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RELAPSE VULNERABILITY, PERCEIVED STIGMATIZATION AND SOCIAL SUPPORT AMONG DRUG ADDICTS

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ABSTRACT
The present research investigated the relapse vulnerability due to perceived stigma and presence or absence of social support among drug addicts. It was hypothesized that there is positive relationship between perceived stigma and relapse vulnerability and negative relationship between social support and relapse vulnerability among drug addicts. The demographics study shows higher level of perceived stigma and relapse vulnerability among illiterate and secondary education in drug addicts. It was hypothesized that there will be less social support with less income as well as there will be high relapse vulnerability among drug addicts belonging to lower income group. Cross sectional research design was used. The samples of 188 relapse drug addicts were selected from different rehabilitation centers of Islamabad and Rawalpindi. The scales were taken in Urdu Version from Punjab University Lahore in which AWARE Questionnaire was used by Rafique & Nahee (2011), Multidimenational scale for perceived social support by Kousar and Zafar (2011) and Perceived stigma of substance abuse scale by Kousar, Ijaz & Mushtaq (2011). Result showed that there is a positive correlation between perceived stigma and relapse vulnerability and negative relationship of relapse vulnerability with social support. Result also showed that perceived stigma, social support, family support and significant others support were higher in drug addicts who have intermediate level of education. There is high relapse vulnerability among people belonging to lower income as were higher on relapse vulnerability. The study has implications for mental health practitioners, to make intervention programmes and focus on family therapy. It is helpful for students, academician and researcher for future research on the current phenomenon.
KEYWORDS: Relapse Vulnerability, Perceived Stigma, Social Support

INTRODUCTION

Relapse is 'a return to drug use after a period of abstention.' Relapse has been defined in a different way by different researchers and clinicians (Moss & Cook, 2012). In *Alcoholics Anonymous* the relapse defined as either using it or typically trying to restrain from it. Relapse is something that occurs has a negative consequences. It has been estimated that 40-60% of the individuals have the relapse after going through the treatment of substance abuse (fisher & Harrison 2005**;** McLellan, Lewis, O'Brien, & Kleber, 2000; National Institute on Drug Abuse [NIDA], 2009). According to Doweiko (2002) relapse has been defined as the complex part in the process of treatment. The National institute on Drug Abuse (NIDA, 2009) of US defined the relapse from the substance addiction which is a ever-lasting process and requires the regular series for the treatment. Relapse treatment helps to restore the individual confidence to adjusted again in the society. Sometime the relapse cause the person to leave the therapy before the completion of the treatment and become addicted again (Doweiko, 2002).

There are different factors present in the relapse process divided into proximal, intrapersonal and interpersonal category. Proximal relapse occur instantly, Intrapersonal occurs while risk factors high such as craving and stress in a person (Greenberg, 2011; Hopper et al., 2006). Interpersonal includes the conflict with the organized set up like stigma, social conflict and lack of social support (Chong & Lopez 2008; Moos & Moos, 2007). These are the kind of provoked categories which lead towards the vulnerability to relapse. When there is ineffectual coping responses it decreases the preventions of the relapse and on the other hand it increase the chances of substance use again.

Addictive disorders are persistent and relapse in its nature. It has been reported that two thirds of the patients get relapse within a week or a month after getting the treatment (Paliwal, Hyman & Sinha, 2008). In many of the illicit drug abuse about 85% of the individuals relapse and indulge themselves in it with in 1 year of treatment (Brandon, Vidrin & Litvin, 2007). In Yale University- affiliated addictive treatment facility in the New Haven,

some patients were discharged. According to their urine toxicology screening it was reported that less than 35% of the individuals remained in sobriety after having the course of 1 year of treatment programme (Dodge, Sindelar & Sinha, 2005). The findings highlights the factors which are behind the relapse and explore more advance treatment to control the risk of the relapse.

Many treatments have proved that there are many psychological withdrawal symptoms like irritability, sleep disturbance and cognitive problems. Major problems are withdrawal phase in cocaine, heroin and alcoholic (Sinha, 2008). The findings of the same study specify that drug dependency is risky and in result, unsatisfactory outcomes of the treatment. Many studies also reported that the stress and catastrophes, tragedies are also associated with the substance relapse (Hyman & Sinha et al., 2008). Some other factors are being associated with the relapse are depressive symptoms. Higher depression leads to relapse and less resistance. In higher craving of drugs gets higher during self-discipline there are more chances to relapse (Epistein et al., 2010).

Genetic factors have close relationship with the relapse. It has been seen in the opiate users. Some individuals also develop nicotine dependency. Goldstein (1978) suggested that the deficiency of endorphin is inherited. If people with this deficiency use narcotics are suffer euphorogenic, leads them to use opiates and it becomes difficult to stay in sobriety. It has been estimated that when the siblings are suffering from addiction the other siblings also have the risk of getting into addiction. According to a research about 40-80% in men and 20-30% in females belonging to the family where their siblings are addictive get drug use as compared to general population who has risk of getting into addiction for about 10-15% (Han, McGue & Iacono, 1999). Genetic researches has concluded in twin and adoption studies that addiction and relapse are 50% due to heritable risk into genes and 50% due to environmental factors (Li, Cheng, Ma & Swan, 2003; Ball, 2008).

The genetic theory also postulates that biochemical abnormality make the individual vulnerable to use drug. Certain abnormality are under study, some individuals with family history of using alcohols has been identified (Schuckit & Duby 1982). When they take alcohols, in response they have more facial flushing as compared to those group of individuals who had no history of family alcoholism. Wilker (1973) explained about the theory of conditioning with the addictions and withdrawals. According to Wilker, there is a relationship between environmental and social stimuli with withdrawal. The study of the individual drug is considered as conditioned stimuli with the conditioned withdrawal. In a case study by Sideroff and Jarvik (1980), there were 8 patients who completed the 14 days of detoxification. They were shown the film clip in which some people were preparing the injection filled with the heroin and were ready to inject. Those patients who watching clip suffered from high level of anxiety, depression, increase hear rate and drug craving as compared to control group. So those researchers considered the environment, emotional stimuli and psychological changes lead to conditioned withdrawal.

Social learning theory is basically focusing on the cognition for the development and maintenance of the behaviour. It focuses on the cognitive process which is being associated between stimulus and the behaviour. It has 3 important factors. First the individual explores with the higher chances of risk during vulnerability, second the individual has a doubt to tackle with the situation without using drugs and third the individual has less coping strategies to deal with the situations which are of high risk. It has been demonstrated that individuals use drugs after encountering higher risk situation leads the person for the feelings of guilt and unsuccessful person or a failure. He enforce to indulge into more drug use. According to Bandura (1978) when the person feels that has no ability to control on himself for the drug use, it decreases the self-efficacy and over react with the traumatic situations.

The Marlatt and Gordaon (1980) presented abstinence violation effect (AVE) which has two main points. One is cognitive dissonance (having a self-image as a nonuser which conflicts with the actual substance-using behaviour) and second is the personal contribution, considering it as a crime as a symptoms of the extreme failure and a person with weakness. These two lead the person to be involved in drug usage again. Social learning theory develop the relapse prevention to identify the higher risk situations. It helps to increase the self-efficacy within the person and also enhancing the skills and coping strategies. Those skills polished to deal with the higher risk situations. Cognitive restructuring developed which help the patient to avoid failure and feelings of guilt as well as learning the new ways to deal with the high risk situations and to prevent relapse. It has been viewed that addiction also the cause of the psychopathology. It was observed that many individuals who were indulge in the drug also showed some behaviours which matched some criteria's of the DSM such as personality disorders. Many alcoholics showed the symptoms of anxiety. It was difficult to understand that whether the personality traits make the individual an alcohols addiction. It was reported that no evidence of psychiatric problem was taken out of those men who later became alcoholic when they were compared to control populations. It has been suggested that sometimes the addicted individual is taking drug as self-medication in order to control psychopathology. If the psychopathology treats well the drug dependency is disappeared. While rehabilitation psychopathology is controlled and somehow resolved but if there is relapse of drug usage. The psychopathology like depression, anxiety are secondary of drug use and treats with the help of medications like depression is caused by using cocaine. (Gawin & Kleber 1985, Smith & Wesson 1985).

According to Goffman (1963), the stigma as an dishonour which spoils the person and ignore others. The important part of the Goffmans definition is the dishonour but the stigma is being focusing on social frame more. According to Herek (2009), Stigma is defined as something which is inferior, pessimistic, worthless and these attribution are given to the people who belongs to specific group by the society. People who are being stigmatized has to interact with the people and live within these societies with an expectation that they are going to be rejected

due to stigma that has been labeled on them and status (Meyer 2003). This rejection and pessimistic expectation from the society develops a mental burden in their mind that lead to more stress.

For example, Herek defines stigma as "the negative regard, inferior status, and relative powerlessness that society collectively accords to people who possess a particular characteristic or belong to a particular group or category" (Herek, 2009; p. 441). It has been proposed by Flanagan (2013) that an individual addicted due to a shame condition that one person puts on it. The person who is being addicted considered him-self a failure, having low standard of living and a feeling of shame. According to Flanagan there is a connection between the shame condition and the person perceived inability to cope with the situations. But there wider connection between the stigma which is attributed by the people and the people who are indulge in addiction. He also mentioned that it is not only the person own stigma but the one which is attributed by the society as well. He stated 'addiction is in which actually a person in a particular social world disorder.'

Stereotype breaks the moral support for the people who are involved in addiction causing to be relapsing again. Moreover the negative stereotype includes rejection but it creates a question that whether this rejection is fair or not. The people mostly who has power or authority in the society can be more successful in making the opinions about certain kind of group specially the addicts. These negative stereotypes are being associated with the public stigmatization that they give towards the people of addicts. The way addict is stigmatizing himself is something noticeable (Lloyd, 2013; Luoma et al., 2007). It is due to negative stereotype, low self-efficacy and most importantly the pessimistic image created by the society. This image makes the person to eliminate himself from the social interaction like not doing jobs, not taking responsibility and looking himself worthless. All these factors influence a addicted person, they started using drugs to cope with the stigma and decrease the pessimistic feelings which are being caused by the shame and public opinion.

The drug abusers have negative self-image which is to them by the society. The feelings of the guilt are irritable for them, In order to avoid those feelings they indulge themselves with more substance dependency as they are unable to improve their lifestyle of living making them to feel guiltier and hate. Shame is one of the factors to use substance again. There is a strong relation of negative self-image and substance use age along with guilt. It encourages them to be more dependent on substances. The stigmatization of the public has a connection with the harsh criticism which creates the pessimistic stereotype and in result it twist and turn the positive behaviours into negative one. Many of the participants of the study claim that the stigma of the people has an effect which includes that they are being influenced to use substances in order to avoid and remove the feelings of guilt. There is need of changes in the policy and programmes which are specially made for the substance abusers so that the behaviours and attitude can be changed towards substance addicts, their life and the way they are interacting with the society (Patterson & Keefe 2008).

Stigma is protective shield for the non-users drug. But once the person is being indulged into this life of addicts then recovery chances decreased. A drug abuser is considered as a person who has no ability to control on his own impulses. A lot of effort was put to educate the public but this misperception was never decreased rather it was increased according to a survey in 1996 and 2006 (Pescosolido, Phelan & Link, 2010). The increasing stereotype, blame, stigma and negative attitude of people towards drug abusers also became a factor due to which the drug abusers avoid the way and a path where they could get treatment and recovery (McGinty, Goldman, Pescosolido & Barry CL, 2015). Boekel et al. (2013) that there is presence of pessimistic attitude of the health professionals with substance users. Cumming et al (2016) shows due to stigma that create hurdle in treating the methamphetamine. Moos (2005) found that those drug users who are taking treatment end up with more worse situation and also stigma is the main factor that decline the several treatment programmes.

According to Folkman and Lazarus (1998), a person having healthy terms with the family members and friends are more strong when they encounter with the harshness of their lives and they have the strategies to deal with the hurdles of life more effectively. They go through the optimistic experiences and healthy outcomes. Social support develops in the family members and then from the friends circle. It is also defined as acquiring and accepting the affection, favour and care of the people (Cohen & Wills, 1985; Shumaker & Brownell, 1984).

While in treating the addiction relapse is the main issue which the drug abuser faces (Nielsen et al, 2012. It has been reported that almost 90% of the substance abuser experienced relapse after the treatment within an year (Naderi et al 2008). In the addiction many factors like psychological, biological and social phenomena are playing a key role. But the social factor is the main one which is contributing in relapse and its continuation. One of the factors is family emotional response and their support. When the family gives the optimistic emotional response that indicates the support, the strength of relationship between the patient and the family (Marom 2005). The way family is responding towards the disease, treatment and post treatment has a greater effect on the vulnerability. The inappropriate and lack of conversation with the family members, and lack of compatibility between the spouse and lack of understanding with the children even with the married one are considered the key factors for the relapse. But the family response towards the patient and their affect are not the centre of attention. The important factor is the social support which is not provided by the professional but the informal groups of the patient and other relationship (Cohen, Gottlieb & Underwood, 2000).

Many studies have shown the role of social support in maintain the abstinence and relapse as well. Blume et al. (1994) stated that the role of family support effects on the treatment and therapy of the patient and also in maintaining the sobriety of the patient in order to prevent relapse. Perceived social support is a kind of shelter that help in preventing the relapse and increases the psychological well-being (Dodge & Potocky, 2000). Richardson

(1999) suggested that after the process of detoxification the support of the family can prolong the sobriety of the patients. Davis and Jason (2005) shows a positive significance between the long duration of abstinence and the social support. When the patient knows that there is presence of social support it can improve their psychological well-being, their functioning and the process of psychotherapy (Chong & Lopez, 2005).

Ellis et al (2004) highlighted that the effect of social support on the relapse of the substance addicts. When the family shows high level of pessimistic emotions, it creates a burden on the patient which makes the person to relapse and get back to the repugnant lifestyle. The stress and pressure on the cognition is caused by the family creates a pessimism which makes the person to be in state of relapse. The studies also proved that there is significant negative relationship between the social support from family, friends and others with the relapse. It means when there is lack of social support from family, peers and others there would be increases chances of relapse vulnerability.

Dodge and Potocky (2000), reflected the effect of social support increase the mental health of the people. It has been suggested that the presence of social support and their web expand the positive treatment programmes for the substance abusers and the relapse anticipation. The absence of the social networks like family, peers and significant others lead them towards relapse and substance usage. When the person is being involved in drug use, feels aloof, isolated and developing support system help them to avoid substance dependency. Whenever the patient will decide to quit he feels he has a support system and developing other chances can motivate the person to change their life style. On the other hand if social support system would be decreased they may eventually relapse.

Relapse is not always be the result of craving for the substance or lack of encouragement but it has also a direct relation with the resentment and to have a position in a society as a normal citizen. The problem that drug abuser faces that they are not get the chance to be part of the society again once they entered into the culture of substance users. In result they feel as a socially excluded citizen. Most of the time when they recovered from the drug rehabs they need for the support and morality from their families, peers and others but unfortunately they face the barrier and get separated from the society.

LITERATURE REVIEW

Relapse is a recurrent process which is increasing among drug abusers (Mishra & Ressler, 2000). The substance abusers experience these repetitive experiences while they are in the process of recovery (Scott, Foss, & Dennis, 2005). It has been estimated that 40-60% people when they enter into the culture of substances they do relapse (Fisher & Harrison, 2005; McLellan et al., 2000; NIDA, 2009). A longitudinal study was conducted in which in which 1271 abusers were receiving the treatment, over the period of different time they receive the treatment again before they pass an year without relapse (Dennis et al., 2005).

Hser & Anglin (2007) conducted a study on the heroin addicts for about 33 years and it was reported that 60% of the abusers continued to take the heroin regularly during that period of time. Relapse is the issues which were faced by the abuses and those keys and factors which are associated with it need to be discovered. Many studies have also indicated that 50-70% of the drug abusers are not able to remain in sobriety in the first year of their treatment (O'Brien & McLellan, 1996).

Stigma is that layers which comes in the pathway of treatment and recovery. Unfortunately people with drug abuse face many labelling, rejection and discrimination. It is also reported that drug abusers are offered less help as compared to those who are suffering from mental illness and any physical abnormality (Corrigan, Kuwabara, O' Shaughnessy, 2009). According to a study Stigma is the main factor which is not only given be the non-substance users but also by the physicians as well (McLaughlin & Long, 1996). Due to this factor it becomes difficult for the substance abusers to get the treatment (Luoma, Padilla & Fisher, 2007). A study revealed that that most of the people in the U.S has pessimistic opinion towards the people with substance users; they considered them as people who are slow and have no bright future (Blendon & Young, 1998). It was also studied that people who use the substances other than alcohol get more public stigma, (Crisp & Rowlands, 2000). Cunningham, Sobell, and Chow (1993) identified that there was increase in public stigma towards the people who used cocaine.

Research has identified that stigmatization among substance addicts are higher as compared to mental illness (Corrigan, Kuwabara, & O'Shaughnessy, 2009; Crisp, Gelder, Goddard, & Meltzer, 2005; Singleton, 2010). Also a substance makes the person to have much craving to be socially isolated and away from the society as compared to obesity and smoking (Phillips & Shaw, 2013). One of the study conducted by World Health Organization across in which locals were asked to give rating to 18 different conditions regarding rejection or stigma, among that all alcoholism and use of the substances were rated at the top of the list **(**Room, Rehm, Paglia, & Ustun, 2001). In most of the countries substances and alcohol was considered something shabby and untidy and even have the evidence to be involved in theft.

Lucht et al. (2011) reported that six different studies identified that drug users seems to be more rejected and socially away as compared to the people who are suffering from schizophrenia and depression. In 1996 there was a survey in U.S which showed that the substance users are getting more social rejection and considered to be in highest rank (Link, Phelan, Bresnahan, Stueve, & Pescosolido, 1999). Unfortunately the follow up of the same survey in 2006 showed no changes in the ranking (Pescosolido et al., 2010; Schnittker, 2008). Six different studies have been conducted from U.S, Britain and Australia and it has identified that smokers, substance users also get

less attention in health care departments (Olsen, Richardson, Dolan, & Menzel, 2003). It shows that stigma is something which not only given by the non-substance users but also by the health care professionals who are responsible to provide care to such people (Stacey, & Dohan, 2008; McCreaddie et al., 2010; Merrill, Rhodes, Deyo, Marlatt, & Bradley, 2002). It is also studied in which methamphetamine users faced greater stigma because they were under the treatment before and were relapse as compared to those people who never took any kind of treatment (Semple et al. 2005). It shows that greater the stigma the higher chances would be of relapse vulnerability.

Social support the conflict that have a greater contribution in the process of relapse and recovery (Moos & Moos, 2007). Chong and Lopez (2008) did research on 346 American Indian Women after their treatment to analyse their relapse. Social conflict was the factor which contributed in their relapse. It was also reported that the conflicts between the substance abusers and the family conflict increases the chances to be indulge in substance use (Chong & Lopez, 2008). It has been investigated that people who had social pessimistic environment had three times more chances to be vulnerable for the relapse and to use the substance of cocaine and 2.5 times to use alcohol after treatment (Broome et al. 2002). Marlatt (1985c) reported that 16% chances are present for the relapse due to social conflict.

Social support can reduce the chances of relapse. A study in Hong Kong revealed that social support is the key factor that can reduces the relapse and can effective recovery (Cheung et al., 2003). It was suggested that social support is the factor that can work as a shield to better the life style of substance abusers and in the process of recovery. It can also play a role in sobriety (Laudet et al., 2006; Beattie & Longabaugh, 1999). Hunter-Reel, McCrady, & Hildebrandt (2009) analyse the research on social support with relapse. It was noted that in substance abusers there is a strong link between the social support and the relapse. Social support can reduce many withdrawal symptoms like craving, coping with the stress and low self-esteem.

McMahon (2001) followed those men who had taken the treatment for cocaine with 12 months follows up after treatment. McMahon divided the groups into two; relapses and non-addicted. The result showed that the individuals who had more stressful life events and decreased social support and fewer members who were supporting for them had more relapse in their follow up as compared to the other group who had high level of social support. McMahon further analyzed that some members were those in the non-relapses who reported the high level of social support in their environment as compared to the 'relapses' they reported no difference in social support in their follow up.

Havassy et al. (1995) investigated that individuals who completed the course of treatment of cocaine they remained in sobriety for 12 weeks and 6 months due to social support and in their follow up they remained rehabilitation because of the perceived social support. It was also reported that low social support had more chances to relapse even if the mood of the abusers is controlled. Rhoads (1983) reported that drug abusers of heroin received the social support which ultimately increases the chances of recovery with the time. In a study of Herman et al. (2000), the patients were diagnosed with substance use and mental illness. They found that individuals who had intent to remain sober and had no family support had more chances to relapse and use the substances in their 18 months follow up as compared to those people who had high level of family support showed less use of substance in their 18 months post treatment. The results showed that there is a significant relationship between the perceived social support and rate of using the substances in their 18 months follow up.

The present study is supposed to investigate the effect of stigma and lack of social support. The study also analyze that their correlation with each other. It provides the evidence that perceived stigma and social support has greater effect on the relapse vulnerability and interpersonal factors are playing major role in the life style of substance users.

Objectives

The objectives of this study are to:

- To explore the impact of stigmatization on relapse.
- To investigate the social support decreases the chances of relapse among drug addicts.
- To explore social support effect that perceived stigmatization
- To investigate the stigmatization effecting and increasing the chance of relapse.

Hypotheses

There are following hypotheses that are discussed in this study:

1. There is a positive relationship between perceived stigma and relapse vulnerability among substance addicts.
2. There is a negative relationship between the social support and relapse vulnerability among drug addicts.
3. There is higher level of perceived stigma and relapse vulnerability among illiterate and secondary education in drug addicts.
4. There is less social support for drug addicts who have low income.
5. There is high relapse vulnerability among drug addicts belonging to lower income group.
6. There is negative correlation between perceived stigma and social support.
7. High social support predicts lower relapse vulnerability in drug addict
8. Higher social support predicts lower perceived stigma among drug addicts

RESEARCH METHODOLOGY

The research is based on cross sectional survey design. A sample of 188 relapse drug abusers were selected, age ranging from 18 years old and above. The method of purposive sampling was used for collecting the data. The income of the relapse substance addicts were divided into two category; low income group and high income group. The income has been categorized according to the data given by the participants. The income from 15,000 -20,000 was in the category of low income whereas income from 20,000- 40,000+ were in high income group category. Different education levels were selected from illiterate to master's level. The number of relapse were also measured in three category, 1st, 2nd and 3rd. The data was analyzed in SPSS . The alpha reliability of the questionnaire was analyzed. For the complete information of the participants in the demograph, frequency was taken out. To understand the correlation between the variables Pearson correlation was used. For multiple comparisons among the income and level of education ANOVA, post hoc was used. For predicting the association between the variables regression was used to analyz

Inclusion Criteria

The drug users of opiate, cocaine, heroin and marijuana were the part of sample.

Exclusion Criteria

The drug users who had any psychotic symptoms and physiological problems like paralysis and other medical conditions were excluded.

Instruments

A self-made demographic sheet was used to measure the demographics of the participants comprises of age, gender, education, profession, type of substances, duration of addiction, marital status, number of children, accommodation and number of admission in rehab center. The AWARE Questionnaire (Advance Warning of Relapse) is designed to measure the symptoms of the relapse. It was designed by Miller and Gorshi (1982). The original scale has 37 items but later researchers recreate it and it has now 28 items scale which was developed by Miller and Haris (2000). This scale is used to know the vulnerability of the relapse in substance users. It's a self-report questionnaire. The scale ranges from 0-7. Only certain items have reverse scoring which are item no 8, 14, 20, 24 and 26. The scale was taken in Urdu version from Punjab University Lahore. It was translated by Rafique and Nashee (2011). The reliability of the scale is .42.

Multidimensional Scale of Perceived Social Support (MSPSS)

This scale was developed by Zimet, Dahlem, Zimet and Farley in 1988. The scale of 12 items used to measure the perception of support. The items are divided into three groups that can be under the category of social support groups, namely family (Fam), friends (Fri) or significant other (SO). Item no 1,2,5,and 10 related to SO, items number 3,4,8,11 for the family and item number 6,7,9,12 are for the friends. It's a 7 point Likert scale ranging from 1 (very strongly disagree) to 7 (very strongly agree). The scale was used in urdu version from Punjab university Lahore. It was translated by Kausar & Zafar (2011). The alpha reliability of the scale is .93.

Perceived Stigma of Substance Abuse Scale (PSAS)

This scale was developed by Link, Struening, Rahav, Phelan, & Nuttbrock. (2010). It contains a 4 point Likert scale ranging from 1 (strongly disagree) to 4 (Strongly agree). This scale has 8 items which measured the stigma related to substance users. Some of its items have reverse scoring and they are item number 1,2,3,4,6 and 8. The scale was used in urdu version from Punjab university Lahore. It was translated by Kousar, Mushtaq & Ijaz (2011). The alpha reliability of the scale is .73.

Procedure

188 relapse patients were selected for the study through convenient sampling Emaan Clinic, Wada Clinic, Institute of rehabilitation and drug addiction (IRADA), Mind Care Rehabilitation Center, Devotion Center, Islamic Medical Caring House, House of wellness and Najjat trust present in different areas of Islamabad and Rawalpindi. The participants were briefly informed about the study and their consent was taken through an informed consent form along with their signature. The necessary instructions were given to them before handling the questionnaire to them. The demographics sheet and the questionnaire were in Urdu Version for their better understanding. The questionnaire was taken in Urdu version from the Punjab University Lahore. When the participant completed their questionnaire it was taken from them. In case of any question, it was answered in order to clear their quarries and satisfied them. Those who were illiterate, they were helped in understanding the questionnaire and making their answers. After collecting the data, the result was analyzed in SPSS (Statistical Package of Social Sciences).

RESULTS

Table 1. *Descriptive Statistics and Alpha Reliability Coefficients for Perceived Stigma, Social Support and Relapse Scales (N = 188)*

		Range					

Variables	*Item*	Actual	Potential	*M*	*SD*	*α*	Skew	Kurtosis
Perceived stigma	08	11-42	8-32	21.17	6.38	.91	.80	1.94
Social support	12	26-60	12-78	47.02	7.70	.75	-.34	-.17
Friends support	04	6-20	4-28	14.63	3.89	.86	-.62	-.69
Family support	04	9-20	4-28	16.42	2.26	.84	-.74	.87
Significant others	04	7-27	4-28	15.96	2.89	.68	-.38	1.56
Relapse	28	28-183	28-196	56.60	22.44	.73	.80	8.73

Table 1 shows descriptive statistics and alpha reliability coefficients for perceived stigma, social support, and relapse. Results show that all scales have satisfactory level of alpha reliability and therefore used for further hypotheses testing. The descriptive statistics indicate that participants reported a moderate level of perceived stigma (M = 21.17, SD = 6.38) and a relatively high level of social support (M = 47.02, SD = 7.70). Among the dimensions of social support, family support showed the highest mean score (M = 16.42, SD = 2.26), followed by significant others support (M = 15.96, SD = 2.89) and friends support (M = 14.63, SD = 3.89), suggesting that family members were the primary source of support for participants. The relapse variable demonstrated the highest mean score (M = 56.60, SD = 22.44) and the greatest variability, indicating substantial differences in relapse experiences among participants. Reliability analyses showed acceptable to excellent internal consistency for all scales, with Cronbach's alpha values ranging from .68 to .91. Furthermore, skewness values ranged from −.74 to .80, indicating no serious departures from normality. Kurtosis values were also within acceptable limits for most variables, although relapse exhibited a relatively high kurtosis value (8.73), suggesting a more peaked distribution and the possible presence of extreme scores.

Table 2. *Pearson Correlation between Perceived Stigma and Social Support with Relapse (N = 188)*

Variables	1	2	3	4	5	6
1. Perceived stigma	---	-.47**	-.42**	-.44**	-.34**	.32**
2. Social support		---	.90**	.78**	.83**	-.26**
3. Friends support			---	.57**	.60**	-.25**
4. Family support				---	.52**	-.39**
5. Significant others support					---	-.04
6. Relapse						---

***p*< .01

Table 2 shows Pearson correlation analysis revealed significant relationships among perceived stigma, social support, and relapse. Perceived stigma was significantly and negatively correlated with overall social support (r = −.47, p < .01), friends support (r = −.42, p < .01), family support (r = −.44, p < .01), and support from significant others (r = −.34, p < .01), indicating that individuals experiencing higher levels of stigma tended to report lower levels of social support. Perceived stigma also showed a significant positive correlation with relapse (r = .32, p < .01), suggesting that greater perceived stigma was associated with higher relapse levels. Overall social support was significantly and negatively related to relapse (r = −.26, p < .01), indicating that greater social support was associated with lower relapse. Similarly, friends support (r = −.25, p < .01) and family support (r = −.39, p < .01) were significantly negatively correlated with relapse, with family support demonstrating the strongest protective association. However, support from significant others was not significantly related to relapse (r = −.04, p > .05). Furthermore, the dimensions of social support were positively and significantly intercorrelated (r = .52 to .90, p < .01), indicating that individuals who perceived greater support from one source were also likely to perceive greater support from other sources. Therefore the 1st hypothesis "there is be positive relationship between perceived stigma and relapse" and 2nd hypothesis "there is be negative relationship between social support and relapse" were supported by results.

Table 3. *Differences on the Basis of Level of Education in Perceived Stigma and Social Support and Relapse (N = 188)*

	Illiterate (*n* = 65)		Matric (*n* = 48)		Intermediate (*n* = 35)		Graduation (*n* = 22)		Masters (*n* = 18)			
Variables	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*F*	*p*

Perceived stigma	22.09	6.52	23.25	7.08	19.45	4.80	19.22	5.10	18.05	5.88	4.07	.00
Social support	46.47	7.81	44.02	7.72	49.91	6.74	48.18	6.63	50.00	7.54	4.20	.00
Friends support	14.33	4.18	13.39	4.12	15.60	3.63	15.68	2.74	15.88	3.00	2.80	.02
Family support	16.35	2.25	15.75	2.26	17.14	2.21	16.27	2.18	17.22	2.10	2.62	.03
Significant others	15.78	2.80	14.87	3.05	17.17	2.62	16.22	2.54	16.88	2.76	4.02	.00
Relapse	57.46	19.41	56.02	20.56	56.11	25.69	63.00	32.87	48.16	12.83	1.12	.34

Table 3 shows one-way ANOVA was conducted to examine differences in perceived stigma, social support, and relapse across educational levels. The results indicated significant differences in perceived stigma among the education groups, $F(4, 183) = 4.07$, $p < .001$, with illiterate and matric participants reporting higher levels of stigma than those with higher educational attainment. Significant differences were also observed for overall social support, $F(4, 183) = 4.20$, $p < .001$, suggesting that participants with intermediate, graduation, and master's level education perceived greater social support than those with lower levels of education. Similarly, significant differences emerged for friends support, $F(4, 183) = 2.80$, $p = .02$, family support, $F(4, 183) = 2.62$, $p = .03$, and support from significant others, $F(4, 183) = 4.02$, $p < .001$, indicating that higher educational attainment was generally associated with greater perceived support across different sources. In contrast, relapse did not differ significantly across education levels, $F(4, 183) = 1.12$, $p = .34$, suggesting that educational attainment was not significantly associated with relapse among the participants. Moreover, multiple comparisons have been investigated through post hoc test.

Table 4. *Post Hoc Test to Investigate Multiple Comparisons among Study Variables (N = 188)*

Dependent Variable	**(I) Education**	**(J) Education**	***MD* (I-J)**	***SE***	***P***	**95% CI**	
						LL	***UL***
Perceived stigma	Intermediate	Illiterate	1.15	1.19	.86	-2.08	4.40
		Matric	5.19*	1.37	.05	.00	7.58
		Graduation	4.02	1.59	.08	-.36	8.41
		Masters/Diploma	3.79*	1.70	.02	.48	9.90
Social support	Intermediate	Illiterate	3.43	1.56	.18	-.86	7.74
		Matric	5.89*	1.65	.00	1.33	10.45
		Graduation	1.73	2.02	.91	-3.85	7.31
		Masters/Diploma	-.08	2.16	1.00	-6.03	5.86
Family support	Intermediate	Illiterate	.78	.46	.44	-.49	2.07
		Matric	1.39*	.49	.04	.02	2.75
		Graduation	.87	.60	.60	-.80	2.54
		Masters/Diploma	-.07	.64	1.00	-1.86	1.70
Significant others	Intermediate	Illiterate	1.38	.58	.13	-.23	3.00
		Matric	2.29*	.62	.00	.57	4.01
		Graduation	.94	.76	.73	-1.16	3.05
		Masters/Diploma	.28	.81	.99	-1.96	2.52

Table 4 shows Post hoc multiple comparison analyses were conducted to identify specific educational groups that differed significantly on perceived stigma and social support variables. For perceived stigma, participants with

intermediate education reported significantly lower stigma than those with matric education (MD = 5.19, $p = .05$) and masters/diploma education (MD = 3.79, $p = .02$), while differences with illiterate and graduation groups were not statistically significant. Regarding social support, the intermediate group reported significantly higher social support than the matric group (MD = 5.89, $p < .001$), whereas comparisons with the illiterate, graduation, and masters/diploma groups were non-significant. Similarly, for family support, participants with intermediate education scored significantly higher than those with matric education (MD = 1.39, $p = .04$), with no significant differences observed between the remaining educational groups. For support from significant others, the intermediate group again demonstrated significantly higher scores than the matric group (MD = 2.29, $p < .001$), while all other pairwise comparisons were non-significant. Therefore the third hypothesis "there will be higher level of perceived stigma and relapse vulnerability among less educated people" was partially supported by results.

Table 5. *Differences on the Basis of Income in Perceived Stigma and Social Support and Relapse (N = 188)*

	15000 rupees (*n* = 80)		**20000 rupees (*n* = 37)**		**30000 rupees (*n* = 39)**		**More than 40000 (*n* = 32)**			
Variables	***M***	***SD***	***M***	***SD***	***M***	***SD***	***M***	***SD***	***F***	***p***
Perceived stigma	20.13	6.24	20.64	5.70	23.27	7.01	27.23	7.47	5.74	.00
Social support	47.68	8.50	47.28	7.23	46.88	6.75	42.07	6.77	2.01	.11
Friends support	14.50	4.16	15.01	3.60	14.72	3.62	12.61	4.62	1.48	.22
Family support	16.81	2.48	16.40	2.08	16.38	1.78	14.53	2.25	3.82	.01
Significant others	16.36	3.00	15.86	2.56	15.77	2.79	14.92	4.38	1.03	.37
Relapse	48.69	18.10	52.61	11.85	73.72	20.92	100.92	36.96	38.61	.00

Table 5 shows one-way ANOVA was conducted to examine differences in perceived stigma, social support, and relapse across income groups. The results revealed significant differences in perceived stigma, $F(3, 184) = 5.74$, $p < .001$, indicating that participants with higher income levels, particularly those earning more than 40,000 rupees, reported greater perceived stigma than those in lower-income groups. Significant differences were also found for family support, $F(3, 184) = 3.82$, $p = .01$, with participants in the lowest income group (15,000 rupees) reporting higher family support compared to those earning more than 40,000 rupees. In contrast, no significant income-based differences were observed for overall social support, $F(3, 184) = 2.01$, $p = .11$, friends support, $F(3, 184) = 1.48$, $p = .22$, or support from significant others, $F(3, 184) = 1.03$, $p = .37$. A highly significant difference was found for relapse, $F(3, 184) = 38.61$, $p < .001$, with relapse scores increasing substantially across income categories, from a mean of 48.69 among participants earning 15,000 rupees to 100.92 among those earning more than 40,000 rupees.

Table 6. *Post Hoc Test to Investigate Multiple Comparisons among Study Variables (N = 188)*

Dependent Variable	(I) Income	(J) Income	*MD* (I-J)	*SE*	*p*	95% CI	
						LL	*UL*
Perceived stigma	15,000	20,00	-.51	.99	.95	-3.09	2.06
		30,000	-3.14	1.63	.22	-7.38	1.10
		More than 40,000	-7.09*	1.86	.00	-11.93	-2.25
	20,00	15,000	.51	.99	.95	-2.06	3.09
		30,000	-2.62	1.58	.35	-6.74	1.48
		More than 40,000	-6.58*	1.82	.00	-11.31	-1.85
	30,000	15,000	3.14	1.63	.22	-1.10	7.38
		20,00	2.62	1.58	.35	-1.48	6.74
		More than 40,000	-3.95	2.24	.29	-9.76	1.85
	More than 40,000	15,000	7.09*	1.86	.00	2.25	11.93
		20,00	6.58*	1.82	.00	1.85	11.31
		30,000	3.95	2.24	.29	-1.85	9.76
Family support	15,000	20,00	.41	.35	.66	-.51	1.34
		30,000	.42	.58	.88	-1.09	1.95
		More than 40,000	2.27*	.67	.00	.53	4.02
	20,00	15,000	-.41	.35	.66	-1.34	.51
		30,000	.01	.57	1.00	-1.46	1.50
		More than 40,000	1.86*	.65	.02	.16	3.57
	30,000	15,000	-.42	.58	.88	-1.95	1.09

		20,00	-.01	.57	1.00	-1.50	1.46
		More than 40,000	1.85	.80	.10	-.24	3.94
	More than 40,000	15,000	-2.27*	.67	.00	-4.02	-.53
		20,00	-1.86*	.65	.02	-3.57	-.16
		30,000	-1.85	.80	.10	-3.94	.24
Relapse	15,000	20,00	-3.91	2.86	.52	-11.34	3.51
		30,000	-25.02*	4.71	.00	-37.24	-12.80
		More than 40,000	-52.22*	5.37	.00	-66.16	-38.28
	20,00	15,000	3.91	2.86	.52	-3.51	11.34
		30,000	-21.10*	4.57	.00	-32.95	-9.25
		More than 40,000	-48.30*	5.25	.00	-61.93	-34.68
	30,000	15,000	25.02*	4.71	.00	12.80	37.24
		20,00	21.10*	4.57	.00	9.25	32.95
		More than 40,000	-27.20*	6.45	.00	-43.92	-10.47
	More than 40,000	15,000	52.22*	5.37	.00	38.28	66.16
		20,00	48.30*	5.25	.00	34.68	61.93
		30,000	27.20*	6.45	.00	10.47	43.92

Table 6 shows Post hoc multiple comparison analyses were performed to determine which income groups differed significantly on perceived stigma, family support, and relapse. For perceived stigma, participants earning more than 40,000 rupees reported significantly higher stigma than those earning 15,000 rupees (MD = 7.09, $p < .001$) and 20,000 rupees (MD = 6.58, $p < .001$), while no significant differences were found between the remaining income groups. Regarding family support, participants earning 15,000 rupees reported significantly higher family support than those earning more than 40,000 rupees (MD = 2.27, $p < .001$), and participants earning 20,000 rupees also reported significantly greater family support than the highest-income group (MD = 1.86, $p = .02$). No other pairwise differences were statistically significant. For relapse, substantial differences were observed across income groups. Participants earning 15,000 and 20,000 rupees reported significantly lower relapse scores than those earning 30,000 rupees and more than 40,000 rupees ($p < .001$). In addition, the 30,000-rupee group reported significantly lower relapse than the more than 40,000-rupee group (MD = -27.20, $p < .001$). The fourth hypothesis "There will be less social support for people with less income" was partially supported as results were significant only on family support. Moreover, the fifth hypothesis "There will be high relapse vulnerability among people belonging to lower income group" was also accepted by current findings as individuals with income of 15000 rupees were higher on relapse vulnerability.

Table 7. *Regression Analysis of the high social support predicting low relapse vulnerability among drug addicts (N = 188)*

		95%CI	
Variables	**B**	**LL**	**UL**
Constant	92.25	[72.8	111.6]
Social Support	-.76	[-1.16	-.351]
R^2	.68		
F	13.51		

Note B- coefficient of regression, CI- Confidence Interval, LL- Lower limit, UL-Upper Limit

Table 7 shows simple linear regression analysis was conducted to examine whether social support predicts relapse vulnerability among drug addicts. The results indicated that social support significantly and negatively predicted relapse vulnerability ($B = -0.76$, 95% CI [−1.16, −0.35]). The negative regression coefficient suggests that for every one-unit increase in social support, relapse vulnerability decreases by approximately 0.76 units. The confidence interval did not include zero, further confirming the statistical significance of the relationship. The regression model was statistically significant, $F = 13.51$, indicating that social support contributes meaningfully to the prediction of relapse vulnerability. The coefficient of determination ($R^2 = .68$) suggests that approximately 68% of the variance in relapse vulnerability was explained by social support.

Table 8. *Regression Analysis of Higher social support predicts lower perceived stigma among drug addicts (N=188)*

			CI

Variables	B		LL	UL
Constant	39.60		[34.56	44.6]
Social Support	-.40		[-.498	-.286]
R^2		.23		
F		53.50		

Note B- coefficient of regression, CI- Confidence Interval, LL- Lower limit, UL-Upper Limit

Table 8 shows simple linear regression analysis was conducted to examine whether social support predicts perceived stigma among drug addicts. The results revealed that social support significantly and negatively predicted perceived stigma ($B = -0.40$, 95% CI [−0.498, −0.286]). The negative regression coefficient indicates that an increase of one unit in social support is associated with a decrease of approximately 0.40 units in perceived stigma. The confidence interval does not include zero, confirming the statistical significance of the predictor. The regression model was statistically significant, $F = 53.50$, demonstrating that social support made a meaningful contribution to explaining variations in perceived stigma. The coefficient of determination ($R^2 = .23$) indicates that 23% of the variance in perceived stigma was explained by social support.

DISCUSSION

The findings of the present study supported the hypothesis that perceived stigma is positively associated with relapse vulnerability among substance addicts. Consistent with previous research, individuals who experience higher levels of stigma are more likely to face discrimination, rejection, reduced self-esteem, and lower self-efficacy, all of which can hinder recovery and increase the likelihood of relapse (Schomerus et al., 2011; Luoma et al., 2007; Luoma et al., 2010). Studies have also shown that stigma discourages treatment-seeking behavior and contributes to negative recovery outcomes among substance users (Livingston et al., 2012; Room & Reuter, 2012). Although stigma may deter initial substance use among non-users, it often becomes a barrier to recovery once addiction develops (Palomar et al., 2012). These findings are particularly relevant in Pakistan, where substance use remains a growing concern, with cannabis and poly-substance use reported at substantial levels (Drug Use in Pakistan, 2024).

The study also supported the hypothesis that social support is negatively associated with relapse vulnerability. Consistent with earlier research, higher levels of support from family, friends, and significant others were associated with lower relapse risk (Davis & Jason, 2005; Nashee et al., 2014). Social support plays a critical role in helping individuals cope with withdrawal, maintain abstinence, and manage the psychological stress associated with recovery (Taylor et al., 2007; Lee et al., 2004). Family support, in particular, has been identified as a key protective factor that encourages sustained recovery and reduces the likelihood of relapse (Vinesh et al., 2014). Conversely, negative family attitudes, social rejection, unemployment, relationship conflicts, and community stigma have been reported as major relapse triggers among recovering substance users in Pakistan (Batool et al., 2017). Overall, the findings highlight that reducing stigma and strengthening social support networks are essential components of effective relapse prevention and recovery interventions for individuals with substance use disorders.

In Pakistan, about 4.25 million substance users need to have certain treatment which can modify them in 2011. There is strong presence of stigma which is being attached with addiction in Pakistan, especially on the youngsters whose aged is less than 18 years. Women are more stigmatized if they ask for the treatment and help in rehabilitation centre (Shafiq et al., 2006). Previous studies indicated that protective factors, for example, family support can help the cessation from addiction (Ellis, Bernichon, Yu, Roberts, & Herrell, 2004; Martin-Storey, Serbin, Stack, Ledingham, & Schwartzman, 2011). Additionally, supportive information raises commitment of addicted individuals and in this manner these individuals are more dynamic in stopping addiction than the ones who are not provided such fruitful information (Lemos et al., 2012; Jason, Davis, & Ferrari, 2007; Atkins & Hawdon, 2007). Despite the fact that in numerous studies, social support is considered as a vital factor in the withdrawal of substance dependent individuals, a few scientists, for example, Macdonald et al. (2004) demonstrated that social support isn't generally a powerful indicator of healing steps, and other different conditions may add to the adequacy of social support.

The findings supported the third hypothesis that illiterate and less-educated substance addicts experience higher levels of perceived stigma and relapse vulnerability. Previous research suggests that education enhances awareness and understanding of addiction and mental health issues, thereby reducing stigmatizing beliefs and attitudes (Johnson, 2017; Chan et al., 2009; Lichtenstein & DeCoster, 2014). Educational interventions have also been shown to correct misconceptions about addiction and mental illness, leading to significant reductions in

stigma (Gillespie-Lynch et al., 2015). Therefore, individuals with lower educational attainment may be more vulnerable to stigma due to limited knowledge and awareness regarding substance use disorders.

The fourth hypothesis, proposing that substance addicts with lower income receive less social support, was partially supported, particularly regarding family support. Previous studies indicate that social support plays a crucial role in helping individuals cope with financial and health-related challenges, while family, workplace, and community networks provide essential emotional and practical assistance (Gudbergsson et al., 2009; Taskila et al., 2006). For low-income families, social support serves as an important resource for financial stability and well-being (Edin & Lein, 1997; Henly, 2002). Consequently, financial hardship may limit access to supportive resources and weaken social support systems.

The fifth hypothesis concerning higher relapse vulnerability among lower-income substance addicts was also supported. Earlier studies have highlighted the role of economic stress, unemployment, and limited social support in increasing the risk of substance use and relapse (Dobkin et al., 2002; Lewandowski & Hill, 2009). Financial difficulties often contribute to psychological distress and reduced access to recovery resources, thereby increasing relapse vulnerability (Earnshaw et al., 2013; Harris & McElrath, 2012). These findings underscore the importance of strengthening social support systems and addressing socioeconomic challenges through community-based and public health interventions to reduce relapse risk and improve recovery outcomes (Berkman & Glass, 2000; Macintyre & Ellaway, 2003; Pollack et al., 2002).

In a research it was estimated that 72% of drug abusers were considered as a financial burden and they used to take money from peers and from their families, most of them were parents of their peers (Batool, Mehmood & Sohail, 2017). In a research of Peshawar, Pakistan, it was concluded those who are illiterate had not much awareness of the negative effect of substances. Those people who have high level of education had more awareness about the substance and its effects as compared to lower level of education (Muhammad, 2003; Masudi, 2006). In a same way individuals who had low income also had less awareness about consequences of drug usage (Hanan, 2012). According to that research high level of the income shows that person awareness of the substance use.

The 6th 'hypothesis shows the negative correlation between perceived stigma and social support was also accepted'. As the level of perceived stigma would be increased the level of social support would be decreased. High social support is giving the evidence that the level of perceived stigma is less. As both behaviours and actions are coming from the society. More social support indicating that presence of stigma is less. One of the study estimated that high level of stigma 92% (mean 30.39%, SD 19.46%) were present among participants showing the low level of social support. In the same study more than 50% participants considered stigma as a barrier due to which they couldn't get the treatment. In 17 studies on the substance addicts it was reported that stigma is considered the top reason for the substance addicts for not getting the treatment (Hammarlund, , Crapanzano, ., Luce, , Mulligan, , & Ward, (2018). Studies also revealed that even if the substance abusers had fear of the effect of registering themselves for treatment as it would cause the stigma (Zemore & Greenfield, (2009).

The findings supported the seventh hypothesis that higher social support predicts lower relapse vulnerability among substance addicts. Consistent with previous research, individuals who receive greater support from family, friends, and significant others are less likely to relapse during recovery. Gutierres, Russo, and Urbanski (1994) reported that substance-dependent individuals with higher social support experienced significantly lower relapse vulnerability. Similarly, Kothari (2003) emphasized that social support networks, particularly family and close relationships, play a critical role in the recovery process and relapse prevention. Research by Kimangao (2016) further demonstrated that effective social support systems facilitate recovery and substantially reduce the likelihood of relapse among substance users.

The findings also supported the eighth hypothesis that higher social support predicts lower perceived stigma among substance addicts. Strong support from family, friends, and significant others fosters feelings of acceptance, belonging, and positive regard, thereby reducing experiences of stigma. Previous studies have shown that supportive social relationships contribute positively to treatment outcomes and protect individuals from the negative psychological effects of stigmatization (Spoth & Redmond, 1994). Similar findings were reported by Blume, Green, Joanning, and Quinn (1994), who concluded that greater social support is associated with lower perceived stigma and improved recovery outcomes. Overall, the present findings highlight the dual protective role of social support in reducing both relapse vulnerability and perceived stigma among substance addicts.

The social support work like a barrier and fence against the relapse and in results increases the psychological health. Richardon (1999) revealed that the presence of the family support has a long lasting effect of the treatment on the substance addicts. Davis and Jason also mentioned in their study in 2005 that there was a strong bond between the social support and substance resistance.

Limitations

Data was collected only from the areas of Rawalpindi and Islamabad which limits the generalizability of results. The current study is quantitative which only investigated the specific aspects of phenomenon. If another qualitative study will be conducted to investigate how social support and stigma impact on relapse vulnerability and which other causes that also impact on relapse vulnerability among addicts.

Implications

The study has implications for mental health practitioners especially who are working in rehab centers for the betterment of mental health of addictive people. On the basis of these findings suggest that social support is significantly important to reduce the relapse vulnerability among substance addicts in Pakistani culture. Government can devise plan to provide supportive social networks to addictive people and their families. The findings is also helpful for students, academician and researcher for future research on the current phenomenon. This study will help to make such intervention programmes that will help and guide the abusers to deal with the negative feedback. It will construct and focus on family therapy. It will clarify that only the substance abuser does not need the training and counselling but also the family members who go with the depression along with the person. Family therapy gives understanding to the family members that there is requirement of their support and moral help and their optimistic attitude is also the part of the environment.

CONCLUSION

The main objective of the study was to investigate the perceived stigma and social support with relapse among substance addicts. Finding of the study showed that perceived stigma can increase the chance of relapse vulnerability where as social support has a negative relationship with relapse vulnerability. Moreover findings on the demographs showed that perceived stigma was higher among those who are less educated and relapse vulnerability were higher among those substance abusers who belonged to low income families. The main objective of the study was to investigate the perceived stigma and social support with relapse among substance addicts. Findings of the study showed that perceived stigma has significant positive relationship with relapse whereas social support has significant negative relationship with relapse among substance addicts. Moreover findings on demographics showed that perceived stigma was higher in less educated addicts, social support and relapse vulnerability were higher in addicts who belong to less income families.

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