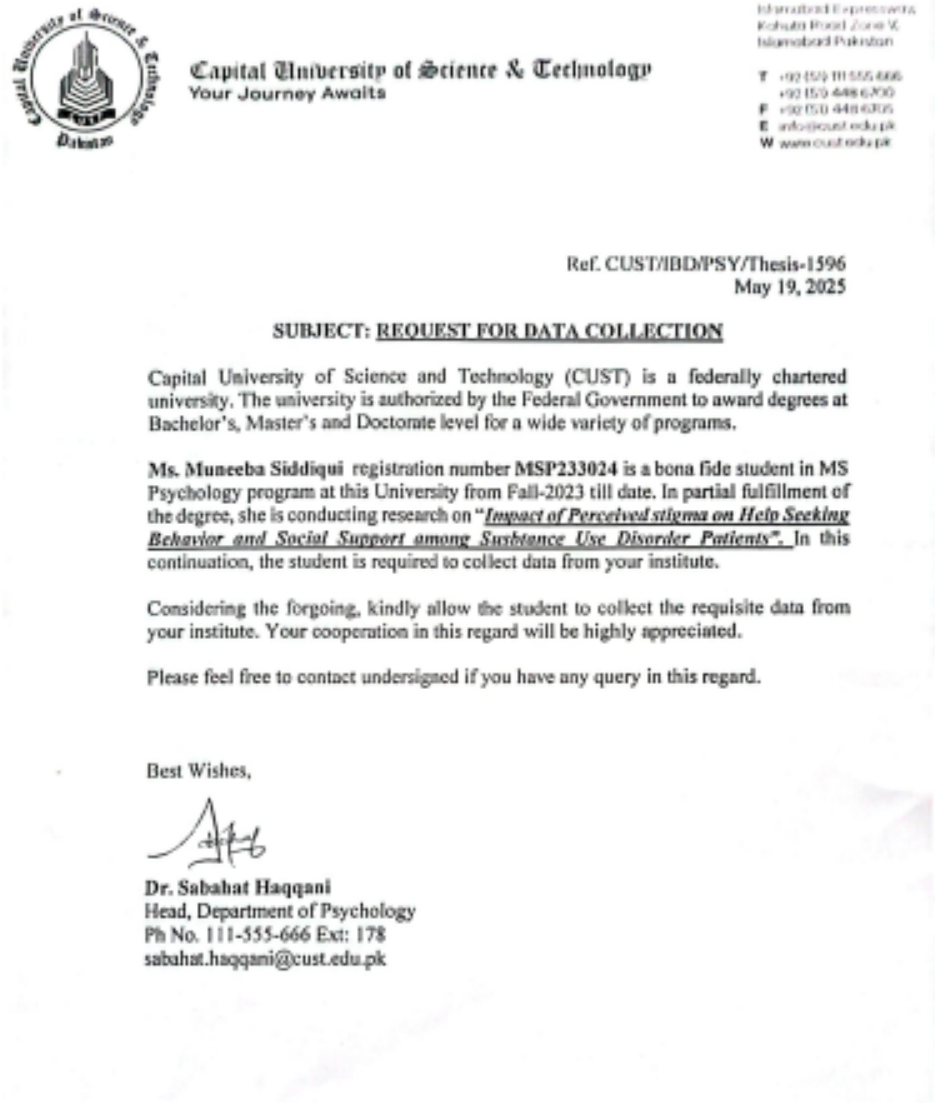
The Scholar is required to notify the Research Ethics Committee in case of any amendment in the project, specifically:

- Any significant change to the project and the reason for that change, including an indication of ethical implications (if any)
- Serious adverse effects on participants and the actions taken to address those effects
- Any other unforeseen events or unexpected developments that merit notification
- The inability of the Principal Investigator to continue in that role, or any other change in research personnel involved in the project
- A delay of more than 12 months in the commencement of the project; and,
- Termination or closure of the project.

Dr. Sabahat Haqqani

Convener, Research Ethics Committee
Faculty of Management and Social Sciences
Capital University of Science and Technology
Islamabad

Appendix E



Capital University of Science & Technology
Your Journey Awaits

Ref. CUST/IBD/PSY/Thesis-1596
May 19, 2025

SUBJECT: REQUEST FOR DATA COLLECTION

Capital University of Science and Technology (CUST) is a federally chartered university. The university is authorized by the Federal Government to award degrees at Bachelor's, Master's and Doctorate level for a wide variety of programs.

Ms. Muneeba Siddiqui registration number **MSP233024** is a bona fide student in MS Psychology program at this University from Fall-2023 till date. In partial fulfillment of the degree, she is conducting research on "***Impact of Perceived stigma on Help Seeking Behavior and Social Support among Susbtance Use Disorder Patients***". In this continuation, the student is required to collect data from your institute.

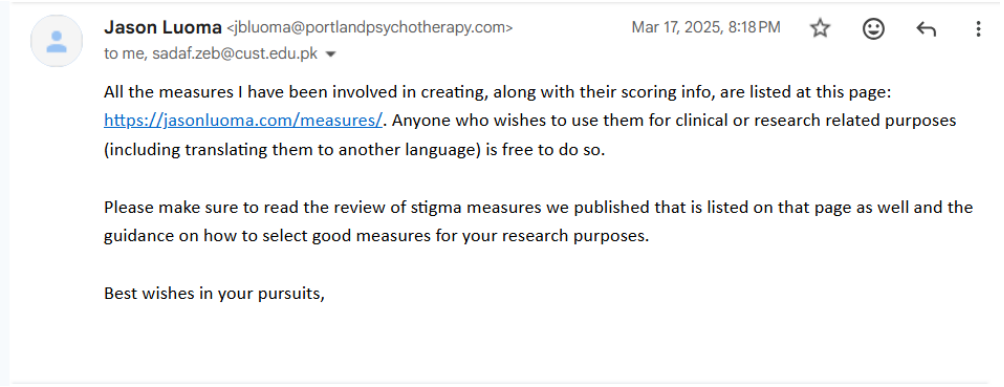
Considering the forgoing, kindly allow the student to collect the requisite data from your institute. Your cooperation in this regard will be highly appreciated.

Please feel free to contact undersigned if you have any query in this regard.

Best Wishes,

Dr. Sabahat Haqqani
Head, Department of Psychology
Ph No. 111-555-666 Ext: 178
sabahat.haqqani@cust.edu.pk

Appendix F

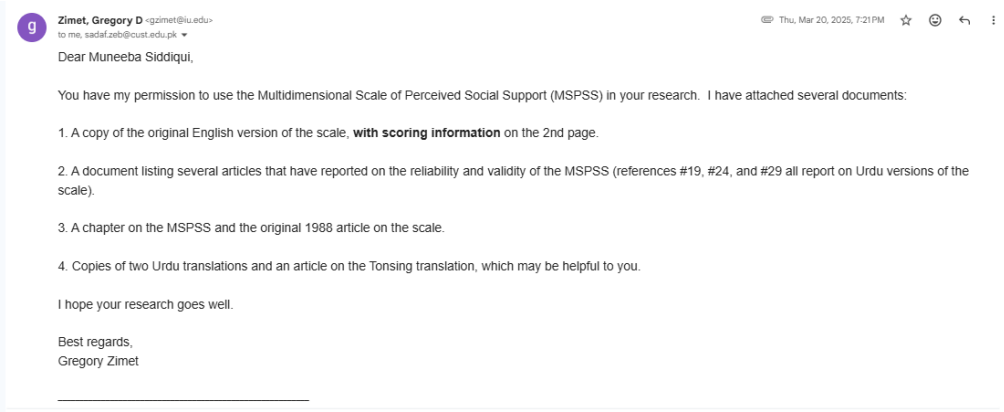


Jason Luoma <jbluoma@portlandpsychotherapy.com> Mar 17, 2025, 8:18 PM
to me, sadaf.zeb@cust.edu.pk

All the measures I have been involved in creating, along with their scoring info, are listed at this page: https://jasonluoma.com/measures/. Anyone who wishes to use them for clinical or research related purposes (including translating them to another language) is free to do so.

Please make sure to read the review of stigma measures we published that is listed on that page as well and the guidance on how to select good measures for your research purposes.

Best wishes in your pursuits,



Zimet, Gregory D <gzimet@iu.edu> Thu, Mar 20, 2025, 7:21 PM
to me, sadaf.zeb@cust.edu.pk

Dear Muneeba Siddiqui,

You have my permission to use the Multidimensional Scale of Perceived Social Support (MSPSS) in your research. I have attached several documents:

1. A copy of the original English version of the scale, **with scoring information** on the 2nd page.

2. A document listing several articles that have reported on the reliability and validity of the MSPSS (references #19, #24, and #29 all report on Urdu versions of the scale).

3. A chapter on the MSPSS and the original 1988 article on the scale.

4. Copies of two Urdu translations and an article on the Tonsing translation, which may be helpful to you.

I hope your research goes well.

Best regards,
Gregory Zimet

The source article for the GHSQ is: Wilson, C. J., Deane, F. P., Ciarrochi, J., & Rickwood, D. (2005). Measuring help-seeking intentions: Properties of the General Help-seeking Questionnaire. *Canadian Journal of Counselling*, *39,* 15-28.

The GHSQ or variants of it have been used in many of the research studies we have published and the reader is referred to the pdf of published articles in the help-seeking area: http://www.uow.edu.au/health/iimh/pdf/help_seeking_journal_articles.pdf