Translation and Validation of Urdu-Perceived Stigma of Substance Abuse Scale (PSAS)

Huma Javed
Department of Humanities, COMSATS University Islamabad, Lahore Campus
Farzana Ashraf*
Department of Humanities, COMSATS University Islamabad, Lahore Campus
Corresponding author: farzana.ashraf@cuilahore.edu.pk
Saba Shahabdin
Department of Humanities, COMSATS University Islamabad, Lahore Campus
Haleema Bokhari
Department of Humanities, COMSATS University Islamabad, Lahore Campus

Abstract

The Perceived Stigma of Substance Abuse Scale is a widely used instrument to measure psychological morbidity in substance abusers. This study aimed to translate and test the reliability and validity of the Urdu version of the Perceived Stigma of Substance Abuse Scale. The English version of the Perceived Stigma of Substance Abuse Scale was translated into Urdu and used in this study. The questionnaire was administered to a consecutive sample of one hundred substance abusers. In general, the Urdu version of the scale was found to be acceptable. Cronbach's alpha coefficient, used to test reliability, is 0.71 for the Perceived Stigma of Substance Abuse Scale, indicating good reliability. In this study, the Perceived Stress and Self-Esteem scales and the Perceived Stigma of Substance Abuse Scale were employed to measure their validity. The validity of the translated and adapted scale, Perceived Stigma of Substance Abuse, was assessed by calculating the item's total correlation and Inter-Item correlation with their respective rankings. Pearson correlation of measures between the perceived stigma of substance abuse, perceived stress, and self-esteem was computed for the study sample to determine the relationship between variables. This preliminary validation study of the English version of the Perceived Stigma of Substance Abuse Scale proved that it is an acceptable, reliable, and valid measure of perception of the prevalence of stigmatizing beliefs among Substance Abusers.
Keywords: Perceived stigma, substance abuse, self-esteem, perceived stress

Introduction

The Perceived Stigma pertains to the beliefs held by stigmatized individuals regarding the prevalence of negative attitudes and actions within society directed toward them. It involves discrimination, a degree of devaluation, and perceptions towards individuals receiving treatment for substance use rather than mental illness (Luoma et al., 2010). Stigma is recognized as a categorization that sets an individual apart from others, linking them to undesirable and objectifiable traits. A typical definition of stigma is a mark of shame attached to a specific situation, trait, or individual that has a substantial impact on people with substance use disorders (SUDs) (Crapanzano et al., 2018).

Social presumptions and misconceptions give rise to this stigma, which creates unfavorable opinions that may affect how people with SUDs are treated in a variety of contexts, such as the workplace, social interactions, and healthcare. The stigma associated with addiction affects not only those who are directly impacted but also their families and communities, leading to social isolation and discrimination, according to the National Institute on Drug Abuse (Gust et al., 2021). It takes various forms, including enacted, perceived, and self-stigma, manifesting as stereotypes, negative perceptions, and judgments about the stigmatized group. Stigmatizing individuals who have a history of drug use is an example of prejudice in society. The related stigma involves serious social and moral ramifications, even throughout the therapy. Drug Addicts face unfair treatment and hostility from their surroundings (Krendl et al., 2023).

Drug abusers often find themselves inaccessible to social circles and gatherings; people generally discriminate against them as a separate group within society and feel reluctant to make connections with them due to stereotypes and negative perceptions, making drug-abusing persons' struggles even tougher. Internalized Stigma Individuals with SUDs frequently internalize negative stereotypes, leading to shame and guilt. This internalized stigma can diminish self-esteem and hinder recovery efforts. Research by Rüsch et al. (2020) highlighted that higher levels of internalized stigma are associated with lower self-efficacy and increased substance use, indicating that shame can perpetuate the cycle of addiction. The effects of this stigma on the individual are profound, resulting in difficulties finding employment, rejection by others, a reduction in one's sense of self-worth, isolation, and avoidance of intimate relationships (Ahmed et al., 2021).

The stigma linked to drug abuse results in unfavorable labels, portraying them as unreliable, irresponsible, immoral, or ethically deficient. Refusal and rejection from friends, family, and romantic partners are common. Internally, individuals grapple with feelings of shame and devaluation, impacting self-image and mental well-being. Additionally, perceived stigma can deter individuals from seeking essential healthcare services, as the fear of judgment becomes a barrier to accessing proper treatment and support (Matsumoto et al., 2021).

The words used to characterize substance abuse and addiction can carry much emotional weight and have the potential to reinforce negative stereotypes. Phrases like addict and substance abuser support a negative social narrative. According to research, stigma is impacted by one's sense of control over substance use, implying that stigma increases when society sees addiction as a personal failing (Kelly et al., 2020). This perspective is in opposition to the knowledge that addiction is a chronic illness that necessitates medical care and assistance. Additionally, words like abuse, which are linked to substance use, elicit intense emotional responses. The word abuse shares emotional valence with terms like homicide and rape. This analogy highlights how words evoke fear, condemnation, and disdain, further isolating individuals with SUDs (Rüsch et al., 2020).

Family members undergo silent suffering when they hear disparaging remarks made about substance users by those they love, care about, and identify with; parents of substance-using children may be the most affected. However, the penalties of stigma are likely to be felt by any close person who cares for and identifies with someone who is fighting a substance use disorder. As they say, the family is in this together. Substance abuse has a detrimental effect on the user as well as the family of people with an addiction (Liahaugen et al., 2022). The longer a person used drugs, the more unfavorable the effects were on the family.

People's willingness to seek treatment is weakened by stigma. Both substance abusers and their loved ones are affected by this. Because stigmatized individuals find it more difficult

to recognize their ailment, delay or refuse treatment, and discontinue treatment earlier than less stigmatized groups, the expectation of stigma exacerbates and prolongs the course of substance use and mental health problems; their families are no different. According to research, keeping information private makes it more difficult for family members to provide both formal and informal support for a loved one who has a mental health condition. Structural obstacles, such as a lack of funding, are less likely to cause delays in seeking aid than stigma (Crapanzano et al., 2018).

The stigma associated with substance misuse makes it rational for people to do whatever it takes in private to keep their lives together rather than seeking aid and risking condemnation and real-life repercussions. The family naturally wishes to escape the label of codependent, just as substance users oppose therapy because they do not want to be classified as people with an addiction. In actuality, family members can play a significant role in helping a substance user change for the better: Help-seeking substance users most frequently claim familial impact as the reason they entered treatment. Because stigma makes people less likely to help their loved ones seek help and less likely to get help for themselves, their hesitation to reach out and become involved is doubly regrettable (Tamutiene et al., 2016).

Isolation, a reluctance to seek treatment, and prolonged suffering are frequently the results for families and their loved ones who use substances. This is troubling because studies have shown that family members can influence change by advocating for their loved ones and encouraging them to participate in improved treatment. To put it another way, one of the main effects of stigma is the loss of what may be the most potent source of motivation for substance users: their families (McCann & Lubman, 2018).

Stigma also exists within the healthcare system, where individuals may be discouraged from seeking necessary treatment due to unfavorable opinions held by healthcare professionals. The difficulties that people with substance use disorders encounter might be made worse by this stigma, which can make it difficult for them to get healthcare assistance. According to a comprehensive analysis, stigmatizing attitudes regarding people with SUDs are frequently held by medical professionals, which results in fewer favorable treatment recommendations and lower-quality care (Boekel et al., 2013). This kind of stigma contributes to varying levels of resistance among different types of drug addicts, and is the evolving negative attitudes of professionals towards long-term drug users. As individuals continue their drug use over prolonged periods, professionals may gradually view them with contempt and disgrace, especially compared to those seeking treatment for the first time. This sprouting attitude can significantly influence the degree of stigma experienced by individuals classified as mild, moderate, severe, or relapsed patients.

Addiction and recovery challenges are sustained by the stigma attached to SUDs. Stigma impedes the establishment of successful public health initiatives that foster empathy and support for individuals impacted by substance use disorders by discouraging candid discussion and education about these problems. According to their study, 75% of individuals with SUDs reported that they were stuck in a cycle of loneliness and prolonged substance use because they were afraid of being judged if they confided in friends, family, or medical professionals (Kumar, 2021).

Experiential research has exposed that stigma and marginalization are almost always experienced by those who have mental illness and use mental health services. It has also been shown that stigma practices influence a variety of mental health outcomes. Too far, there has not been as much research done on the stigma associated with drug use disorders or the understanding of those getting treatment for drug addiction (Zoubaa et al., 2022).

Additionally, prior research relating to drug users who have multiple stigmatized characteristics related to race, age, sex, sexual orientation, and poverty has demonstrated that prejudice based on drug use was the most protruding type of discrimination that affected their lives. The portrayal of substance use as a moral and criminal matter has been linked to a significant degree of stigma among the public towards people who struggle with substance abuse (Kulesza et al., 2013). This has resulted in negative attitudes and beliefs about substance abuse and the idea that it is something that can be controlled, which places guilt and blame on those who suffer from this disorder (Yang et al., 2017).

Present Study

Individuals with substance use disorders typically experience stigma in many forms, but there is no standardized diagnostic method that gauges stigma perception in this particular patient population. The stigma that substance users experience has not been adequately examined or quantified, even though a variety of instruments are employed to assess stigma among individuals with mental illness. Luoma et al. (2007) designed the Perceived Stigma of Addiction measure (PSAS) to address this gap by employing an existing measure that was first created for use with mental illness, according to her, people with substance use disorders experience three distinct forms of stigma: self-stigma (a negative internalized self-view), perceived stigma (attributions of others' attitudes), and enacted stigma (real experiences of discrimination). The goal was to translate this reliable and meaningful measure of perceived stigma that people seeking assistance with substance use disorders could employ. In this manner, researchers can examine the relationship between treatment-associated activities, such as seeking assistance or undergoing therapy, and perceived stigma.

In order to ascertain this, Luoma and associates developed the Perceived Stigma of Addiction Scale (PSAS) by altering an already-existing instrument that was first intended for individuals with severe mental illness. A psychometric study was done to look at the validity and reliability of the PSAS, which was given to individuals who were already receiving treatment for substance use problems. The PSAS was developed as a significant milestone in stigma research, providing a much-needed measure of perceived stigma among substance users and examining its relationship to treatment participation and recovery results. The scale demonstrated satisfactory content validity.

Since the majority of research and measurement tools have been produced and conceptualized in Western cultures, this study was conducted to frame the idea of perceived stigma against individuals with drug use problems in the local cultural context. Cultural differences in ideas, values, and conventions influence how stigma is experienced and internalized, even though Luoma created the Perceived Stigma of Addiction Scale (PSAS) to gauge people's impressions of societal judgment toward substance users. In contrast to Western samples, substance use issues may raise reported stigma and treatment-seeking behavior in most collectivist societies, including our own, where they are frequently linked to intense moral condemnation, familial shame, and social exclusion. Therefore, the PSAS must be adopted and used locally to achieve cultural appropriateness and accuracy when analyzing how local stigma functions. In order to assist in creating more effective stigma-reduction and treatment engagement interventions tailored to the needs of our population, this study aims to close that gap by examining the scale's applicability, sensitivity, and significance in our sociocultural setting.

Method

Translation of Scale

Utilizing tools already created with strong psychometric qualities can save time and

effort in cross-cultural research. However, these tools must be culturally acceptable and properly translated to be considered genuine; only when cross-cultural researchers employ suitable tools can the potential advantages of cross-cultural studies be realized. The translation process thus becomes a crucial component of cross-cultural research. In most cases, a direct translation of an instrument from one language to another does not ensure that the translated scale has the same substance (Brislin et al., 1970). Scholars concur that an instrument's back-translation is necessary for validation and cross-cultural study applications (McDermott & Palchanes, 1992).

Phase 1: Translation and Tryout

This phase was carried out in two steps. In the first step, English scales, such as Perceived Stigma of Substance Abuse, were translated into Urdu. In the second step, all these translated versions and their psychometric properties were tested.

Objectives

The primary objectives to achieve the goals of the first phase of this study are listed here:
1. Translate the Perceived Stigma of Substance Abuse Scale.
2. To ensure the psychometric properties of the translated versions of this scale.

Step I: Translation

When an instrument is applied to a culture other than its origin, it must be translated and adapted to that culture. The primary purpose of instrument translation is to present questions similar to the original scale to yield matching response options (Harkness & Schou Glusberg, 1998).

Instruments

The instruments that were translated in Phase I to use in Phase II are as follows:

1- Perceived Stigma of Substance Abuse Scale (PSAS; Luoma, 2010): The Substance Abuse Perceived Stigma scale was designed by Luoma (2010). This scale is used to assess perceived stigma in substance abusers. It comprises an entire notch that reaches from 8 to 32. It is a 4-point Likert scale ranging from 1 (*Strongly Disagree*) to 4 (*Strongly Agree*). The higher the score, the greater the perceived stigma. Sample items include: "*Most people would willingly accept someone who has been treated for substance use as a close friend,*" and "*Most people would hire someone who has been treated for substance use to care for their children.*" Reversed scored items include 1, 2, 3, 4, 6, and 8. The scale's alpha value was acceptable (0.71), highlighting good reliability. Perceived stigma of substance abuse was translated into Urdu according to MAPI guidelines before being used in the present study.

Procedure. Different methods are available to translate instruments from one language to another. A standardized translation procedure was followed to solve this

scale. A crew of psychologists and bilingual experts translated the scales from English into Urdu. The translation was done to maintain theoretical uniformity between the original and translated scale versions. Different approaches to solving the problem exist, ranging from the original to alternative languages. The method includes back translation, decentering, the bilingual system, and the committee technique.

Back Translation

It is a method of scale translation from one language to another. One advantage of this method is that it is both time- and cost-effective. The scale involves three steps. First, the instrument is translated by a bilingual expert from the original language to the target language. After that, another bilingual expert translates the translated device back into its original language. Then, comparisons are made between the two drafts to identify any disparities.

According to Brislin (1980), the procedure is repeated from the start if large

discrepancies between the two versions are found. The process is repeated until the original and translated versions are deemed equivalent.

Preparation. The present study requested two bilingual experts to participate in the translation procedure. After their agreement, they were briefed about the whole process. Afterward, the experts compiled a scale to be translated from English to Urdu, forming a document comprising 10 items or statements. The team members were also provided definitions of the key terms and the study variables used in the instruments.

Translation. After all the preparations were completed, the translation procedure started. In this step, two professoionals translated the instrument from English to Urdu. After that, another meeting was arranged with the adjudicator. In this meeting, they reviewed the translated versions of the instruments and compared all the drafts. Then, the most suitable and appropriate translations for the items were selected to form the translated versions of the scales.

Step II: Tryout. In the second step, the translated scales were administered on a small sample (N=100) to examine the internal consistency of the rankings and to see if there were any flaws in the translated version. This step is summarized below: Sample. The sample for the tryout was selected using the random sampling technique from a diverse group of university students in Punjab, Pakistan. The sample consisted of one hundred substance abusers aged 19 to 45.

Procedure

Below, the process of step I is explained in detail:

Pretesting: The translated versions of the questionnaires are now ready for pre-testing On a sub-sample from the target population. In this step, the confirmed version of the instruments was administered to a sample of 100 substance abusers. Then, to verify the internal consistency, the total correlation of the items was calculated across the scales, and the psychometric properties were also confirmed.

Revision: In this step, a meeting is arranged to modify the less significant items. All the team members who attended this meeting reconciled the items present. If required, the items with low or non-significance levels or negative correlation with the total scale are excluded from the questionnaire. Still, in the present study, all variables were significantly correlated with the entire scale. Therefore, no items were removed from the questionnaires.

Documentation: The last stage of the translation procedure is documentation. Documentation is completed throughout the translation process, and at the end, it is compiled into a final report. First, all the required documents related to the questionnaire translation were assembled. Translation team members were provided with the six scales, key terms, and definitions of all the variables used in the instruments. A briefing on the entire translation procedure was provided. Two experts independently translated the questionnaire items. A meeting was held to review all aspects of the translated versions, and the concluding drafts of these questionnaires were prepared. The final versions of the instruments were monitored on a sub-sample to examine their psychometric properties and internal consistency. Finally, the results revealed significant positive correlations between all items and their respective scales' total scores, and the committee recommended no further changes in the final draft.

Measures

1- Perceived Stigma Scale of Substance Abuse Scale (PSAS): The Substance Abuse Perceived Stigma scale was developed by Luoma (2010) using a 4-point Likert scale. This scale is used to assess perceived stigma in substance abusers. It comprises an entire notch that reaches from 8 to 32. It is a 4-point Likert scale ranging from 1 (Strongly Disagree) to 4 (Strongly Agree).

The higher the score, the greater the perceived stigma. Reversed scored items include 1, 2, 3, 4, 6, and 8, e.g., "Most people believe that someone treated for substance use is just as trustworthy as the average citizen." The scale's alpha value was acceptable (0.71), highlighting good reliability. The perceived stigma of substance abuse was translated into Urdu according to MAPI guidelines before being used in the present study.

2. Rosenberg Self-Esteem Scale (RSE): The Rosenberg Self-Esteem Scale was developed by Rosenberg (1979) based on a 4-point Likert scale. This scale measures Self-Esteem in various groups, such as adults. It ranges from 1 (*Strongly Agree*) to 4 (*Strongly Disagree*). Responses indicating low self-esteem include "strongly agree" or "agree," the items are 2, 5, 6, 8, and 10. At the same time, select "disagree" or "strongly disagree" for items 1, 3, 4, 7, and 10, e.g., "On the whole, I am satisfied with myself" and "I feel that I have several good qualities." The scale's alpha value was acceptable (0.92), highlighting excellent reliability.

3- Perceived Stress Scale (PSS): The Perceived Stress Scale was developed by Cohen, Kamarck, and Mermelstein (1983) based on a 5-point Likert scale. This scale is used to measure stress levels in people. It ranges from 0 *(Never)* to 4 *(Very Often),* e.g., *(In the last month, how often have you been upset because of something that happened unexpectedly?), (In the last month, how often have you felt that things were going your way?).* Higher scores on the PSS indicate higher perceived stress. Individual scores vary from 0 to 40. The scale's alpha value was acceptable, highlighting good reliability and validity.

Results

The validity of the translated and adapted scale, Perceived Stigma of Substance Abuse, was assessed by calculating the item's total correlation and Inter-Item correlation with their respective rankings (see Tables 1 to 3). Pearson correlation of measures between the perceived stigma of substance abuse, perceived stress, and self-esteem in substance abusers was computed for the total sample to determine the relationship between variables (see Table 1)

Internal Consistency

To assess the internal consistency of the measures, the scores of the sample's entire set of research variables were evaluated to determine the total correlation of the items across all scales of the present study. The inter-item correlations between stigma and the eight items (PS1-PS8) are displayed in the table. The PS5 has a maximum correlation of r = 0.388 with stigma, indicating a weak association. On the other hand, PS3 has a maximum correlation of r = 0.805** with stigma, indicating a significant link. In comparison, PS5 has weaker correlations overall, with the highest correlation being (*r*=0.388**) with stigma. Items like PS3 (maximum correlation of *r*=0.805**) and PS2 (maximum correlation of *r*=0.665**) with stigma have stronger relationships with stigma. PS3 exhibits the highest overall association with stigma, while the Min-Max values illustrate the range of correlations for each item.

Accordingly, some items, such as PS3 and PS2, are more essential to comprehending stigma than others. Convergent and Divergent validity were also found to be satisfactory.

Exploratory Factor Analysis

The results show significant connections between stress, self-esteem, and stigma. There is a negative correlation between stigma and self-esteem (r = -.24*), indicating that self-esteem tends to decline as stigma rises. At the 0.05 level, this association is statistically significant. Additionally, there was a positive correlation between stigma and stress (r =.27*), suggesting that higher stigma is linked to higher levels of stress. This relationship was statistically significant at the 0.01 level. Finally, a negative correlation exists between stress and self-esteem (r = -.23), indicating that individuals with higher self-esteem tend to have lower stress levels. At the .05 level, this association is likewise statistically significant. In conclusion, the interconnectedness

of these factors is highlighted by the fact that stigma is linked to both higher stress and worse self-esteem, while higher self-esteem is linked to lower stress.

Table 1: *Item Total Correlation of the Perceived Stigma of Substance Abusers Scale for the Sample of Substance Abusers (N=100).*

Items	Inter-item correlations	Item total correlations	Items	Inter-item correlations	Item total correlations
PS1	0.16 - 0.41	0.34**	PS5	0.01 - 0.24	0.13
PS2	0.12 - 0.52	0.41**	PS6	0.01 - 0.45	0.42**
PS3	0.17 - 0.68	0.57**	PS7	0.16- 0.49	0.49**
PS4	0.05 - 0.68	0.51**	PS8	0.13- 0.57	0.57**

*Note: *p<.05, **p<.01, ***p<.001*

Table 2: *Inter-Item and Total Correlation analysis (N=100)*

Variables	Inter-Item Correlations								Item-total Correlation
	PS1	PS2	PS3	PS4	PS5	PS6	PS7	PS8	Stigma
PS1	-	.22*	.40**	.41**	.24*	.22*	.16	.34**	.59**
PS2		-	.52**	.48**	.12	.43**	.26**	.41**	.66**
PS3			-	.68**	.17	.40**	.36**	.571**	.80**
PS4				-	.05	.45**	.36**	.514**	.77**
PS5					-	.015	.24*	.13	.38**
PS6						-	.28**	.42**	.61**
PS7							-	.49**	.59**
PS8								-	.74**

Note: >.05, >.01**, >.001****

Table 3: *Correlation analysis between Perceived Stigma, Perceived stress, and Self-Esteem (N=100)*

Variable	Perceived Stigma	Self-Esteem	Perceived Stress
Perceived Stigma	-	-.24*	.27**
Self-Esteem		-	-.23*
Perceived Stress			-

Note: >.05, >.01**, >.001****

Discussion

The overall aim of this study was to develop the Perceived Stigma of Substance Abuse Scale in the Urdu language and to examine its psychometric properties. According to the results, this endeavor effectively produced an extremely brief unidimensional measure with strong construct validity, reliability, and face validity. A final eight-item scale was developed by further examining internal consistency and correlations between scale items, after which it underwent psychometric testing. A one-factor solution with high item loadings was revealed using factor analysis.

Convergent validity was demonstrated through correlations with measures such as the Perceived Stress scale. These results suggest that those who perceived higher levels of stigma tended to have higher levels of perceived stress. Perhaps this is because early experiences with stigma have a more profound influence on perceptions of stigma than current experiences. Divergent validity was demonstrated through correlation with the Self-esteem scale, which indicated that higher levels of stigma were associated with lower levels of self-esteem.

There are several potential avenues for further investigation. Researchers can now more easily examine the magnitude of the association between perceived stigma and its role as a barrier to treatment attendance, thanks to the availability of a quantitative measure of perceived stigma. Alternatively, research on interventions aimed at lessening stigma among people with an addiction could make use of this measure. Fear of perceived stigma is one aspect of self-stigma, and education is a popular solution (Luoma et al., 2010). Interventions involving stigma education might raise perceived stigma, which could exacerbate feelings of self-shame and ultimately hinder recovery. Such a hypothesis might now be tested using this measure.

Ferrari and Burch (2023) looked at the impact of stigma on recovery after treatment and discovered that continuous social criticism raises stress levels and encourages recurrence. According to their research, people in recovery who feel stigmatized are more likely to suffer from anxiety and sadness, two conditions that frequently lead to substance abuse. The study promoted improving mental health, lowering the chance of relapse, and establishing recovery environments free from stigma.

Yang et al. (2021) investigated how stigma affects addiction and recovery in two ways. Throughout the addiction and treatment spectrum, they discovered that stigma serves as an ongoing obstacle. Stigma keeps people from getting help before therapy, and it keeps them away from social support networks after treatment. The researchers suggested community-based programs to support people at all stages of recovery and reduce stigma.

Conclusion: In summary, the findings from this preliminary validation study indicate that the Urdu version of the PSAS is a reliable and valid measure of perceived stigma, and it can now be used in studies of SUDs.

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Annexure-A

براہ کرم ہر بیان کو احتیاط سے پڑھیں اور آئٹم کے نیچے والے نمبر کو سرکل کریں جو ہر بیان کے ساتھ آپ کے معاہدے یا اختلاف کی ڈگری کی نشاندہی کرتا ہے۔

شدید غیر متفق	غیر متفق	متفق	شدید متفق	بیانات	سیریل نمبر
1	2	3	4	زیادہ تر لوگ اپنی مرضی سے کسی ایسے شخص کو قبول کریں گے جس کا منشیات کے استعمال کا علاج کیا گیا ہو۔	1
1	2	3	4	زیادہ تر لوگوں کا خیال ہے کہ جس شخص کا منشیات کے استعمال کی وجہ سے علاج کیا گیا ہے وہ عام شہری کی طرح ہی قابل اعتماد ہے۔	2
1	2	3	4	زیادہ تر لوگ کسی ایسے شخص جس کا منشیات کے استعمال ہوا ہو۔ ایک پبلک اسکول میں چھوٹے بچوں کے استاد کے طور پر قبول کریں گے۔	3
1	2	3	4	زیادہ تر لوگ اپنے بچوں کی دیکھ بھال کے لیے کسی ایسے شخص کی خدمات حاصل کریں گے جس کا منشیات کے استعمال کا علاج کیا گیا ہو	4
1	2	3	4	زیادہ تر لوگ ایسے شخص کے بارے میں بُرا سوچتے ہیں جو نشہ آور اشیاء کے استعمال کا علاج کروا چکا ہو۔	5
1	2	3	4	زیادہ تر مالکان کسی ایسے شخص کی خدمات حاصل کریں گے جس منشیات کے استعمال کی وجہ سے علاج کیا گیا ہو اگر وہ نوکری کے لیے اہل ہے۔	6
1	2	3	4	زیادہ تر مالکان کسی ایسے شخص جس کا منشیات کے استعمال کی وجہ سے علاج ہو اہو۔ اُس کی درخواست کو کسی دوسرے درخواست گزار کے حق میں منتقل کر دیں گے۔	7
1	2	3	4	زیادہ تر لوگ کسی ایسے شخص کے ساتھ رومانوی تعلق کے لیے تیار ہوں گے جس کا منشیات کے استعمال کا علاج کیا گیا ہو۔	8