



**ADDIS ABABA UNIVERSITY, COLLEGE OF HEALTH  
SCIENCES, SCHOOL OF MEDICINE, DEPARTMENT OF  
PSYCHIATRY**

**STIGMA AMONG HELP SEEKING PEOPLE WITH  
ALCOHOL USE DISORDER, ADDIS ABABA, ETHIOPIA: A  
FACILITY BASED QUALITATIVE STUDY**

PRIMARY INVESTIGATOR- DR. YODIT ENDALAMAW (THIRD YEAR  
PSYCHIATRY RESIDENT)

MARCH 2024

ADDIS ABABA, ETHIOPIA



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A THESIS SUBMITTED TO THE DEPARTMENT OF PSYCHIATRY, SCHOOL OF  
MEDICINE, COLLEGE OF HEALTH SCIENCES, ADDIS ABABA UNIVERSITY FOR  
THE PARTIAL FULFILMENT OF THE SPECIALITY CERTIFICATE IN PSYCHIATRY.

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## **ACRONYMS**

AAU - Addis Ababa University

AMSH - St. Amanuel Mental Specialized Hospital

AUD - Alcohol Use Disorder

CAGE-AID - Cut down, Annoyed, Guilty, Eye opener- Adapted to Include Drugs

CIWA-AR - Clinical Institute Withdrawal Assessment of Alcohol Revised Scale

DSM-5-TR - Diagnostic and Statistical Manual of Mental Disorders, fifth edition, Text Revision

HICs - High Income Countries

LMICs - Low- and Middle- Income Countries

OPD - Outpatient Department

PI- Principal Investigator

PSAS - Perceived Stigma of Substance Abuse

SUD - Substance Use Disorder

WHO - World Health Organization

ZMH - Zewditu Memorial Hospital

## **ABSTRACT**

**Background-** Alcohol use disorder (AUD) is one of the most highly stigmatized conditions. Stigma has several impacts on people with AUD such as decreasing their self-esteem, negatively affecting social relationships, and leading to maladaptive coping strategies like withdrawal and secrecy. Despite evidence indicating that individuals with AUD perceive and experience stigma in the healthcare system, leading to decreased help seeking behavior and diminished recovery in various contexts, there is a lack of understanding regarding the stigma of AUD in Ethiopia.

**General Objective-** This study aimed to explore the perceptions and experiences of stigma among help seeking individuals with AUD.

**Methods-** A phenomenological type of qualitative study was used. The study participants were individuals with a diagnosis of AUD who were receiving care at the substance treatment ward and outpatient service at Amanuel Mental Specialized Hospital (AMSH) and Zewditu Memorial Hospital (ZMH) during the data collection period. A purposive sampling technique was used to recruit the participants. Sampling continued until theoretical saturation was achieved and fifteen in depth interviews were conducted. The interviews were audio recorded, transcribed in Amharic and then translated into English. Thematic analysis was used to identify major themes.

**Findings-** Five main themes emerged from the data: (1) Other people's views and beliefs regarding AUD, (2) Stigma among people with AUD, (3) Experiences of stigma in healthcare facilities, (4) Impact of stigma, and (5) Coping, resilience and positive interpretation of stigma. Participants indicated that the public endorsed psycho-socio-cultural attributions and family history of alcohol addiction as causes of AUD and individuals with AUD were frequently blamed for their condition. This study also explored the different forms of stigma among those with AUD such as perceived stigma, enacted stigma and self-stigma. Individuals with AUD also reported stigma by healthcare professionals which affected their help seeking behaviour and recovery. Multiple negative impacts of stigma, ways of coping, resilient responses and positive interpretations of stigma were also underscored in the findings.

**Conclusion-** Different experiences of stigma among individuals with AUD were evident in the study and the impacts of stigma were found to be far-reaching. Thus, it is essential to utilize the views and experiences gained from this study to develop interventions aimed at

reducing stigma. Public awareness campaigns and policy changes that protect the rights of individuals with AUD should be implemented. Healthcare professionals should also receive training on how to provide a non-judgmental and empathetic care that addresses the needs of those with AUD.

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# **1. INTRODUCTION**

## **1.1 BACKGROUND OF THE STUDY**

Since the early days, alcohol has been utilized for a variety of purposes, such as pleasure, cultural practices, stress relief, socialization, and many others. Although it is hard to ascertain the exact time when people first began to prepare and consume alcoholic beverages as part of their everyday lives, there is some anecdotal evidence that such practices began in Ancient Egypt (1). In Ethiopia, in addition to commercially imported and produced alcoholic beverages, a broad variety of traditional alcoholic beverages are also made and consumed. These beverages are usually prepared in small batches and are primarily consumed locally. Some common ones include Tej, Tella, and Areke, each having a different alcohol content (2).

According to the Diagnostic and Statistical Manual of Mental Disorders, fifth edition, Text Revision (DSM 5, TR), substance use disorders (SUDs) involve cognitive, behavioral and physiological symptoms that are caused by a substance that an individual continues taking despite its negative effects (3). Alcohol comprises one of the most prevalent addictive behaviours that also cause the largest harm (4). Around 38% of adults worldwide report alcohol consumption within the past 12 months (5). One global report indicated that approximately 4.9% of the world's adult population suffer from alcohol use disorder (AUD), with higher prevalence rates in men (7.8%) compared to women (1.5%) (4).

Studies also indicate that in Africa, 43% of people over the age of 15 have consumed alcohol at some point in their lives, while 30% have used alcohol in the past year (6). It is estimated that 3% of people in Africa have AUDs, which are more common in men (6). As countries in sub-Saharan Africa develop and move away from drinking homebrewed alcohol primarily at ceremonies to being influenced by marketing by commercial alcohol companies, there is a growing evidence of increased alcohol consumption and heavy use across this region (7).

A systematic review and meta-analysis of the epidemiology of alcohol consumption in Ethiopia found the pooled prevalence of hazardous alcohol consumption to be 8.94%. It was higher in men (11.58%) than in women (1.21%). There has also been a considerable recent increment in the magnitude of hazardous alcohol consumption in Ethiopia (6).

Alcohol consumption causes more than 60 different medical conditions and the burden of disease is determined by the volume of consumption and the patterns of drinking. Overall, alcohol is responsible for 4.0% of the global burden of disease (8). AUDs, cancer, cardiovascular disease, liver cirrhosis and injuries are the most significant categories of disease caused by alcohol (9). AUDs are also linked to high death rates (10). In 2004, 3.8 % of all worldwide deaths were attributed to alcohol consumption, 6.3 % for men and 1.1 % for women due to the difference in volume and heavy drinking between the two sexes (9).

In low- and middle-income countries (LMICs), the disease burden per litre of alcohol consumed is higher than in high income populations and the effects of alcohol abuse are most severe in poor populations (11).

In many societies, a person's patterns of psychoactive substance use are not only of interest to the public health system but are also a source of social evaluation in terms of honour or stigma in daily life. The assessments associated with a specific pattern of substance use change over time and between cultures depending on the circumstance and the user (12).

There are different types of stigma: public stigma, self-stigma, structural stigma, and double or multiple stigma. Public stigma which is also known as enacted stigma includes the stereotypes, prejudice and discrimination that's targeted towards a certain stigmatized group by the majority of the society. Self-stigma occurs when people within a stigmatized group internalize and incorporate the public stereotypes into their self-concept or sense of self. Structural stigma results when governmental policies or private institutions limit the opportunities of stigmatized groups. Additionally, people with multiple socially disadvantaged identities may face double or multiple stigma (13). Other researches have also described a perceived stigma which refers to the belief of stigmatized group's members about the prevailing stigmatizing attitudes and behaviors in the society (14).

AUDs are one of the most highly stigmatized of the psychiatric conditions (15). On a World Health Organization (WHO) survey, alcohol addiction was the fourth most stigmatised condition when compared to other conditions like substance unrelated mental illnesses, HIV positive status, physical disability and having a criminal record (16).

Stigma has several effects on individuals with AUDs. After someone has been labelled, other people might continue to reject the labelled individual and stigma may also cause harm through internalized expectations of rejection on the part of those who are stigmatized. Consequently, rejection experiences or expectations may lead people to adopt coping

strategies like withdrawal or secrecy, which can result in isolation and other harmful outcomes (17).

There are a few studies in Ethiopia on the stigma among people with AUDs. One study reported the prevalence of internalized stigma among people with AUD to be 70% (18). Yet, despite its increasing prevalence and high disease burden, there is a dearth of evidence about the perceptions and experiences of people with AUDs, especially in healthcare facilities. Broader areas of stigma and its implication on help seeking and treatment needs an exploration.

Thus, this study aimed to explore stigma among people with AUD seeking help at health facilities and to give an insight into the stigma related to healthcare system.

## **1.2 STATEMENT OF THE PROBLEM**

A systematic review of population studies on the public stigma of AUD published from the year 2010 to 2020 showed that stigmatizing attitudes and actions toward people with AUD were widespread in society. Furthermore, people with AUD consistently had a higher desire for social isolation than the general population (19).

Despite the advancement in educating health care workers and the general public about the genetic and neurobiological factors associated with SUDs, stigma has persisted being one of the reasons for limiting the use of treatment services. People with AUD with high perceived stigma are half as likely to seek treatment as those with low perceived stigma (20).

Stigma might also hamper the recovery of people with AUD by diminishing their self-esteem, hope for recovery, negatively affecting social relationships, and worsening their pattern of alcohol use. It is also indicated that stigma increases avoidant coping, suicide risk, reduces treatment adherence and vocational functioning. Stigmatizing terms like “addict” and “alcoholic” in professional literature cause a wider treatment gap for SUDs than other psychiatric conditions (20).

People with AUD have a high chance of being hospitalized due to conditions resulting from the complications of alcohol or other health related needs (21). Alcohol was the major substance for admission (93%) to a substance-related treatment centre according to the study done in Zewditu Memorial Hospital (ZMH), Addis Ababa, Ethiopia (22). This creates many opportunities to interact with the healthcare system and healthcare professionals (21), but the

perceptions and relationships among the healthcare providers and people with AUDs seeking treatment has not been explored.

A few existing previous studies done in Ethiopia focused on the magnitude of stigma among people with AUD, but there are no studies that give a deeper insight how these group of people perceive and experience stigma in the public as well as in the healthcare system. In addition to exploring the stigma among those with AUD, this study also aimed to explore how it has impacted their lives and help seeking behaviour and to also understand how they cope with the stigma.

### **1.3 RATIONALE OF THE STUDY**

This study can help to understand the subjective experiences of different types of stigma among people with AUD including the stigma associated with the healthcare system and the impact it has in their lives. This is fundamental to create more awareness into the problem and help to develop interventions to reduce stigma.

One of the most frequent social obstacles in relation to accessing addiction treatment, which has been widely highlighted in research, is stigma. Numerous studies have observed that those who suffer from substance abuse tend to be hesitant to seek out treatment due to fear of being stigmatized (23). Thus, addressing the stigma in health facilities will increase help seeking behaviour, narrow treatment gap, and improve quality of care. By identifying ways to reduce stigma, we can reduce the negative consequences associated with it and improve treatment outcomes.

## **2. LITERATURE REVIEW**

### **2.1 THEORETICAL FRAMEWORK OF STIGMA**

Historically, stigma comes from the Greek word *stigmata*, which refers to “a mark of shame or discredit” (24). Ever since modern psychiatry began two centuries ago, the term stigma has been studied and applied to various situations, becoming a common expression in everyday language. Stigma research is derived from social sciences which examines a variety of social factors that can affect the onset and progression of mental disorders (13).

Link and Phelan’s conceptualization of stigma states that, stigma exists when there is a convergence of interrelated elements like, labelling, stereotyping, separation, status loss and discrimination. In the first part, individuals identify and label human differences. In the

second, prevailing cultural beliefs associate labelled individuals with undesirable traits—with negative stereotypes. In the third part, labelled individuals are grouped into distinct categories to achieve some level of "us" versus "them" separation. Then, those who are labelled suffer from status loss and discrimination, which have unfavourable effects. Finally, stigmatization is entirely dependent on having access to the social, economic, and political power necessary to recognize differences, create stereotypes, group people with labels into distinct categories, and fully implement rejection, exclusion, and discrimination (25).

There are different theories about the construct of stigma including social identity, self-stigma, structural stigma, and social cognitive theories (24). Social identity theory looks into how people use different categories to label someone who isn't like them. Goffman, who first wrote the concept of social identity, discussed how people with mental disorders form a different social identity when they become looked down on by society and become outcasts. This is because mental disorders have been viewed as a sign of bad character for a long time. Goffman came up with the term 'spoiled collective identity' to talk about people who were stigmatized and seen as totally different from everyone else. People with mental disorders are usually judged by their behaviour, though this does not reflect their whole identity. With a "spoiled collective identity" a person who's been stigmatized is seen as inferior and discounted (24).

Self-stigma is the second theory of stigma. It is related to the way that people evaluate themselves internally. According to self-stigma theory, although messages from social norms may have contributed to this judgment, in the end, the person is the one who creates the judgment. People with self-stigma believe that they don't fit in or aren't good enough to live up to the standards others place on them, which lowers their self-esteem. In contrast to the self-stigma theory, structural stigma theory bears resemblance to Goffman's concept of a "spoiled collective identity", because it's an external judgement of a person that is based on social expectations and norms. This theory takes a closer look at how stigma works in a culture and how it can operate like a system. It also looks at the tangible obstacles that those with mental illness can face. Mental illnesses can lead to a denial of certain rights and privileges that people without such health issues may take for granted (24).

Another theoretical framework of stigma that's most commonly used to explain the stigma process is the social-cognitive model of stigma. According to this model, stigma generally consists of three social-cognitive structures which are stereotypes, prejudice and

discrimination. Stereotypes are the attitudes or opinions of the public and the common stereotypes of mental illness include dangerousness, incompetence and permanence. Prejudice is the cognitive and emotional reaction associated with agreeing to stereotypes. And discrimination is defined as a behavioral response or action that results from stereotypes and prejudice. This behavior can take the form of avoidance, withdrawal, segregation and coercion causing a negative impact on the access to employment, housing, school, health care and also limiting opportunities for stigmatized groups to be involved in the community (13).

Thornicroft's framework of stigma also suggests that stigma is made up of three components: problems of knowledge (ignorance), problems of attitude (prejudice) and problems of behaviour (discrimination). Problem of Knowledge (ignorance) or the propensity for people to misunderstand those with alcohol use problems, is probably brought on by a lack of access to reliable information and helpful resources. This may include misconceptions that people with AUDs are "weak," "lazy," or "not trying hard enough." Problem of Attitudes (Prejudice) implies the negative emotional reactions that may go along with the thoughts that people may have about those who have AUDs. Fear of violence, anxiety, and general unease are a few examples of these emotional reactions. Contextual factors like negative media portrayals or the government's inadequate prioritization of AUDs as a health priority can influence stigmatizing attitudes. Problems of behaviour (discrimination) consists of those behaviours that individuals may exhibit toward people with mental illness or AUD, regardless of conscious attitudes, knowledge, or beliefs (26).

According to Room, there are three moralizations and stigmatizations associated with alcohol use. The first is the stigmatization of public intoxication which is seen as morally unacceptable in most contexts. A person who is under the influence of alcohol is seen as unpredictable and disinhibited. The second area of moralization and stigmatization is related to addiction. Modern cultural understandings of the nature of alcoholism and addiction have always placed a loss of control over the substance use as well as over one's life as the key component, leading to frequent descriptions of these disorders as "diseases of the will". The third area is in terms of substance use per se, which is not universally applied. The general stigmatization for alcohol applies only in certain cultural contexts ,for example for religious people, a pregnant woman or an on-duty bus driver, where any use tends to be stigmatized regardless of intoxication (12).

In Ethiopia, these frameworks might be different or similar. Exploratory studies have not been implemented to understand the stigma that exists among people with AUDs. The findings of this study will serve as a foundational step towards a comprehensive understanding of AUD stigma and it will also help to develop locally tailored frameworks about the stigma associated with AUD, which will be tested using quantitative studies.

## **2.2 PUBLIC PERCEPTIONS AND ATTITUDES TOWARDS AUD**

On a systematic review conducted on the public attitudes towards alcohol dependence, 27 studies from western countries published up to 2008 were included, and the results of the review showed that while many recognized alcoholism as an illness, there was a strong tendency to blame those with AUD for their condition. Psychosocial reasons for AUD prevailed over biological explanations. Individuals with AUD were often perceived as unpredictable and dangerous. The inclination for social distancing is more pronounced towards those with AUD compared to individuals diagnosed with conditions like depression or schizophrenia, with only those addicted to illicit drugs facing more significant rejection (27).

A scoping review that was published on 2021 examined the state of empirical literature evaluating the relationships between religious and spiritual beliefs and attitudes toward addiction and addiction treatment. A total of 36 studies from USA, United Kingdom, Australia, Israel, Brazil, Canada, Kuwait, Russia, Norway, and India were included and the results showed that religious leaders were viewed as providers of treatment or first-line support for addiction in many communities (28).

A nationwide survey conducted in US was published on 2011 and it aimed to characterize public conceptions of mental illness and the results found that stressful circumstances were the most commonly endorsed cause of alcohol dependence and the second most commonly endorsed cause was the way the person was raised (29).

A cross sectional study conducted in Brazil to describe the public perception of alcohol dependence in 2002 found that most of the population didn't believe that alcohol dependence was a mental illness. Alcohol dependence was seen as a psychosocial and moral problem placing responsibility on the afflicted individual. In addition, individuals with alcohol dependence were perceived as violent and capable of arising negative reactions among

members of the community, such as negative ideas and reactions of avoidance and distancing (30).

### **2.3 PREVALENCE AND ASSOCIATED FACTORS OF STIGMA**

A review of 20 studies that was done in the US, UK and other European countries and published before August 2016 was conducted to identify information on public stigma towards individuals with SUDs. The review found that those with SUDs generally received more stigmatizing responses than other psychiatric disorders and these people were often seen as responsible for having the disorder (31).

Another systematic review of 26 articles published before November 2011, and which were mostly done in the US, was conducted to investigate the stigma experienced by individuals with SUDs. One of the studies reported that lower level of education was associated with higher perceived stigma towards people who use alcohol. A positive relationship between the severity of alcohol use and self-stigma was also reported by one of the articles. Another study that looked into the relationship between stigma and whether a person is an active user of alcohol or in recovery, reported that public stigma was higher for those actively using alcohol than those who were in recovery. Two studies assessed the relationship between stigma and the type of substance used, and one of the studies found that individuals with drug dependence were viewed as being more dangerous to others, unpredictable, difficult to talk to, and taking blame for their action compared to those with depression, schizophrenia, alcohol dependence and other mental illnesses. Their findings implied that, while being stigmatized more than other participant subgroups, those with alcohol dependence experienced less stigma than those with drug dependence. The other study assessed the level of public stigma associated with drug, alcohol, or tobacco dependence and results showed that stigmatization of study participants was highest for those who used cocaine or alcohol, and lowest for those who used tobacco (32).

A systematic review of 17 representative population-based studies from Europe, North America, New Zealand, Brazil and Ethiopia published before July 2010 was done to compare the stigma of alcohol dependence with other mental disorders. The findings showed that alcohol-dependent individuals were less frequently classified as mentally ill than those with other, substance-unrelated mental disorders. They were also held much more accountable for their condition, experienced more social rejection and negative emotions, and were

particularly vulnerable to structural discrimination. While dangerousness was viewed similarly in alcoholism and schizophrenia, however the interpretations of why this behaviour occurs varied. Schizophrenia was generally looked as an illness with limited personal accountability of those affected, while alcoholism was usually seen as a voluntary situation, and was not considered as an illness (33).

Another systematic review was conducted to update the above review, and it included 24 studies from Europe, US, Australia, Brazil, Singapore, South Korea and Germany that were published between October 2010 and December 2020. The level of stigmatization experienced by those with AUD was shown to be high and it remained constant over the past decades and the findings were similar with the previous systematic review (19).

To assess health professionals' attitudes towards patients with SUDs and its consequences on healthcare delivery in Western countries, a systematic review of 28 studies that were published between 2000 and 2011 was done and it concluded that health professionals had negative attitude towards these group of patients which affects the sense of empowerment and treatment outcomes of the patients. The majority of the research suggested that health professionals working with these patients had lowered regard, less motivation and feelings of dissatisfaction. Some explanation was health workers' perceptions that these patients are possibly violent, manipulative, or unmotivated, which may lead to sentiments of frustration, resentment, and helplessness among the professionals (34).

A scoping review of literature reviews published on 2023 assessed the stigmatization of people with addiction by health professionals and the results showed that healthcare professionals had unfavourable and negative attitudes/beliefs regarding SUD. Training in addiction and clinical experience with individuals dealing with SUD was associated with a less negative attitude. Healthcare professionals who held negative beliefs, lacked time, or lacked support showed reduced engagement in addiction care (35).

### **2.3.1 HIGH-INCOME COUNTRIES (HICs)**

In the southern states of USA, a study was conducted in 2004 to determine the prevalence of public stigma perceived by at risk drinkers among 733 participants and a large proportion of perceived stigma was identified regarding the public's opinion of people with problematic drinking habits (86.1%), seeking help from primary care (48.9%), visiting specialists (56.3%), and patients being judged by their primary care providers (35.7%) (36).

On another study done in 2006 to investigate the stigma in individuals receiving treatment for substance abuse at residential and outpatient treatment facilities in Nevada, USA, 197 patients were included, and the result reported a high level of perceived, enacted and self-stigma. Those with multiple previous episodes of treatment had a higher frequency of stigma associated rejection. Overall, on the scale measuring perceived stigma, about 60% of participants scored higher than the midpoint. Internalized stigma was more related to psychological well-being and quality of life than perceived stigma and rejection suggesting that interventions targeting self-stigma might be more important in these group of patients (14).

On a community-based qualitative research conducted in 2018 in USA to explore the public stigma of SUD from the perspectives of four groups (current users, former users, family members, and service providers), twelve focus groups revealed 66 stigma themes. Stereotype themes consisted of “dangerous, self-destructive, and no job potential” while themes for prejudice involved pity, fear, confusion, and indifference. And discrimination themes generally included avoidance, being suspicious, and drug testing. While there were some similarities between the stigmas of SUD and mental illness, there were also significant differences. Among these distinctions were discrimination based on drug testing, subtle prejudice like curiosity, and stereotypes of criminal behaviour towards people with SUDs (37).

A study was conducted in South Korea in 2013 to investigate the stigma-related perceptions and experiences of alcohol-dependent patients and their family members where 106 patients and 60 family members participated. According to this study, the biggest reason for not seeking treatment was the fear of being confined in a hospital room, followed by the stigma of getting help from a mental health facility and the fear of being treated like an addict. Family members also had negative views and judgment about treatment for mental illness and they reported higher levels of perceived stigma when compared to the patients. Those family members who gave less emphasis on the importance of the social role of drinking felt more stigmatized. Patients, on the other hand, had different experiences. Female patients and those who put more importance on the social role of drinking felt more stigma and younger age was also a marginally significant predictor (38).

A qualitative study that was conducted in 2014 in England explored how those who self-identify as in recovery from alcohol problems view themselves and their difficulties with

alcohol and how they make sense of others' responses to their addiction. It involved 6 participants and the findings showed that respondents were still judged and blamed despite years of sobriety (39).

### **2.3.2 LOW- AND MIDDLE- INCOME COUNTRIES (LMICs)**

According to a study done in South Africa in 2012 to examine the negative attributions of the general population towards people with SUDs, 868 participants were involved and the results indicated high levels of public stigma for all classes of substances, and the public viewed people who used substances in a more negative manner than those with other types of mental disorders similar to the studies done in HICs. It was observed that cannabis users were perceived as less dangerous than those who used alcohol, which was contrary to the outcomes of studies conducted in HICs where the use of "harder" drugs such as methamphetamine or heroin were viewed more negatively than the use of "softer" drugs like alcohol and cannabis. A possible explanation stated was the high prevalence of AUD in South Africa and the widespread burden of alcohol-related issues like injuries, violence, and crime. Attitudes toward women who used alcohol were different than what people had towards men. Women who used alcohol elicited positive responses like 'offering to help' compared to men, which elicited responses of coercion into treatment. This finding is different from past studies done in HICs that found high stigma towards women with AUD. Though it was not clear why this was, a possible explanation stated was the public's view that women's drinking was less connected to crime and violence when compared to men (16).

A qualitative study published on 2016 aimed to investigate the stigma and discrimination related to addiction in treatment centres in Mexico City, and 35 in-depth interviews of drug users, family members, and providers were conducted. The findings of the study found that alcohol users internalized the negative stereotypes associated with addiction (40).

On a cross sectional study conducted in a tertiary care centre in India in 2017, which aimed to assess internalized stigma among individuals with SUDs and its relationship with the quality of life, 201 patients with a diagnosis of at least opioid or alcohol use disorder were included. The results showed that 3.5% of the sample had mild stigma, 30.8% had moderate stigma, and 65.7% had severe stigma. In addition, the more internalized stigma people had, the worse their quality of life was. Generally, over 95 % of the study population reported experiencing a moderate to severe level of stigma, with none of the respondents indicating that they had not experienced at least a minimal amount of stigma (41).

Another qualitative study that was conducted in India to explore the stigma towards dependent drinking included 11 participants with alcohol dependence in the study and the findings showed that stigma functioned as a barrier to a proper course of treatment and care. Stigma towards dependent drinking in the forms of ignorance, prejudice and discrimination was also prevalent within homes, workplaces and health systems (42).

A community and facility based cross sectional study was done in a rural district in Uganda in 2017 to estimate the prevalence of AUD among men and the results revealed that men who had AUD had internalized stigma which is consistent with findings from studies in HICs. Those with AUD didn't believe that they could make big decisions on their own, so they relied on others to do it for them. Drinking usually happened in groups, but when it came to the bad effects of drinking, like hangovers, people usually had to go through it alone and self-reflect, which made them feel lonely and like they were not good enough. Additionally, the majority of men with problematic patterns of alcohol use never sought professional treatment because they believed that AUD could not be treated (43).

### **2.3.3 ETHIOPIA**

An evidence synthesis of 37 records found in Ethiopia was published in 2022 to synthesize evidence on mental health stigma and discrimination, and the findings showed that people with mental illnesses dealt with many kinds of stigma; public, structural, courtesy and self-stigma (44).

On a cross-sectional study conducted at Jimma University Specialized Hospital in 2012 to assess the magnitude and associated factors of perceived stigma among adults with mental illness in Ethiopia, a total of 384 participants were involved and the prevalence of low perceived stigma was found to be 49.2% and high perceived stigma 50.8%. Those with no substance use history were 0.6 times less likely to develop perceived stigma when compared to patients who had history of substance use (45).

Another facility-based cross-sectional study that included 365 participants was done in 2021 at the University of Gondar Comprehensive Specialized Hospital, Northwest, Ethiopia on the Internalized stigma and associated factors among people with mental illness. This study found the prevalence of high internalized stigma to be 27.9% and factors associated with higher internalized stigma were life time substance use, male gender, occupation, specifically government employee, low self-esteem, and history of hospitalization (46).

According to a community based cross sectional survey done to investigate the magnitude and associated factors of perceived stigma towards problematic substance use in Bahir Dar, Northwest Ethiopia in 2021, 540 participants who screened positive for problematic substance use (alcohol, hashish, tobacco and khat) by using the Cut down, Annoyed, Guilty, Eye opener- Adapted to Include Drugs (CAGE-AID) questionnaire were then interviewed with Perceived Stigma of Substance Abuse Scale (PSAS) and the percentage of participants who reported perceived stigma above the mean value PSAS was 63.9 %. Mean values showed that 36.1% had low-perceived stigma and 63.9% had a high perceived stigma score. Of the total participants who reported perceived stigma, 80.87% were khat users, and 61.7% poly-substance users. Low socioeconomic status and unemployment, a history of being estranged from family members before the age of 18, poly-substance abuse, and awareness of the economic impact of substance use were all variables that were positively associated with perceived stigma. Generally, about three in five people with problematic substance use had perceived stigma. Poly-substance abuse had a stronger association with perceived stigma than mono-substance abuse (47).

A community based cross-sectional survey including 1500 participants was conducted in Sodo district, South Ethiopia in 2018 to assess the treatment gap, help seeking, stigma and magnitude of AUD. The results showed that there was a high prevalence of AUD, large treatment gap, low help-seeking behaviour and 70.0% reported high internalized stigma (18).

A phenomenological study was done in Mekelle city, Northern Ethiopia in 2019 to explore the lived experiences of addicted youths on substance abuse, and the study included 15 male youths who were attending a rehabilitation service. The youths reported experiencing stigma from the community due to engaging in socially unaccepted behaviours like chewing khat, smoking, and excessive drinking. Participants in the study frequently mentioned being socially isolated and family members usually labelled substance abusers as lazy people. As a result, they were not involved in family decision-making processes or the sharing of responsibilities. According to the respondents, the social stigma affects not only them but also their family members' ability to interact socially. In most societies, families were held accountable for the substance use of their children and blamed for not raising them properly. Even though the majority of respondents spoke about experiencing stigma from their community, a few of them mentioned stigmatizing themselves because of their perceived low self-esteem and felt disregarded around other people as a result of their substance abuse. As a

result, they preferred to maintain a distance from their families and restrict their relationships to those who also used substances (48).

## **2.4 THE OVERALL IMPACT OF STIGMA AMONG PEOPLE WITH AUD**

Despite the fact that AUD is associated with serious health issues, including diseases and injury, there is a large gap between the number of people affected and the number of people receiving treatment when compared to other mental health disorders. A survey conducted in 26 countries indicates that only 7.0% of those with SUDs get the necessary treatment (15). It's estimated that around 78% of people with AUDs globally do not get treatment, and in LMICs the number increases up to 95% (18).

On an epidemiologic survey that was done in the US in 2004-2005 to test whether perceived stigmatization of alcohol was associated with a lower likelihood of receiving alcohol related services, it was found that those individuals with high perceived stigma in the society were less likely to use alcohol treatment services (49).

Another qualitative study done in Australia to better understand the experiences of patients receiving treatment for AUDs involved a total of 34 patients receiving treatment and the study showed how crucial it was for patients to have good and reliable connections with staff. It also found that the quality of the relationships with staff affected patients' perception of stigmatization (50).

A review was conducted to give insights into the effects of social stigma experienced by individuals with AUD and other SUDs in Turkey and it included articles published between 2004 and 2021. The findings of this review suggested that there was a negative perception in the society about these individuals and that they may be excluded from interactions with those who are seen as 'normal' and this stigma could lead to the formation of an 'addicted identity' (51).

According to a qualitative study conducted to explore perspectives and experiences of service users and providers on a brief intervention for AUDs in Ethiopian primary health care, stigma was found to be one barrier for seeking interventions from healthcare in addition to other reasons like believing that they could solve their issue on their own, that they didn't have a serious issue or that AUDs were untreatable (52).

Excessive stereotyping can lead to strong negative emotions, similar to those seen towards those with SUDs, such as pity, rage, fear, and a desire to avoid social interaction. This kind of extreme stereotyping can result in discrimination, which is evidenced by the willingness of participants to make individuals with SUDs undertake treatment and exclude them from responsible positions in society. Those with SUDs are likely to be viewed as unpredictable and dangerous, incapable of making decisions about their own care or finances, and blamed for their condition (31).

Perceived stigma among people with AUD might increase the risk of internalizing psychiatric comorbidity such as mood and anxiety disorders (53). These negative effects are found to be mediated by internalized shame and internalized stigma. People who experience their close friends and family as supportive rather than stigmatizing report less internalization of public stigma, which in turn has a good impact on their health (54).

A review of literature published on 2020 focused on structural stigma within healthcare settings, examining its impact on individuals dealing with mental health and substance use problems, its manifestation within the healthcare system and strategies aimed at minimizing its effects. The literature regarding structural stigma in healthcare emphasized two primary concerns: access and quality. The disparity in access occurred through uneven resource allocation, inadequate treatment of health issues, withheld services, and fragmented care. Individuals facing mental health and substance use issues encountered more obstacles in accessing healthcare compared to the broader population. This review found three major areas of inequitable access for people with lived experience which included the under-resourcing of mental health and substance use services, the ways people were deprioritized, undertreated, and otherwise denied access to care and the systemic separation of mental health, substance use, and physical health services (55).

There has been a continuous debate whether stigmatizing alcoholism is an effective tool for improving public health. However, drinking per se is generally not stigmatized. On the contrary, it is usually associated with acceptance into a social group and can even be seen as a symbol of power and status. It is only when someone's drinking becomes problematic that they may start to experience stigma, which can be too late to prevent addiction. Additionally, self-stigma among people with alcohol addiction has been linked to lower drinking-refusal self-efficacy, which may make sobriety more difficult. Additionally, public stigma may also

lead to secrecy and prevent people from seeking help, thus prolonging and exacerbating the issue (33).

Stigma appears to be a reaction to unhealthy drinking patterns without actually altering this behaviour rather than a way of discouraging people from harmful alcohol consumption (56).

People with substance use problems are more likely to seek coping mechanisms for the threat of rejection as a result of both expectations and actual experiences of rejection. One mechanism is, patients may choose to keep their treatment history a secret from employers, relatives, or potential partners. And another way of coping to avoid the possibility of rejection is that patients might limit interaction or withdraw from social environment (17).

Individuals with AUD who have high resilience experience lower probabilities of relapse, and as their resilience increases, their tendency toward deeper self-disclosure is intensified during the recovery phase indicating that it's essential to create an environment conducive to enhancing the capacity of AUD patients to recover (57).

Despite the high disease burden of AUD and the recent increment of hazardous alcohol use in Ethiopia, the stigma towards people with AUD and its impacts especially associated with help seeking has not been well explored.

### **3. RESEARCH QUESTIONS**

- What are the perceptions and experiences of different types of stigma among people with AUD who are being treated at AMSH and ZMH?
- What are the impacts of stigma in this group of people?
- How do they cope with the stigma?

### **4. OBJECTIVES**

#### **4.1 GENERAL OBJECTIVE**

- To explore stigma among individuals seeking help for AUD at two governmental hospitals AMSH and ZMH, Addis Ababa, Ethiopia.

## **4.2 SPECIFIC OBJECTIVES**

- To explore the subjective experiences and perceptions of stigma among help seeking people with AUD.
- To explore the impact of stigma among help seeking people with AUD.
- To explore the experiences of stigma of people with AUD while seeking/receiving treatment at health facilities.
- To explore how people with AUD cope with the stigma.

## **5. RESEARCH METHOD**

### **5.1 STUDY SETTING AND STUDY PERIOD**

The study was conducted at AMSH and ZMH in Addis Ababa, Ethiopia. There are currently three governmental hospitals in Addis Ababa that provide both inpatient and outpatient treatment services for substance use and related disorders. Two of the three hospitals were selected to find people with a confirmed diagnosis of AUD and with an experience of help seeking so that the stigma related to healthcare could be well explored. The PI was also familiar with the study settings which facilitated interaction and rapport with the participants.

AMSH was established in 1930 E.C, and it is the only specialized mental hospital in Ethiopia. It is located in the western part of Addis Ababa in Addis Ketema Sub-city. AMSH gives both inpatient and outpatient treatment for people with mental illness and other medical illness. The Hospital has 259 beds including 11 private wing beds and 23 emergency beds and it also has 13 outpatient departments (OPDs). An average of 10,320 patients get service per month. The substance-related treatment at AMSH includes both an inpatient ward with 14 beds and an outpatient service.

ZMH is located in Kirkos sub-city, Addis Ababa, Ethiopia. The hospital was built by Seventh-day Adventist church but was nationalized in 1976 E.C. It gives both inpatient and outpatient services in different specialties including psychiatry. It has a total of 128 beds. The substance-related disorders treatment center has a total of 4 inpatient beds and an outpatient service. Detoxification, individual psychotherapy, and group therapy services are provided in the center.

Data was collected from Aug 4-Dec 4, 2023.

## **5.2 STUDY DESIGN**

A phenomenological type of qualitative study was conducted to explore and give insight into stigma among people with AUD receiving care at the substance treatment ward and outpatient service at Amanuel Mental Specialized Hospital (AMSH) and Zewditu Memorial Hospital (ZMH).

A phenomenological qualitative design describes what all participants in a study have in common as they experience a phenomenon. While using this type of qualitative design, researchers first identify a phenomenon (an ‘object’ of human experience) and data will be collected by exploring and gathering information from the perspectives of those who have experienced the phenomenon. The objective of this approach is to describe the essence of a phenomenon, both in terms of ‘what’ was experienced and ‘how’ it was experienced (58). Thus, the researcher selected a phenomenological type of qualitative design to explore the subjective experiences and perceptions of stigma among those with AUD.

## **5.3 SOURCE AND STUDY POPULATION**

- The source population of the study were all help seeking people with AUD at AMSH and ZMH and the study population were people with AUD who were receiving care at the substance treatment ward/ outpatient service at AMSH and ZMH during the data collection period.

## **5.4 INCLUSION CRITERIA**

- Those with a diagnosis of AUD receiving care at the substance treatment ward/ outpatient service at AMSH and ZMH.
- Those who were willing to participate.
- Those who were able to participate in an interview conducted using Amharic language.
- Those who were 18 years old and above.

## **5.5 EXCLUSION CRITERIA**

- Those with a clinical diagnosis of any comorbid substance-unrelated mental illness.
- Those with an additional diagnosis of alcohol intoxication or whose documented Clinical Institute Withdrawal Assessment of Alcohol Revised scale (CIWA-AR) score was above 7 (moderate to severe withdrawal) during the time of the interview.

## **5.6 SAMPLING TECHNIQUE AND SAMPLE SIZE**

A purposive type of non-probability sampling technique was used in this study. Purposive sampling (also known as judgmental or subjective sampling) relies on the researcher's judgement in selecting the participants to be studied. The researcher decides which participants will be included in the sample based on a range of factors, such as expertise in the topic of the study, or capacity and willingness to participate in the research. The main objective of purposive sampling is to focus on particular characteristics of a population that are of interest, which will best enable us to answer our research questions (59).

Sampling continued until theoretical saturation was achieved and fifteen participants were interviewed. Twelve of the participants were receiving care at ZMH, and three of them were receiving care at AMSH. Additional participants from AMSH could not be included in the study as those individuals seeking care for AUD during the data collection period also had comorbid mental illnesses.

A maximum variation technique was employed as much as possible to include participants with different characteristics in regards to sex, educational status, and different phases of recovery process. Among the participants, 14 were males and only 1 participant was a female because there weren't more females available at the substance treatment ward and outpatient service both at AMSH and ZMH during the study period.

Individuals with a diagnosis of AUD receiving care at the substance treatment ward and outpatient service at AMSH and ZMH who fulfilled the eligibility criteria were first identified by psychiatry residents and nurses working at these sites. Those who fulfilled the criteria were then approached by the primary investigator (PI) and they were given a brief explanation about the study and they were invited to participate. For those who were willing to participate, a detailed information about the study was provided in the form of an information sheet, and they were required to sign an informed consent form after they agreed to participate and have the interview through an audio recording.

## **5.7 OPERATIONAL DEFINITION**

- **Alcohol**- all forms of beverages (both locally produced and commercially imported) that are perceived as an “alcoholic drink” by the consumers.
- **AUD**- a diagnosis made by any health professional working at the substance-related treatment ward or outpatient service based on the DSM-5-TR diagnostic criteria for an AUD.

- **Healthcare professional-** an individual who provides healthcare services to patients.
- **In early remission-** a specifier that indicates that none of the DSM-5-TR diagnostic criteria for AUD have been met for at least 3 months but for less than 12 months, with the exception of craving.
- **In sustained remission-** a specifier that indicates that none of the DSM-5-TR diagnostic criteria for AUD have been met for a period of 12 months or longer, with the exception of craving.

## **5.8 DATA COLLECTION METHODS AND PROCEDURE**

Data was collected by the PI by using an in-depth interview. The interviews were held in a private outpatient clinic at AMSH and ZMH. Initially, the socio-demographic data of the participants was collected by using a structured form. Then a semi structured face-to-face interview was carried out by using a topic guide to help direct the process. The topic guide questions were translated in Amharic and all interviews were carried out in Amharic language. Nobody opted out of audio record. The questions were asked in a way that was easy to understand and leading questions were avoided as much as possible. In addition, the PI also made note of nonverbal communications of participants. Participants were informed that quotations might be used from the interviews in the final report of the study while still maintaining anonymity. The interviews lasted between 30- 90 minutes.

## **5.9 DATA ANALYSIS**

The audio recorded data was initially transcribed in Amharic and then translated to English for analysis. Data collection and analysis were done concurrently. The data collected was analyzed by using thematic analysis. Open Code software 4.02 was used for the coding of data generated from the text information. The identified codes were categorized based on their similarities and subthemes and themes emerged. The emerged themes were then compared with the original data set to make sure that the themes accurately represented the data.

Thematic analysis is a method of qualitative data analysis that involves looking through a data to identify, analyse and report recurring patterns (60). The purpose of thematic analysis is to comprehend the patterns of meanings emerging from data on experiences pertinent to the research question (61).

This qualitative study employed a combined approach that integrated both inductive and deductive strategies. The PI approached the data with an inductive lens, allowing themes to

emerge originally from the raw data, but as the PI did a review of existing theories and frameworks of AUD stigma, it was not possible to fully employ an inductive approach of data analysis. Some subthemes and themes were informed from these previous theories and frameworks of AUD stigma.

## **5.10 TRUSTWORTHINESS**

A variety of methods were taken into consideration to achieve trustworthiness of findings, with a focus on the study's credibility, transferability, dependability and confirmability.

**Credibility-** Peer reviewing was done during data analysis to confirm study findings by other peers by presenting the study findings to them and receiving comments to improve its quality.

**Transferability-** A detailed description of the research context, participants, and methods is provided so that others can assess whether the findings of this study can be applicable to their own contexts or populations.

**Dependability-** An in-depth methodological description of the study is provided by the researcher to allow the study to be repeated.

**Confirmability-** The PI had regular discussions with thesis Supervisors to critically examine and reflect on personal biases and assumptions and how they might influence the interpretation of data.

## **5.11 ETHICAL CONSIDERATIONS**

Ethical approval for the study was obtained from the Department of Psychiatry, College of Health Sciences, Addis Ababa University, AMSH and ZMH. The purpose of the study was explained to all participants. Prior to the interview, written informed consent and permission for audio recording was obtained from the participants. They were informed about the objectives, procedure, benefits and potential risks of participating in the study and the right to withdraw from the interview at any time. The participants were also informed that their participation in the study will not have an impact on the care they receive from the hospitals. To ensure confidentiality, interviews were conducted in a private setting and the audio-recordings were deleted after transferring the data to a personal computer. The data was stored in a secure location with access limited only to the researcher. A code was also assigned to each of the participants and their personal information was not included during data collection, analysis and reporting.

Participants were paid 150 ETB reimbursement or compensation for their transportation during outpatient follow up interview and for their time during an inpatient site interview respectively.

## 6. FINDINGS

Fifteen participants among those who were seeking treatment for AUD at the substance treatment ward and outpatient service at AMSH and ZMH were interviewed. The average age of the participants was 42 with a range of 27-62 years. Fourteen of the participants were males, and one participant was a female. All of the them were from Addis Ababa, Ethiopia. Two of the participants were married, five were divorced, one was separated, and the remaining seven participants were single.

The participants had AUD treatment and follow up from a minimum of 1 month to 11 years duration, and four of the participants were seeking treatment for the first time. Eight of the participants had no other comorbid SUD, while three had comorbid Tobacco Use Disorder, another three had comorbid Khat and Tobacco Use Disorder, and one participant had comorbid Khat Use Disorder.

The participants were in different stages of recovery. Six of the participants were in early remission and one participant was in sustained remission, while the remaining eight participants were not in remission during the time of the interview.

Table 1. Summary of characteristics of participants

<b>Characteristics of participants</b>	<b>Number</b>
<b>Age (years)</b>	
25-35	3
36-45	9
46-55	2
56-65	1
<b>Sex</b>	
Male	14
Female	1
<b>Residence</b>	

Urban	15
Rural	0
<b>Marital status</b>	
Single	7
Married	2
Others (divorced, separated)	6
<b>Educational level</b>	
Primary	5
Secondary	6
College and above	4
<b>Employment status</b>	
Unemployed	3
Employed	10
Self-employed	2
<b>Duration of follow up for AUD</b>	
< 1 year	9
1-10 years	5
>10 years	1
<b>Comorbid SUD diagnosis</b>	
Yes	7
No	8
<b>Stage of recovery</b>	
Not in remission	8
In early remission	6
In sustained remission	1

The findings of the study are organized into 5 major themes and 13 subthemes.

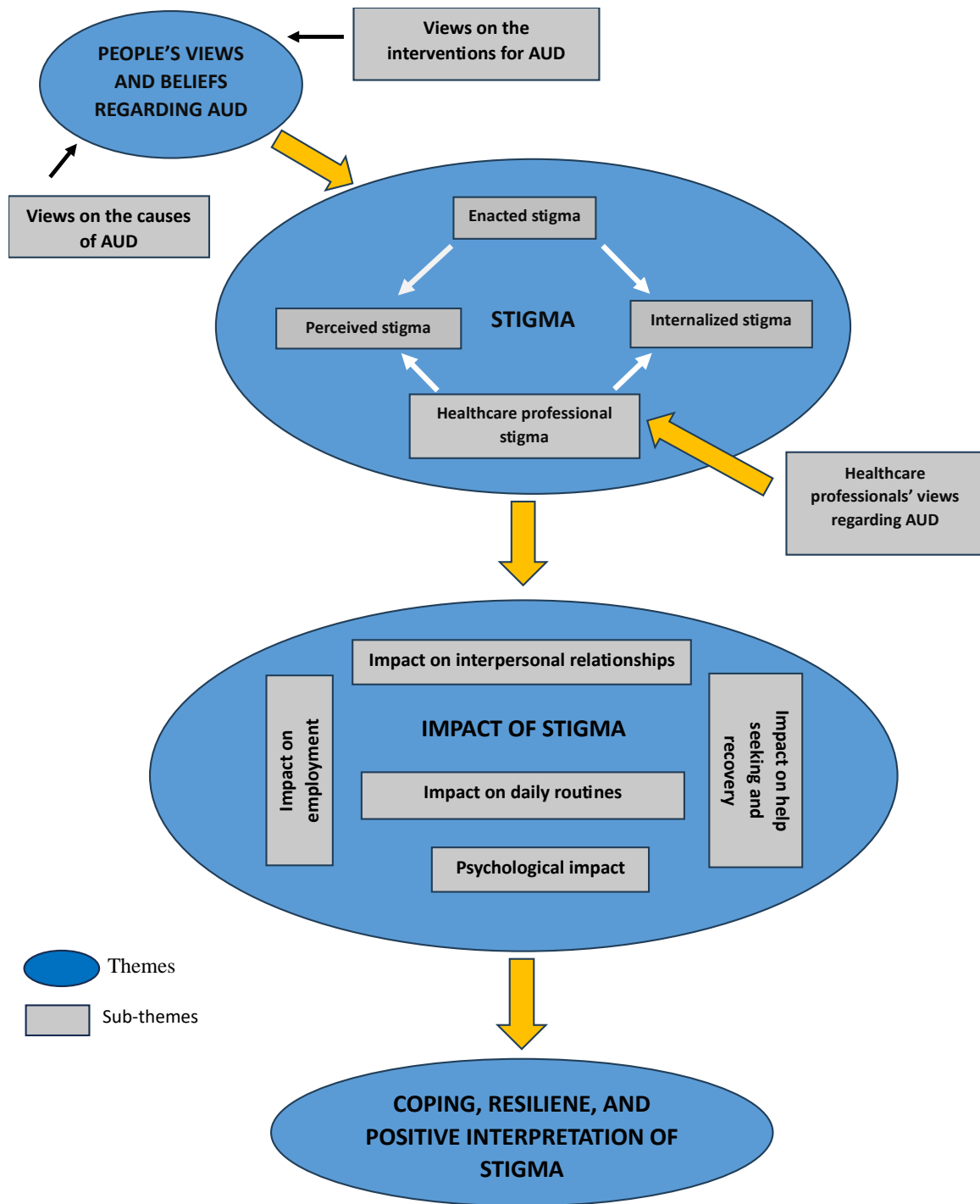


Figure 1. Conceptual model of themes and subthemes of AUD stigma.

## 6.1 OTHER PEOPLE'S VIEWS AND BELIEFS REGARDING AUD

The participants mentioned that they have encountered different views and beliefs that are endorsed by the society regarding the causes and interventions of AUD.

### 6.1.1 Views on the cause of AUD

The participants stated that they encountered various societal views about the causes of alcohol addiction. These views included being betrayed by a spouse, emotional turmoil like anger or grief, family issues, educational setbacks, spiritual factors like being possessed by an evil spirit, being cursed, and peer influence as causes for alcohol addiction.

*“Those who don't drink believe that a person with AUD is possessed by an evil spirit or a curse has been put on him.” (p09, Male, 49 years)*

Participants also mentioned hearing from others in their society that culture led people into addiction because alcohol is integrated into the culture and drinking is normalized and socially accepted, while others in the society believed that alcohol addiction was a result of being wealthy and overindulgence.

*“Some people think alcohol addiction is a result of our culture...during old times, when there was a wound on the body, the solution was to put Areke<sup>1</sup> on it...alcohol is integrated with the culture...but slowly, day by day, you find yourself addicted to it...it's easy to access it when it's part of the culture. And some people think a person drinks because he's rich and spoiled.” (p05, Male, 50 years)*

Another causal factor described by the participants from their interactions with people in the society was a family history of alcohol addiction.

*“Some people say ‘his father used to drink and now he drinks too’...people think genetics plays a role in addiction...” (p14, Male, 40 years)*

There were participants who reported being held accountable for their addiction, and they were blamed not only for their addiction but also for the consequences of their alcohol use.

*“When I was being treated for a liver disease, people were saying that I got sick because of my own fault...they said that I brought the addiction upon myself.” (p03, Male, 41 years)*

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<sup>1</sup> Areke is a traditional homemade alcoholic drink produced from a mixture of ingredients such as milled “Gesho”, finely ground and baked cereals, malt, and water called mash, followed by distillation process.

### **6.1.2 Views on the interventions for AUD**

Different societal opinions have been encountered by the participants on how to address alcohol addiction, such as religious and medical approaches. They highlighted those individuals within their social circle, including family and friends, advise them to stop drinking and seek professional help. Other participants stated that society generally downplays and undermines addiction, perceiving the journey to recovery as something easily attainable. Some also mentioned that people tell them to seek a religious healing rather than seeking help from a substance treatment centre.

*“People think recovering from an addiction is something that can be done easily...they think I can quit at any moment...they don't understand how difficult it is. When I sought treatment, my relatives and neighbours said that I was exaggerating it and that I could've stopped if I just drank holy water.” (p14, Male, 40 years)*

Participants also reported instances where they engaged in conversations with individuals who expressed their belief that no external intervention was necessary for alcohol addiction, emphasizing instead that an individual's mindset was the key factor enabling them to overcome it.

*“I wanted to stop drinking for the last 7 years but my body had already adapted to it and I had severe withdrawal symptoms whenever I tried to cut down...people say ‘If you make yourself believe, you can quit. It's all about your mindset’... but it's not that easy when your body has become fully dependent on the alcohol.” (p05, Male, 50 years)*

And others mentioned that they have been told that it was impossible to stop drinking once a person becomes addicted to alcohol.

## **6.2 STIGMA AMONG PEOPLE WITH AUD**

The participants described their perceptions of being stigmatized in the society and they also described their direct experiences of stigma as a result of their alcohol addiction. In addition to being stigmatized by the society, they also reported stigmatizing themselves and having an internalized shame because of their condition.

### 6.2.1 Perceived stigma

Participants perceived that their family, friends, colleagues and society as a whole judged them negatively because of their alcohol addiction. They reported that they believed people in the society viewed them as worthless, irresponsible, hopeless, untrustworthy, and unstable.

*“A person who is addicted to alcohol is not viewed as responsible or trustworthy in the society or at any workplace.” (p10, Male, 39 years)*

Many of the participants also expressed feeling undervalued and viewed as inferior by others. Those who were employed had a fear that their co-workers might reject and disregard their opinions because they were labelled by their alcohol use. Participants also mentioned feeling as though the society viewed them as liars and thieves because of their alcohol use. And they expressed a fear of approaching people because they might be perceived as someone who is involved in theft or dishonest actions.

*“Alcohol addiction makes you scared of approaching people...I get scared to approach people and ask them what time it is... I can't even ask people for directions because I feel like they would think that I am a thief who's trying to steal from them.” (p02, Male, 62 years)*

The stigma towards those with alcohol addiction was believed to be greater than the stigma associated with other medical conditions like HIV/AIDS.

*“I feel like a person with HIV/AIDS doesn't get as stigmatized as a person with alcohol addiction. Previously, there used to be a huge campaign against the stigma towards HIV/AIDS... but now a days, I believe that no one gets stigmatized like an alcoholic.” (p05, Male, 50 years)*

A female participant expressed her belief that society stigmatized women with alcohol addiction more when compared to men with alcohol addiction due to societal norms and gender role expectations. Additionally, she stated a perceived lack of sympathy from society towards women dealing with alcohol addiction.

*“I feel like society stigmatizes an alcoholic woman more because of our traditional norms...I once saw a lady holding a child with one hand and Areke with the other, and she was begging for money on the streets...and nobody gave her money, but if a drunk man had asked them, I'm sure they would have given him.” (p11, Female, 27 years)*

## 6.2.2 Enacted stigma

Many of the participants reported experiencing stigma and rejection in the society. They were frequently labelled by stigmatizing terms and received negative comments because of their alcohol use. They also described facing stigma in their work places and from law enforcement officers.

### 6.2.2.1 Social stigma

There were different experiences of stigma that were reported by the participants. They shared their experiences of being ignored by people in their community and being excluded from various social gatherings because of the assumption that they will end up intoxicated and disturb others or become destructive. Participants also highlighted that individuals within their communities would not help them if they became ill or injured. They claimed that people mocked them for being intoxicated when they sustained accidents instead of assisting them to get treatment.

*“Some years back, when I was crossing a road, I got into a minor car accident and the car hit my leg and I fell down. The driver and his friend were shocked and they said that they’ll take me to a hospital...but there were youngsters who knew that I drink alcohol in the area, and they said that I was probably drunk and that’s why I fell.... then the men left without taking me to a hospital.” (p02, Male, 62 years)*

Many of the participants mentioned that while in public spaces, those around them often covered their mouth and nose because of the smell of alcohol and they reported that this reaction from people is stigmatizing for them.

*“When I sit inside a church, people next to me cover their nose and mouth with their hands or a scarf so that they won’t smell the alcohol.” (p06, Male, 39 years)*

Although there were experiences of stigma described by participants, few of them expressed having positive experiences with their family, relatives, and neighbours and they stated that they haven’t faced any stigmatizing attitudes or discrimination directly.

*“Most of my relatives still care for me and they are available whenever I need help.” (p13, Male, 45 years)*

### **6.2.2.2 Verbal stigma**

Respondents frequently mentioned that they were labelled as an “alcoholic”, “drunkard”, “shots” etc. They also depicted being mocked by people and receiving judgmental comments in regards to their alcohol use.

*“They labelled me as an alcoholic in the society...they comment saying my mouth smells...they say they feel bad for the woman that I will marry...I couldn't even go to church because they'll mock me saying 'you drink alcohol at night and drink holy water in the morning to relieve your hangover' ....” (p06, Male, 39 years)*

According to a female participant, women dealing with alcohol addiction faced criticism, including negative remarks about promiscuity and the possibility of unplanned pregnancies, alongside being labelled as a drunkard.

*“People in the society label those with alcohol addiction as drunkards ...and if it's a girl, they say that she'll sleep around and end up with a bastard child.” (p11, Female, 27 years)*

Although few participants mentioned that they hadn't personally been labelled with stigmatizing terms, they stated witnessing others with alcohol addiction being labelled in the society.

### **6.2.2.3 Structural stigma**

The other frequently mentioned experience of stigma was an institutional stigma within employment settings, workplaces, and the legal system. Participants reported that they had difficulty being employed despite being qualified and passing pre-employment tests. They mentioned that employers often refused to hire them upon learning about their alcohol use. They also stated that employers held the belief that individuals dealing with alcohol addiction will be unreliable in terms of punctuality and fulfilling their work duties, thus restricting their chances of securing employment opportunities.

*“I applied to a job vacancy once and passed the pre-employment test, then I went for the interview. They had already made a background check from the office where I used to work at and heard that I drink alcohol. And the employer said to me 'You're an alcoholic, you can't carry out your responsibility and you won't be punctual' ...so, I ended up not getting the job.” (p12, Male, 43 years)*

In addition to the stigma related with finding a job, some of them also stated that they did not receive a fair pay for their work. They also said that employers don't trust them because of their alcohol use despite possessing the skills and capability to perform the job adequately.

*"I used to work as a carpenter and my boss sent me to a customer's house to fix their door, but when I went and the owners saw my face, they refused to let me work. They could tell by my face that I drink alcohol...your face becomes dark and thin when you drink alcohol for a long time. People don't even pay you the appropriate money for your work because they know that you'd still want the money for the alcohol and that you'll accept their offer even if it's low." (p05, Male, 50 years)*

Participants also depicted their experiences of being treated as if they were thieves by police officers without evidence, simply because they were found walking at night after consuming alcohol. They also mentioned instances where police officers assumed they would disturb the community if found drinking alcohol, even without clear evidence of any disruptive behaviour.

*"Sometimes when you are drinking in bars, the waitresses lie about the bill to make you pay more because they think that you wouldn't remember how much drink you had...and when you complain that your bill is wrong, they will call the police, and the police officers will immediately blame you for making a commotion just because you had alcohol... and they hit you when you try to explain the situation... I have experienced this." (p05, Male, 50 years)*

A participant reported encountering an institutional stigma regarding substance treatment services, and that at times admission was not possible because due to centres being utilized for other purposes which limits the access to treatment and causes frustration.

*"I recently went to a hospital with a substance treatment ward because I decided to stop using alcohol...then the health professional told me to have lab investigations done first and appointed me for admission...and when I went back after a few days, he told me that the ward was being used for wounded soldiers and they were not admitting patients with substance use disorder." (p02, Male, 62 years)*

### **6.2.3 Self-stigma**

Participants expressed having negative views about themselves, with many attributing blame to themselves for their alcohol-related issues. They believed that they were irresponsible and

reported feeling angry and disappointed at themselves for not achieving what's expected of them. They frequently mentioned that they felt ashamed and isolated themselves from the society as well. The negative impact of alcohol on their self-care also affected their confidence, and they reported avoiding those who didn't drink alcohol to reduce their shame. They stated that they preferred to be friends with those who had the same lifestyle because they believed they would be more understanding towards them.

*“Alcohol decreases self-care...so I don't have equal confidence with others even when I have a better knowledge, experience, or position than them...you feel like you are wearing a shame hat when you have AUD...but I usually become friends with people who are like me, so it decreases that burden. I feel uncomfortable and ashamed when I spend time with people who don't drink.” (p14, Male, 40 years)*

According to a female participant, drinking alcohol as a woman was associated with losing self-respect when compared to men who drink alcohol.

*“It's better if a man is addicted to alcohol than a woman...when you drink Areke as a woman, you lose your self-respect.” (p11, Female, 27 years)*

## **6.3 EXPERIENCES OF STIGMA IN HEALTHCARE FACILITIES**

### **6.3.1 Views of health professionals regarding AUD**

Participants reported that they encountered different views from healthcare professionals concerning AUD. Professionals working in departments other than substance treatment facilities mostly focused on highlighting the harmful effects of alcohol and they often advised them to reduce alcohol intake or abstain from drinking. Additionally, the participants also reported that they encouraged them to change their drinking patterns and advised them not to give up.

Other respondents mentioned that healthcare professionals in other departments had conveyed to them that it was impossible to quit drinking alcohol, and that even if they stopped drinking for a while, they would eventually resume drinking.

*“I once asked a health professional how I could stop drinking alcohol...and he told me that it was impossible to quit using alcohol once a person becomes addicted.” (p03, Male, 41 years)*

According to participants, healthcare professionals in other departments downplayed addiction and lacked in-depth discussions with patients about their alcohol use. They also stated that they did not provide them with information on strategies for change or direct them toward treatment options.

*“Healthcare professionals advise me to stop drinking just like everyone else...but they should lead those with AUD into treatment...because a lot of people don’t know that it’s a disorder and that it can be treated...they undermine the problem and don’t talk much about it.” (p05, Male, 50 years)*

*“When I tell healthcare professionals about my alcohol use, they say ‘think of what will happen to your children if you keep on drinking’ instead of telling me the solution on how I can cut down my use...I think that a health professional is supposed to tell you how to get treatment.” (p13, Male, 45 years)*

A few others mentioned that they hadn’t engaged in discussions about their alcohol use with healthcare professionals except with the ones working in substance treatment centres.

There were also different views that participants encountered from healthcare professionals working in substance treatment centres. They often gave them advice on the harmful effects of problematic alcohol use, to identify situations or stressors that would trigger them to start drinking again, they also advised them to take care of their personal hygiene. Healthcare professionals also encouraged those with AUD that they could change their patterns of alcohol use if they were motivated to do so. Participants also reported that healthcare professionals working in substance treatment facilities viewed relapse as a normal part of recovery.

*“I had frequent relapses over the years after I started treatment and the health professionals have taught me that relapse is a normal part of recovery and tell me not to give up.” (p02, Male, 62 years)*

### **6.3.2 Healthcare professional stigma**

Participants shared experiences of encountering stigma from healthcare professionals. They mentioned that healthcare professionals working in other departments showed reluctance in treating individuals with AUD and displayed less respect toward them. Additionally, participants reported being labelled by healthcare professionals.

*“Healthcare professions might not treat you appropriately if you have an addiction. For example, one time I went to a hospital because I had an epigastric pain and the healthcare professional made me sit far away because I smelled like alcohol and he didn’t even ask me about my complaint in detail. He just ordered lab tests...his face also looked like he was disinterested to talk...I was disappointed.” (p07, Male, 32 years)*

A participant reported that a healthcare professional refused to treat him because he was tired of his drinking problems despite having a medical complication as follows:

*“I have a follow up for hypertension and my blood pressure usually rises because I drink alcohol, so I go to the hospital often seeking treatment....at one of my follow ups, the healthcare professional told me that he wouldn’t treat me anymore because he was tired of me...I used to take medication but I used to drink on top of that.” (p09, Male, 49 years)*

The respondents had experiences of being treated for their AUD at different governmental and private substance treatment wards/outpatient services and also at rehabilitation centres. Some of the participants mentioned that they had been ridiculed and labelled as an addict by healthcare professionals working in these facilities.

*“One time I took my friend to a rehab centre that I was previously admitted at, because he was suffering with alcohol use problem...then I explained his problem to the healthcare professional so that he could admit him but he responded saying that I was also an addict and mocked me for trying to help another addict...then I told him I was already in recovery but he proceeded to say ‘an addict will never recover from his addiction’. Then we got into an argument and we just left without getting any help.” (p03, Male, 41 years)*

Although it was reported that healthcare professionals in substance treatment facilities viewed relapse as a normal part of recovery, a different encounter was also mentioned by participants that they received demoralizing comments after relapse.

*“...I used to have frequent admissions at a substance treatment facility...and then I finally told the healthcare professionals that I will not go back to drinking and that it was going to be my last admission...after a year I relapsed and went again, one of*

*them said 'you will not improve with treatment, at your age you should try holy water and pray instead' ...It was sad and demoralizing to hear that.” (p02, Male, 62 years)*

Participants mentioned that healthcare professionals working in substance treatment facilities saw them as inferior to them and that they spoke to them in a rude and impolite manner. A participant also reported that they order them around in the wards as if they're incapable of making decisions for themselves.

*“Some of the health professionals working in substance treatment wards see us like we're worthless when they see us wearing the hospital pyjama...they see us like we are inferior to them...they speak to us rudely and they are impolite. They treat us similarly with those who have severe mental illness...they order us around as if we are unable to decide what's good for ourselves.” (p13, Male, 45 years)*

Others had observed instances where other patients were mocked and labelled by healthcare professionals, even though they hadn't personally encountered such behaviour themselves.

### **6.3.3 Positive experiences with healthcare professionals**

There were positive experiences with healthcare professionals that were reported by participants. They mentioned that healthcare professionals working in other departments treated them well and cared for them. Healthcare professionals were also described to be patient and tried to calm intoxicated patients.

*“Sometimes I get into a fight and end up going to a hospital drunk, and the health professionals try to make me calm...I might even be argumentative when I am drunk, but they are patient with me.” (p08, Male, 38 years)*

Many of the participants also described having a positive experience with the healthcare professionals working in substance treatment facilities. They reported that they had a good relationship with them and they felt comfortable asking questions and had an honest communication with them. health care professionals gave them books to read, advised them to do physical exercises in the facilities, and encouraged them on their decision to change their patterns of alcohol use. Respondents also had positive perceptions of healthcare professionals, believing that these professionals held optimistic views about their ability to change and instilled hope in them.

*“I think healthcare professionals have good views and they believe that I can change...the people in the society tell us that we can't recover and we'll go back to*

*drinking, but the knowledge that we gain from the healthcare professionals is not the same...so far, I have a good relationship with them.” (p04, Male, 45 years)*

Others added that besides treating them, the healthcare professionals in substance treatment facilities also talked with them closely as a friend. Health care professionals approached them and had conversations with them closely if there was anything troubling them.

*“They check on us frequently...they greet me as soon as they enter the ward...this has a big value for me...they make me feel like it’s a friendship...we discuss many issues. It is beyond a physician-patient relationship...it also feels like a friendship.” (p14, Male, 40 years)*

## **6.4 IMPACT OF STIGMA**

Stigma had multiple impacts which were reported by the participants including psychological impact, impact on interpersonal relationships, impact on employment, impact on daily routines and impact on help seeking behaviour.

### **6.4.1 Psychological impact**

The respondents expressed feeling a wide range of negative emotions due to the stigma they have faced in their lives. They frequently mentioned that they felt sad and angry.

*“I used to ruminate about the stigmatizing comments that people used to give me...and it made me feel very sad.” (p09, Male, 49 years)*

Many of them stated that being stigmatized by others led them to blame themselves for their condition and develop self-hatred.

*“It made me hate myself...I blamed myself for my addiction...I used to think that I wouldn’t have been mocked if I didn’t drink...I used to feel sad.” (p06, Male, 39 years)*

Stigma also caused them to feel less confident and lowered their self-esteem. They also reported that they felt worthless and hopeless at times. A few also mentioned having suicidal thoughts in the past.

### **6.4.2 Impact on interpersonal relationships**

Participants mentioned that stigma made them distant from others and isolated, which subsequently resulted in feelings of loneliness.

*“Stigma has made me distant from my family. I felt lonely...and I used to think about killing myself. But I am fine now because I have stopped drinking...even though it was difficult back then.” (p08, Male, 38 years)*

They also stated that they stopped attending social gatherings and ceremonies because they felt like others would stigmatize them, further causing them to be excluded from society. Due to the fear of being judged, they also reported that they ended friendships with those who didn't use alcohol and preferred to be close with those who drink alcohol instead.

*“I don't attend important social events such as funerals and weddings because I feel like people will ridicule me because of my alcohol addiction.” (p12, Male, 43 years)*

*“I became distant from my previous friends who didn't use alcohol...and all my new friends were alcoholics.” (p05, Male, 50 years)*

### **6.4.3 Impact on employment**

Participants repeatedly emphasized that stigma had an impact on their process of employment and they had reduced opportunities of getting a job because of stigma and discrimination. They also mentioned encountering financial hardship as they were unable to secure employment, leading to challenges in self-care and an inability to support their families.

*“I had difficulty finding a job several times because employers usually assume that a person is unable to do his work effectively if he is addicted to alcohol.” (p15, Male, 35 years)*

*“I couldn't engage in as much work as I wanted because employers stigmatize individuals like us...and because of that I had financial difficulties and I couldn't support my family.” (p01, Male, 41 years)*

The respondents depicted that they encountered difficulty finding a job despite recovery because people within the community believe that they would go back to drinking alcohol.

*“When I went out from a rehab, I told a mechanic in our neighbourhood that I wanted to work at his garage without a pay...but he said that the alcohol was still in my system because my face was dark. I told him that I didn't need any pay and I just wanted to distract myself with work... I also told him that I just got out of rehab and I was sober...but he refused to let me work. He was concerned about my face looked...this is how people stigmatize you even after recovery.” (p06, Male, 39 years)*

#### **6.4.4 Impact on daily routines**

Participants expressed difficulty in performing their daily routines like using public transportation, due to the fear of being judged for smelling like alcohol. This led them to walk longer distances, and wasting their time to avoid potential judgment.

*“I feel ashamed when I use a taxi because I fear that the smell of alcohol will disturb others and they will judge me, so I rarely use public transportations even when I need to...sometimes I just walk to the places I want to go to...and when I do use public transportations, I try to hold my breath in as much as possible...I feel very uncomfortable.” (p15, Male, 35 years)*

One respondent also stated that he wasn't able to do the things that he wanted such as going out shopping because he perceived that people would judge him negatively due to the smell of alcohol coming from his breath.

*“Stigma has made me unable to do the things that I want...I can't even go inside a boutique and buy a cloth that I like. It's my sister who mostly buys clothes for me...because I worry that my mouth will smell like alcohol and the people there will judge me...she also buys groceries for me because I don't want to go inside a supermarket.” (p12, Male, 43 years)*

#### **6.4.5 Impact on help seeking and recovery**

Almost all participants described that being stigmatized made them lose their courage to change their drinking pattern. They mentioned feeling discouraged from seeking help or treatment which worsened their addiction consequently. A few of the participants reported that they felt ashamed for seeking treatment because they blamed themselves for their addiction.

*“When I'm stigmatized by others, I just give up...and instead of seeking treatment or support for my addiction, I continue to drink.” (p02, Male, 62 years)*

*“I feel like this is the time for me to be working instead of being admitted at a hospital...I feel ashamed for being here because it's my own fault. If it was another illness, you'd accept it as God's will and continue your treatment...but the fact that I am here because of my own fault makes me unhappy.” (p13, Male, 45 years)*

Those in recovery reported that people within their communities did not acknowledge their change after they started their recovery journey, and they still gave them comments that they would start drinking again and that a person with AUD doesn't recover, which was a challenging experience for them to continue on their path. One participant mentioned that being stigmatized by health professionals in substance treatment centres hinders recovery because it can be discouraging for the person to change.

*“When some of the health professionals talk to you rudely in the wards, it hurts your morals and you lose the courage to continue your recovery process. We are not admitted here to be judged after all....” (p13, Male, 45 years)*

## **6.5 COPING, RESILIENCE AND POSITIVE INTERPRETATION OF STIGMA**

There were different ways of coping with stigma that were described by the respondents of the interview. Many of them mentioned that they coped with stigma by drinking alcohol and by avoiding people who stigmatized them. And others used religious coping and seeking social support to deal with the stigma.

*“Sometimes I go to church and pray to forget about it, but I don't do it persistently. I prefer to drink on it and hide my feelings by alcohol.” (p02, Male, 62 years)*

The participants mentioned that these coping mechanisms only offered temporary relief from the impact of stigma. They also stated that trying to cope with the stigma by drinking more and avoiding others just exacerbated their alcohol use problem and led them into more isolation, instead of helping them.

*“When I drink, my mind becomes free and I stop thinking about all of the stigma...but unfortunately, it's a temporary relief...when you wake up the next morning, you feel the same way about yourself. You'll once again feel like you're inferior and start blaming yourself all over again.” (p12, Male, 43 years)*

*“Trying to cope by avoiding people was not really effective in my experience...it just makes you isolate yourself more...and it worsens your addiction.” (p03, Male, 41 years)*

A participant who was seeking treatment for the first time mentioned that despite facing stigma in the society, he chose to let it go and move on because dwelling on it further would cause him internal distress. Others in recovery also mentioned that they don't allow the

stigma from the society affect them negatively because they had already made the decision to change despite challenges and start a new journey in their life.

*“I don’t dwell on my experiences of stigma...I just let it go because I know that it will hurt me if I think about it more and more, so I choose to let it go and move on.” (p12, Male, 43 years)*

*“I personally feel like I have a new life after recovery despite what anyone says...a new spirit and mind...so, I don’t go back to my past and think about the stigma that I experienced. I want to live and grow like a new person.” (p08, Male, 38 years)*

Although the majority of the participants stated that stigma only had negative impacts in their lives, two of the participants on the other hand depicted that stigma had been useful for them. One participant mentioned that being stigmatized by others helped him to gain an insight into the severity of his problem and pushed him to seek treatment.

*“Stigma actually helped me to come here...when my friends stigmatized me, I asked myself why that was happening, and I knew that the problem was my own alcohol use...so, I had to change myself by seeking treatment. But if my friends kept on calling me, asking me to meet up and go out, and if they kept buying me drinks...I will have no insight into my problem and I might end up dying. So, I can say that their rejection has helped me.” (p10, Male, 39 years)*

Another participant stated that stigma helped him to identify the people who genuinely cared for him from those who didn’t.

*“One advantage of stigma is that it helps you find out who your real friends are and those who don’t actually care about you... the people who truly care for you will not stigmatize you.” (p09, Male, 49 years)*

## **7. DISCUSSION**

This phenomenological type of qualitative study aimed to explore the perceptions and experiences of stigma among help seeking people with AUD, the impact of stigma in their lives and how they coped with the stigma. Five themes emerged from the data. The themes were other people’s views and beliefs regarding AUD, stigma among people with AUD, experiences of stigma in healthcare facilities, the impact of stigma, and coping, resilience and positive interpretations of stigma.

One of the findings of this study indicated that various factors such as psychological, social, spiritual, cultural factors, and family history of alcohol addiction were believed to be the causes for AUD within people living in the society. Alcohol addiction was also seen as a sign of weakness and those with AUD were blamed for their condition by the society. In addition, those with AUD were viewed as wilfully engaging in their alcohol use and they were held accountable for the consequences of their alcohol use. A systematic review done on the public attitudes towards alcohol dependence found that there was a strong tendency to blame those with alcohol dependence for their condition and psychosocial reasons for AUD prevailed over biological explanations (27). Another review of population studies also found that alcohol-dependent people were less frequently regarded as mentally ill (19). These results were consistent with the findings of this study. One possible explanation for these beliefs in the society might be the lack of information or knowledge regarding AUD and these beliefs in turn might contribute for the stigmatizing attitudes towards those with AUD.

The other major finding of the study was the perceptions and experiences of stigma among the participants. Perceived stigma was described frequently by participants and the findings were similar to previous qualitative and quantitative studies that also reported high level of perceived stigma regarding the public's opinion of people with problematic alcohol use (14,36,38). The current study found that a female participant perceived more stigma when compared to men with AUD due to societal norms and expectations. This finding was consistent with other studies done in South Korea and Tanzania that showed that females had felt more stigma and being a female was associated with higher perceived discrimination (8,38). There is a notable gap in understanding the stigma among women with AUD due to the reduced number of women seeking help at substance treatment facilities when compared to men, highlighting the need for further exploration.

Participants also described their experiences of stigma such as being excluded and discriminated in the society due to the society's negative labels that they will disturb others or become destructive. They also reported being mocked by people, and receiving judgmental comments in regards to their alcohol use. A systematic review of population studies on the public stigma of AUD showed that stigmatizing attitudes and actions toward people with AUD were widespread in society (19). The findings of this study were also similar with existing literature which identified that people with AUD were perceived as dangerous (27,30). A verbal stigma towards women with AUD involved negative remarks about

promiscuity which is similar to a previous mixed-methods study done in Tanzania on the sex differences in experiences of stigma associated with AUD (8).

The current study also found experiences of structural stigma among individuals with AUD in the process of employment, in a workplace, and by the law enforcement officers. Population based studies showed that alcohol-dependent individuals were particularly vulnerable to structural discrimination (33). Structural stigma in health-care contexts showed that the health-care system deprioritizes people living with substance use issues (55) which was also revealed in the findings of this study where substance treatment facilities were used for other purposes limiting the access to treatment and negatively affecting people who are seeking these services. A possible explanation for this institutional stigma might be due to the deprioritization of people with SUDs in delivery of healthcare while other medical/physical conditions are given a higher priority in treatment whenever there's a scarcity of resources.

Participants frequently internalized the perceived negative beliefs of the society and they mentioned that they blamed themselves for their conditions and had feelings of shame which led them to isolate themselves and withdraw from the society. These reports were consistent with studies done in other countries and also with another local study which reported a high level of internalized stigma among those with AUD (14,18,41). A qualitative study done in Mexico also revealed that alcohol users internalized the negative stereotypes associated with addiction (40).

Individuals with AUD also had experiences of stigma in healthcare facilities. Healthcare professionals working in other departments showed reluctance in treating individuals with AUD, displayed less respect and used stigmatizing language such as labelling terms. The respondents also mentioned that they had been ridiculed and labelled by healthcare professionals working in substance treatment facilities. Healthcare professionals gave them demoralizing comments after relapse and talked to them in a disrespectful manner. Previous studies done to assess health professionals' attitudes towards patients with SUDs concluded that health professionals had negative attitude towards these group of patients which affects the sense of empowerment and treatment outcomes of the patients. The majority of the research suggested that health professionals working with these patients had lowered regard, less motivation and feelings of dissatisfaction (34).

A scoping review that aimed to assess the stigmatization of people with addiction by health professionals also showed that healthcare professionals had negative attitudes and beliefs

regarding SUD (35). These results were consistent with the current findings and the possible reasons for healthcare professional stigma highlighted in this study could be due to health professionals' views regarding AUD and the inadequate training of addiction treatment. Prevalent societal stigma regarding AUD might also have an influence on healthcare professionals' attitudes and beliefs. Insufficient support or resources within the healthcare system for professionals dealing with addiction might also contribute to stigma or disengagement from providing adequate care.

There were no reported differences in the perceptions and experiences of stigma among participants with AUD only and those with comorbid Khat and Tobacco Use Disorders.

This study found that stigma had various negative impacts on psychological well-being, interpersonal relationships, employment, ability to seek treatment and recovery which are consistent with existent literatures from both HICs and LMICs (17,20,48,53). Self-blame, perceived and experienced healthcare professional stigma in substance treatment facilities notably had an impact on help seeking behaviour. According to a qualitative study conducted to explore perspectives and experiences of service users and providers on a brief intervention for AUDs in Ethiopian primary health care, stigma was found to be one barrier for seeking interventions from healthcare which is consistent with the finding of this study (52). The impact of stigma on the help seeking behavior noted on this study can increase the gap in treatment of individuals with AUD, thus raising awareness on stigma and developing training programs for healthcare providers can reduce this gap in treatment and improve recovery.

This study also explored how those with AUD coped with stigma and the findings indicated that participants used different coping mechanisms such as drinking alcohol to find temporary happiness or feel numb, coping by avoiding potential sources of stigma (including both non-drinkers and other people who might stigmatize them), relying on religious beliefs for support, and seeking social connections to cope with stigma. Limiting interactions and withdrawal from social environment was also found to be a way of coping in previous studies (17).

A resilient response to stigma was also revealed in the study such as an emotional resilience to bounce back from stigma-related setbacks and continue on the path to recovery. Other studies have found that individuals with AUD who had resilient responses had a better recovery (57). Another interesting finding in this study was the positive interpretation of stigma, which implicated that stigma helped a person to have an insight into one's alcohol use

problem and seek help/treatment which contrasts with existing evidence. Although stigma is a negative experience, adopting a positive interpretation of stigma and reframing the experience in a more positive light might help mitigate its negative effects on mental well-being and allow individuals to navigate stigmatizing experiences with resilience, self-reflection, and the potential for personal development. Thus, comprehensive research dedicated to understanding and examining the positive interpretation of stigma might be needed.

This study involved participants with AUD seeking help at substance treatment facilities to explore the structural stigma within healthcare settings beyond the societal level. Although those without help seeking experience were not included in the study, stigma among the participants was explored across their lifespan to capture their experiences prior to initiation of treatment retrospectively as well. Thus, the findings of this study can also be transferable to those with AUD with no history of help/treatment seeking.

All forms of stigma may not have been comprehensively explored in the current study since stigma can manifest in multifaceted ways, necessitating further exploration.

## **8. STRENGTHS AND LIMITATIONS**

This study is unique in that it tried to explore the perceptions and experiences of stigma among help seeking individuals with AUD in the public as well as in healthcare facilities in Ethiopia. It also allowed for a personal narrative of the participants and an in-depth understanding of their experiences and the impact of stigma on their lives. Furthermore, the findings of the study can inform interventions and policies aimed at reducing stigma against individuals with AUD both within society and healthcare settings.

The study also had some limitations. The PI acknowledges the possibility that personal perspectives and biases might have influenced data interpretation. However, efforts were made to collaborate closely with thesis Supervisors to consider alternative interpretations and the PI has actively fostered self-awareness throughout the study which would help to minimize bias.

The study might not have captured the diverse perspectives and experiences related to stigma due to the underrepresentation of some groups with regards to sex and residence of participants. The perspectives of those who had no treatment /help seeking experience was also not captured.

The presence of comorbid SUDs in some of the participants, which might also be associated with stigma, might have influenced the findings of the study. Another limitation of the study is that participants might have had difficulty disclosing their true experiences of stigma in healthcare facilities because the PI was a healthcare professional and the interview was conducted in a hospital.

## **9. CONCLUSION**

This qualitative study explored the stigma among help seeking individuals with AUD and revealed multifaceted dimensions of stigma. The findings have highlighted the presence of perceived stigma, self-stigma and enacted stigma both in the public and in healthcare facilities. These stigmatizing attitudes and behaviours can have negative effects on individuals with AUD leading to feelings of shame, negative self-perception, difficulties securing employment, isolation, and reluctance to seek help. Stigma within healthcare settings might also hinder access to quality care affecting recovery outcomes. Furthermore, it can impede the recovery process by affecting adherence to treatment plans and reducing motivation for sustained recovery efforts. These varied forms of stigma paint a comprehensive picture of the challenges faced by individuals seeking help for AUD, emphasizing the need for targeted interventions and systemic changes to mitigate the detrimental effects of stigma in both societal and healthcare settings.

By highlighting how stigma occurs in the public and healthcare facilities, we can better develop specific policies and community-based interventions aimed at reducing stigma, correct misconceptions regarding alcohol use disorders, and enhance access to care.

## **10. RECOMMENDATIONS**

At the individual and society level:

- Developing anti-stigma campaigns targeting the general public to increase awareness and reduce stigma towards individuals with AUD.
- Providing information about the medical model of addiction to the public to address misconceptions about AUD.
- Creating support groups and peer-led interventions for individuals with AUD to address the stigma they face and provide a safe space for them to seek help.

- Promoting positive stories of recovery and treatment effectiveness through local medias.

At healthcare facilities:

- Developing anti-stigma campaigns targeting healthcare professionals to increase awareness and reduce stigma towards individuals with AUD.
- Providing education and training for healthcare professionals on how to provide a nonjudgmental and empathetic care for those with AUD.
- Implementing the use of non- stigmatizing and “first-person” language in healthcare facilities.
- Offering psychotherapeutic interventions and counselling that could help people with AUD to recognize and manage internalized stigma.

At governmental level:

- Implementing policy changes that protect the rights of individuals with AUD and ensure that they receive fair treatment in healthcare settings.

Further research is recommended to better understand the magnitude and impacts of stigma on help seeking behaviour and recovery of people with AUD in order to inform targeted interventions and advocate for policy improvements. In addition, future research is also needed to evaluate the effectiveness of interventions to determine which works best in tackling the stigma towards AUD in our local setting.

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## 12. APPENDICES

### I- Additional file: Socio-demographic characteristics of the participants

Code number	Age	Sex	Residence	Marital status	Educational level	Occupation	Duration of follow up for AUD	Comorbid diagnosis
01	41	M	A.A	Single	Advanced diploma	Electrician	1 <sup>st</sup> time	-
02	62	M	A.A	Divorced	Advanced diploma	Street vendor	11 years	-
03	41	M	A.A	Divorced	8 <sup>th</sup> grade	Gardener	10 months	Khat use disorder
04	45	M	A.A	Single	8 <sup>th</sup> grade	Parking attendant	10 months	Khat & tobacco use disorder
05	50	M	A.A	Single	12 <sup>th</sup> grade	Electrician	1 year	-
06	39	M	A.A	Single	8 <sup>th</sup> grade	Unemployed	4 months	Tobacco use disorder
07	32	M	A.A	Single	8 <sup>th</sup> grade	Daily labourer	8 years	Tobacco use disorder
08	38	M	A.A	Separated	10 <sup>th</sup> grade	Public taxi driver	6 months	Tobacco use disorder
09	49	M	A.A	Married	8 <sup>th</sup> grade	Executive member in an office	1 year	-
10	39	M	A.A	Divorced	12 <sup>th</sup> grade	Ride taxi driver	1 month	Khat & tobacco use disorder
11	27	F	A.A	Single	10 <sup>th</sup> grade	Unemployed	1 <sup>st</sup> time	-
12	43	M	A.A	Divorced	Diploma	Employee at a government office	1 <sup>st</sup> time	-
13	45	M	A.A	Married	11 <sup>th</sup> grade	Owner of a furniture shop	8 years	-
14	40	M	A.A	Divorced	MSc degree	Unemployed	1 year	-
15	35	M	A.A	Single	10 <sup>th</sup> grade	Carpenter	1 <sup>st</sup> time	Khat & tobacco use disorder

## **II: English Version Participants' Information Sheet**

**Introduction:** Greetings! My name is Dr. Yodit Endalamaw, I'm a third-year psychiatry resident at Addis Ababa University. My advisors are Dr. Awoke Mihretu and Professor Atalay Alem. I am conducting a study on the stigma among help seeking people with Alcohol Use Disorder at two governmental hospitals, Amanuel Mental Specialized Hospital and Zewditu Memorial Hospital, in Addis Ababa.

This information sheet is prepared to explain the research project that you are asked to take part in. It explains the purpose and procedure of the study, its confidentiality, your role in the study, benefits and risks of being involved in this study, reimbursement and contact information of the research team, the Department of Psychiatry and the Ethical Committee of Addis Ababa University.

**Purpose:** The purpose of the study is to explore stigma among help seeking people with Alcohol Use Disorder.

**Procedure:** The reason I chose you as this study's participant is because you are currently seeking care at the substance treatment ward / outpatient substance treatment service at Amanuel Mental Specialized Hospital/ Zewditu Memorial Hospital.

You will be asked some questions including demographic ones, and questions on stigma related to your alcohol use. The interview will take about 45 minutes to an hour on average, with a break in between. It will be conducted in a private office and will be audio recorded. I will be taking notes in addition to audio recording during the interview. Your participation in this study is voluntary. If you decide to take part in this study, you need to understand the purpose of the study and sign a consent form.

**Confidentiality:** The information collected in this research project will be kept confidential. The audio records and additional notes will only be used for this research and I will not use your name or other identifying information. To ensure confidentiality, I will assign a code (numbers) that will be used on all research notes and documents. The audio-recording will be deleted after transferring the data to a personal computer in a written format. The data will be stored in a secure location with access limited only to the researcher.

**Benefits:** There will not be any direct benefit for you due to your participation in this study. But your participation will help to gain an understanding of the different types of stigma people with Alcohol Use Disorder face and its impacts. Both positive and negative feedbacks that you provide will be helpful to create more awareness into the problem and develop interventions to reduce stigma in healthcare facilities and improve the quality of care for patients.

**Risks:** The principal investigator has not identified any risk to be incurred by participating in this study. If you feel uncomfortable with any of the question in the interview, you have a right not to answer.

**Reimbursement:** After completing the interview, you will be paid 150 ETB reimbursement for your time and transportation.

**Right to refuse or withdraw:** You have full right to refuse from participating in this research. Even after signing the consent form, you are still free to withdraw anytime during the interview. Your decision whether or not to participate in the study will have no effect on your care at AMSH/ZMH.

**Contact information:** This research project is reviewed and approved by the Ethical Committee of Addis Ababa University, School of Medicine, and Department of Psychiatry. If you want to have more information or if you have any complaint, you can contact the committee through the address below. You can also contact the members of the research team by the contact information provided below.

Principal Investigator: Dr. Yodit Endalamaw

Advisors: Dr. Awoke Mihretu

Professor Atalay Alem

Phone – (+251)913660190

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Address of Department of Psychiatry, Addis Ababa University:

Phone- (+251)118962052

Ethics committee office at Addis Ababa University:

Phone- (+251)115 538734

If you are willing to participate in the study, you will be given a copy of the information sheet and you will be asked to sign an informed consent form.

### **III-Informed Consent Form**

I have received information and understood the information provided about the research, procedure, risks, benefits and that participating in the research won't impact the treatment I receive at AMSH/ZMH. I am informed that an audio will be recorded during the interview and that the researcher will ensure my confidentiality. I consent to participate voluntarily in the research on stigma among help seeking people with Alcohol Use Disorder at AMSH/ZMH.

Participant's Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness' Signature (If the participant is not able to read the information sheet, he/she will be told about the details of the information by the researcher in the presence of a witness)

\_\_\_\_\_

Researcher's Signature \_\_\_\_\_ Date \_\_\_\_\_

### **Payment Acknowledgment Form**

I \_\_\_\_\_ have participated in the research study titled "Stigma among help seeking people with Alcohol Use Disorder at two governmental hospitals, Amanuel Mental Specialized Hospital and Zewditu Memorial Hospital. I acknowledge that I have received reimbursement for my time and transportation in the amount of 150 ETB.

Signature of the participant: - \_\_\_\_\_

Date: - \_\_\_\_\_

Name of the person making the payment: - \_\_\_\_\_

Signature: - \_\_\_\_\_

Date: - \_\_\_\_\_

## **IV- Socio-Demographic Characteristics Of Participants**

Date - \_\_\_\_\_

Identification number- \_\_\_\_\_

Thank you for agreeing to participate in the study. I will now ask you questions about yourself.

1. Age- \_\_\_\_\_
2. Sex - \_\_\_\_\_
3. Residence- \_\_\_\_\_
4. Marital status- \_\_\_\_\_
5. Educational status- \_\_\_\_\_
6. Occupation- \_\_\_\_\_
7. Diagnosis- \_\_\_\_\_
8. Duration of follow up- \_\_\_\_\_

## **V- Semi-Structured Interview Guide**

Identification number: \_\_\_\_\_

1. Can you tell me about your experiences of alcohol use?

- When did you start drinking alcohol?
- How did you start using it?
- How frequently do/did you use it?

2. How has your alcohol use affected your life?

- How do you find the attitudes of others towards your alcohol use?
- Do you talk about your experiences with others and if so, what sort of views have you encountered?
- Do people blame you for your alcohol use related difficulties? Tell me more about this.

3. How do you think society views a person with AUD?

- In what ways do they view you differently from someone who does not have AUD?

4. Can you describe how you are treated in the society/public in relation to your alcohol use?

- What are the situations/circumstances that you have been treated differently because of your alcohol use?
- How do people address you?
- Can you describe your experiences of rejection or direct experiences of stigma?
- Can you describe any experiences of being treated unfairly in your education, housing, in finding or keeping a job, by the legal system or other institutions?

5. What do you think/feel about yourself in relation to your alcohol use?

- How do you feel about yourself when you compare yourself to others who don't have an AUD?
- Can you describe any feelings of being ashamed or embarrassed about your alcohol use?

6. How do you think healthcare providers in general think/feel about you in relation to your alcohol use?

- What sort of views have you encountered while speaking about your alcohol use with healthcare professionals?
- How do you feel talking about it with healthcare professionals?

7. Can you describe your experiences while seeking treatment for any cause at a health facility?

- Have you ever been treated differently in a healthcare facility because of your alcohol use? How so?
- How do healthcare professionals address you?
- Can you describe any experiences of stigma or rejection by healthcare professionals?

8. Can you describe your experience while seeking treatment for your AUD?

- What are the challenges or barriers you faced while accessing care?
- How do you think health professionals in the substance treatment ward/ outpatient service think/feel about you in relation to your alcohol use?
- Have you experienced stigma by health professionals at the inpatient or outpatient substance-related treatment service? If yes, In what way?

9. What is the impact of stigma in your life?

- How does stigma make you feel?
- What is the impact of stigma on your mental well-being?
- What is the impact on your relationships with others?
- What is its impact on your ability to seek help and treatment?
- what is the impact upon your recovery?
- Has stigma had any positive impacts on your day-to-day life?

10. How do you cope with the stigma related to AUD?

- Describe these coping strategies.
- How effective has it been in reducing the impact of stigma in your life?

11. How do you think healthcare providers and the society can better support individuals struggling with AUD and reduce stigma?

We have reached the end of the interview. Is there anything else that you would like to share about your experiences of stigma in relation to your AUD?

Thank you again for your time. I appreciate your participation in the study. Your input is extremely important and helps greatly to understand the stigma among people with AUD.

## VI. Amharic Version of Appendices

### ለጥናቱ ተሳታፊዎች የመረጃ ቅጽ

**መግቢያ:** ሰላም! ዶ/ር ዮዲት እንዳላማው እባላለሁ። በአዲስ አበባ ዩኒቨርሲቲ የሶስተኛ አመት የአእምሮ ህክምና ስፔሻላይዜሽን ሰልጣኝ (ሬዚደንት) ሆኪም ነኝ። የጥናት አማካሪዎቼ ዶ/ር አወቀ ምሕረቱ እና ፕሮፌሰር አታላይ አለም ናቸው። በአዲስ አበባ በአማኑኤል የአእምሮ ስፔሻላይዜድ ሆስፒታል እና በዘውዲቱ ሆስፒታል በተመላላሽ ወይም ተኝተው የአልኮል ሱስ ሕክምና በሚያደርጉ ሰዎች ላይ ሊኖር ስለሚችል መገለል ጥናት እያካሄድኩ ነው። ይህ የመረጃ ወረቀት እንዲቀላቀሉ የተጠየቁትን የጥናት ፕሮጀክት ለማብራራት የተዘጋጀ ነው። የጥናቱ አላማና ሂደት ፣ ስለሚሰጡን መረጃ ምስጢራዊነት ፣ በጥናቱ ውስጥ ያለዎትን ሚና፣ በዚህ ጥናት ውስጥ የመሳተፍ ጥቅሞች እና ስጋቶች፣ ማካካሻ ፣ እንዲሁም የጥናት ቡድኑና የአዲስ አበባ ዩኒቨርሲቲ አድራሻ ይገልጻል።

**የጥናቱ ዓላማ:** የጥናቱ ዓላማ የአልኮል ሱስ ሕክምና በሚያደርጉ ሰዎች ላይ ሊኖር የሚችል መገለልን ለመዳሰስ ነው።

**ሒደት:-** የዚህ ጥናት ተካፋይ እንዲሆኑ የተመረጡበት ምክንያት በአሁኑ ጊዜ በአማኑኤል የአእምሮ ስፔሻላይዜድ ሆስፒታል/በዘውዲቱ ሆስፒታል በተመላላሽ/ ተኝተው የአልኮል ሱስ ሕክምና እያደረጉ ስለሚገኙ ነው። የስነ-ህዝብ ጥያቄዎችን ጨምሮ እንዲሁም ከአልኮል አጠቃቀም ጋር በተያያዘ ሊኖር ስለሚችል መገለል አንዳንድ ጥያቄዎችን እጠይቅዎታለሁ። ቃለ መጠይቁ በአማካይ ከ45 ደቂቃ እስከ አንድ ሰዓት ይወስዳል። በመካከል እረፍት መውሰድ ይቻላል። ቃለ መጠይቁን የምናደርገው ምስጢራዊነቱ በተጠበቀ የግል ቢሮ ውስጥ ነው እንዲሁም ቃለመጠይቁ በድምፅ የሚቀዳ ይሆናል። በቃለ መጠይቁ ወቅት ተጨማሪ ማስታወሻ እይዛለሁ። በዚህ ጥናት ውስጥ ያለዎት ተሳትፎ በፈቃደኝነት ነው። በዚህ ጥናት ውስጥ ለመሳተፍ ፍቃደኛ ከሆኑ የስምምነት ቅጹን መረዳት እና መፈረም ያስፈልግዎታል።

**በጥናቱ ላይ ያለዎትን ተሳትፎ ማስጠራዊነት በተመለከተ:** በዚህ ጥናት ላይ ያለዎት ተሳትፎ ምስጢራዊነቱ የተጠበቀ ይሆናል። የድምጽ መዝገቦቹ ለዚህ ጥናት ብቻ ጥቅም ላይ ይውላሉ። በሁሉም የጥናት ማስታወሻዎች እና ሰነዶች ላይ የኩድ ስሞችን ወይም ቁጥሮችን በመመደብ ምስጢራዊነቱን እጠብቃለሁ። የእርስዎን ስም ወይም ሌላ መለያ መረጃ አልጠቀምም። መረጃዎቹ ቁልፍ ባለው ሳጥን ውስጥ የሚቀመጡ ይሆናሉ። ከመቅረፅ-ድምጹ የተገኘው መረጃ በጽሁፍ ከሰፈረ እና መረጃው ከተተነተነ በኋላ የድምጽ መረጃው የሚደመሰስ ይሆናል። ይህ ጥናት ከተጠናቀቀ በኋላ የሰጡን መረጃ ሌሎች ተመራማሪዎች ሊጠቀሙበት ይችላሉ። ነገር ግን በምንም መንገድ የእርስዎን ማንነት ሊያውቁ የሚችሉበት ሁኔታ አይኖርም።

**በጥናቱ ላይ በመሳተፍዎ ሊገኙ የሚችሉ ጥቅሞች:** በዚህ ጥናት ውስጥ በመሳተፍዎ ምንም አይነት ቀጥተኛ ጥቅም አያገኙም። ነገር ግን የእርስዎ ተሳትፎ የአልኮል ሱስ ችግር ያለባቸው ሰዎች ስለሚገጥሟቸው መገለሎች እና ስለሚያስከትላቸው ተጽእኖዎች ግንዛቤ ለማግኘት ይረዳል። እርስዎ የሚነግሩኝ ማንኛውም አወንታዊ ወይም አሉታዊ መረጃዎች/አስተያየቶች በችግሩ ላይ የበለጠ ግንዛቤን በመፍጠር በጤና ተቋማት ውስጥ ያለውን መገለል ለመቀነስ ዘዴዎችን ለማዘጋጀት እና ለታካሚዎች የህክምና ጥራትን ለማሻሻል ይረዳል ።

በጥናቱ ላይ በመሳተፍ ሊከሰትብዎ የሚችሉ ስጋቶች፡ በዚህ ጥናት መሳተፍ ምንም አይነት ችግር ያደርስብዎታል ብለን አናምንም። ሆኖም የሚነሳው ጥያቄ ቅር የሚያሰኝዎት ወይም ለመመለስ የማይመችዎት ከሆነ ለጥያቄው መልስ አለመስጠት ይችላሉ።

**ማካካሻ፡** ቃለ መጠይቁን ከጨረሱ በኋላ ለጊዜዎ እና ለመጓጓዣዎ ማካካሻ 150 ብር ይከፈልዎታል ።

በዚህ ጥናት ለመሳተፍ ወይም ላለመሳተፍ ሙሉ በሙሉ የእርስዎ ውሳኔ ነው። ለመሳተፍ ከወሰኑ በሃላ በማንኛውም ጊዜና ምንም አይነት ምክንያት መስጠት ሳያስፈልግዎ ተሳትፎዎን ማቋረጥ ይችላሉ። በጥናቱ ለመሳተፍ መወሰን ያለበት ለመሳተፍ ከፈለጉ ብቻ ነው። በጥናቱ ለመሳተፍ ፍቃደኛ ሳይሆኑ ቢቀሩ የሚከሰትብዎት ጉዳት ወይም የሚያጡት ጥቅም አይኖርም።

የሰጡት መረጃ ለመጨረሻ ሪፖርት ተጠናቅሮ እስካልተዘጋጀ ድረስ በማንኛውም ሰዓት ከጥናቱ እንዲወጣልዎ የመጠየቅ መብት አለዎት።

በዚህ ጥናት ላይ በማንኛውም ጊዜ ጥያቄ ወይም ቅሬታ ካሎት ለአዲስ አበባ ዩኒቨርሲቲ የአዕምሮ ህክምና ትምህርት ክፍል የጥናት ግምገማ ቦርድ ከታች በተጠቀሰው አድራሻ ጥያቄዎትን ወይም ቅሬታዎትን ማቅረብ ይችላሉ።

የጥናቱ ተመራማሪ ስም - ዶ/ር ዮዲት እንዳላማው

አማካሪዎች - ዶ/ር አወቀ ምሕረቱ

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ስልክ -(+251)115538734

በዚህ ጥናት ላይ ለመሳተፍ ከወሰኑ የዚህ የመረጃ ቅጽ አንድ ኮፒ ይሰጥዎታል ፤ የፈቃደኝነት መጠየቂያ ቅጹንም እንዲፈረሙ ይጠየቃሉ።

**የፈቃደኝነት መጠየቂያ ቅጽ**

ስለ ጥናቱ መረጃ ተስጥቶኛል። ስለ ጥናቱ አሰራር፣ ስጋቶች፣ ጥቅም እንዲሁም በጥናቱ መሳተፌ በአማኑኤል የአእምሮ ስፔሻላይዝድ ሆስፒታል/ በዘውዲቱ ሆስፒታል የማገኘው ህክምና ላይ ተጽእኖ እንደማይኖረው ከቀረበው መረጃ

ተረድቻለሁ። በቃለ መጠይቅ ጊዜ ድምጽ እንደሚቀረጽ እና የማንነቴ ሚስጥር እንደሚጠበቅ ተነግሮኛል። በአማኑኤል የአእምሮ ስፔሻላይዥስ ሆስፒታልና በዘውዲቱ ሆስፒታል በተመላላ ወይም ተኝተው የአልኮል ሱስ ህክምና በሚያደርጉ ሰዎች ሊኖር ስለሚችል መገለል ያተኮረ ጥናት ላይ ለመሳተፍ ፈቃደኝነቴን በፊርማዬ አረጋግጣለሁ።

የጥናት ተሳታፊ ፊርማ \_\_\_\_\_ ቀን \_\_\_\_\_

የምስክር ፊርማ (ተሳታፊው ማንበብ የማይችሉ ከሆነ ከዚህ በላይ የተዘረዘሩት ነጥቦች ግልጽ ይደረግላቸዋል) \_\_\_\_\_

የጥናቱ ተመራማሪ ፊርማ \_\_\_\_\_ ቀን \_\_\_\_\_

**የክፍያ ማረጋገጫ ቅጽ**

በአማኑኤል የአዕምሮ ስፔሻላይዥስ ሆስፒታል እና በዘውዲቱ ሆስፒታል የአልኮል ሱስ ህክምና በሚያደርጉ ሰዎች ላይ ሊኖር የሚችል መገለል በሚል ርዕስ በተደረገው ጥናት ተሳትፎያለሁ። ለጊዜዬ እና ለትራንስፖርት ማካካሻ 150 ብር ተከፍሎኛል።

የጥናት ተሳታፊ ፊርማ:- \_\_\_\_\_

ቀን:- \_\_\_\_\_

የከፋይ ስም:- \_\_\_\_\_

ፊርማ:- \_\_\_\_\_

ቀን:- \_\_\_\_\_

**የተሳታፊዎች አጠቃላይ መረጃ**

ቀን: \_\_\_\_\_

የተሳታፊ መለያ ቁጥር: \_\_\_\_\_

በጥናቱ ላይ ለመሳተፍ ስለተስማሙ አመሰግናለሁ። በቅድሚያ ስለ እርስዎ አጠቃላይ መረጃ እጠይቅዎታለሁ።

1. ዕድሜ- \_\_\_\_\_
2. ጾታ- \_\_\_\_\_
3. የመኖሪያ ቦታ- \_\_\_\_\_
4. የጋብቻ ሁኔታ- \_\_\_\_\_
5. የትምህርት ደረጃ- \_\_\_\_\_
6. ሥራ- \_\_\_\_\_
7. የህመም ዓይነት \_\_\_\_\_
8. በክትትል ላይ ለምን ያህል ጊዜ ቆይተዋል? \_\_\_\_\_

**የቃለ መጠይቅ መምሪያ**

1. ስለ አልኮል አጠቃቀም ሊነግሩኝ ይችላሉ?
  - አልኮል መጠጣት የጀመሩት መቼ ነበር?
  - በምን ሁኔታ ነበር መጠጣት የጀመሩት?
  - በየሰንት ጊዜ አልኮል ይጠጣሉ?
2. የአልኮል አጠቃቀም በህይወትዎ ላይ ምን ዓይነት ተጽእኖ አለው?
  - የእርስዎ አልኮል አጠቃቀም ላይ ሌሎች ሰዎች ምን ዓይነት አመለካከት ያላቸው ይመስሉታል?
  - በዚህ ጉዳይ ከሰዎች ጋር የሚነጋገሩ ከሆነ ምን ዓይነት አስተያየቶች አጋጥመዎታል?
  - ሌሎች ሰዎች ለአልኮል ሱስ ህመም ራስዎ ተጠያቂ እንደሆኑ/ በአልኮል ሱስ ህመም የተነሳ የሚደርስብዎት ችግር የእርስዎ ጥፋት እንደሆነ ያስባሉ? ሁኔታውን ሊያብራሩልኝ ይችላሉ?

3. የአልኮል ሱስ ህመም ያለበትን ሰው ማህበረሰቡ እንዴት ይመለከተዋል ብለው ያስባሉ?
  - የአልኮል ሱስ ከሌለበት ሰው ጋር ሲነፃፀር በምን መንገድ የተለየ ነው ብለው ያስባሉ?
4. በአልኮል ሱስ ህመም ምክንያት ከማህበረሰቡ ዘንድ ምን አይነት ባህሪ አጋጥሞቻት ያውቃል?
  - ከማህበረሰቡ ዘንድ የተለየ ያጋጠመቻትን ባህሪ ሊያብራሩልኝ ይችላሉ?
  - በማህበረሰቡ ዘንድ ምን አይነት መጠሪያ ይሰጥዎታል?
  - በአልኮል ሱስ ህመም ምክንያት ያጋጠመቻት በሰዎች ዘንድ ተቀባይነት ማጣት ወይም መገለል ካለ ሊያብራሩልኝ ይችላሉ?
  - በትምህርት ቤት ፣ ከመኖሪያ ቤት ጋር በተያያዘ ፣ ስራ የመፈለግ ሂደት ላይ ወይም በመስሪያ ቤት ውስጥ ፣ በህግ አካላት በኩል ወይም በሌላ ድርጅት የደረሰብዎት አድልዎ ከነበረ ሁኔታውን ሊያብራሩልኝ ይችላሉ?
5. ከአልኮል አጠቃቀም ጋር በተያያዘ ስለራስዎ ምን ያስባሉ/ይሰማዎታል?
  - ራስዎን የአልኮል ሱስ ህመም ከሌለበት ሰው ጋር ሲያነጻጽሩ ምን ያስባሉ/ይሰማዎታል?
  - በአልኮል ሱስ ህመም የተነሳ የሚሰማዎት የማፈር ወይም መሸማቀቅ ስሜት ካለ ያብራሩልኝ።
6. ከአልኮል አጠቃቀም ጋር በተያያዘ የጤና ባለሙያዎች በአጠቃላይ ስለእርስዎ ምን የሚያስቡ / የሚሰማቸው ይመስሉታል?
  - ስለ አልኮል ሱስ ህመም ከጤና ባለሙያዎች ጋር ሲነጋገሩ ምን አይነት አስተያየቶች አጋጥሞታል?
  - ከጤና ባለሙያዎች ጋር ስለዚህ ሁኔታ ሲነጋገሩ ምን ይሰማዎታል?
7. ከዚህ በፊት በማንኛውም ምክንያት ወደ ጤና ተቋም ለህክምና ሲሄዱ ምን አይነት ተሞክሮ/ተለምዶ አለዎት?
  - በአልኮል ሱስ ህመም ምክንያት ከጤና ባለሙያዎች ዘንድ የተለየ ባህሪ አጋጥሞቻት ያውቃል? ሁኔታውን ሊያብራሩኝ ይችላሉ?
  - በጤና ባለሙያዎች ዘንድ ምን አይነት መጠሪያ ይሰጥዎታል?
  - በአልኮል ሱስ ህመም የተነሳ በጤና ባለሙያዎች ያጋጠመቻት መገለል ወይም መገፋት ከነበረ ሁኔታውን ሊያብራሩኝ ይችላሉ?
8. ለአልኮል ሱስ ህክምና በሚያደርጉ ጊዜ በሆስፒታል ውስጥ ከጤና ባለሙያዎች ጋር ያለዎትን ተለምዶ መግለጽ ይችላሉ?
  - ህክምና ለማግኘት በሚሞክሩበት ወቅት ያጋጠሙዎት ችግሮች ምን ነበሩ?
  - ከአልኮል አጠቃቀም ጋር በተያያዘ በሱስ ህክምና ክፍል ውስጥ የሚሰሩ የጤና ባለሙያዎች ስለእርስዎ ምን የሚያስቡ / የሚሰማቸው ይመስሉታል?

- በአልኮል ሱስ ህክምና ተመላላሽ ክፍል ወይም ተኝተው በሚታከሙበት ወቅት በጤና ባለሙያዎች መገለል ደርሶቦት ያውቃል? መልሱ አዎ ከሆነ በምን መንገድ ነው የተፈጠረው?

9. በአልኮል ሱስ ህመም የተነሳ ያጋጠመዎት መገለል በህይወትዎ ላይ ምን አይነት ተጽኖ አለው?

- በመገለል ምን አይነት ስሜት ይሰማዎታል?
  - በአእምሮ ጤንነትዎ ላይ ምን ተጽእኖ አለው?
  - ከሌሎች ሰዎች ጋር ባለዎት ግንኙነት ላይ ምን ተጽኖ አለው?
  - መገለል እርዳታ እና ህክምና የመፈለግ አቅምዎ ላይ ምን ተጽዕኖ አለው?
  - በአልኮል ሱስ ህክምና ላይ ባለዎት የማገገም ሂደት ላይ ምን ተጽዕኖ አለው?
  - ከአልኮል ሱስ ህመም ጋር በተያያዘ መገለል በህይወትዎ ላይ አዎንታዊ ተጽእኖ አለው?

10. ከአልኮል ሱስ ህመም ጋር በተያያዘ የሚሰማዎትን ወይም የሚደርስቦትን መገለል በምን መልኩ ይቋቋሙታል?

- የሚጠቀሟቸውን የመቋቋሚያ ስልቶች ይግለጹ::
- እነዚህ ስልቶች በህይወትዎ ውስጥ የመገለልን ተፅእኖ ለመቀነስ ምን ያህል ውጤታማ ነበሩ?

11. በአጠቃላይ የጤና ባለሙያዎች እና ህብረተሰቡ የአልኮል ሱስ ህመም ያለባቸውን ግለሰቦች አንዴት በተሻለ ሁኔታ መደገፍና ማግለልን በምን መልኩ ሊቀንሱ ይችላሉ ብለው ያስባሉ?

ወደ ቃለመጠይቁ ማጠቃለያ ደርሰናል:: ከአልኮል ሱስ ህመም ጋር በተያያዘ ስላጋጠመዎት መገለል ሊያካፍሉት የሚፈልጉት ሌላ ነገር አለ?

በጥናቱ ላይ ስለተሳተፉ በጣም አመሰግናለሁ:: የሰጡኝ መረጃ የአልኮል ሱስ ህመም ባለባቸው ሰዎች ላይ ያለውን መገለል ለመረዳት በእጅጉ ይረዳል::

### **13. DECLARATION OF ORIGINAL WORK**

I the undersigned, declare that this thesis report is my original work, where my work is indebted to the work of others, it has not been accepted or presented for a degree in this or any other university and that all sources of materials used for the thesis have been fully acknowledged.

Name of Investigator- Dr. Yodit Endalamaw (Third year psychiatry resident)

Signature-

Date of submission- March 19, 2024

This thesis has been submitted with my approval as University Supervisor.

Name and Signature of the first Supervisor- Dr. Awoke Mihretu

Name and Signature of the second Supervisor- Professor Atalay Alem