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An examination of stigmatization and family belonging of individuals with substance use disorders

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Abstract

This study aims to examine the relationship between stigmatization and the sense of family belonging among individuals with substance addiction or illicit substance use. The research was conducted on a sample of 351 male participants under probation. The Substance Use Stigma Mechanisms Scale (SU-SMS) and the Family Belonging Scale (FBS) were employed to measure the relevant variables, and a correlation analysis was performed to assess their relationship. The findings indicate a significant negative correlation between participants' sense of family belonging and their experiences of stigmatization. Accordingly, it is crucial that all professionals who serve individuals with substance use disorders and their families should be provided with regular psychosocial support, and they should prioritize socialization processes. By ensuring the continuity of this approach, we are hopeful that prioritizing solution-focused interventions that meet the needs of clients will increase their sense of family belonging and reduce stigma.

Keywords: addiction, family belonging, stigmatization, substance use disorders

Main points

- Stigma negatively impacts the recovery process of individuals with substance use disorders.
- Stigma prevents the individual from socializing.
- Individuals with substance use disorders need to have strong family belonging.
- Minimizing stigma positively affects the improvement of family belonging among individuals with substance use disorders.

Introduction

Addiction is a significant social issue that adversely impacts individuals' social functioning and carries broader societal repercussions. While the medical aspect of addiction should not be overlooked, its social and economic dimensions are equally critical. Without a holistic approach to addressing alcohol and substance use disorders, challenges such as relapses, persistent substance-seeking behaviors, and the failure to implement long-term solutions may arise. Society often perceives individuals struggling with alcohol and substance addiction as the other, reinforcing exclusionary tendencies that categorize and isolate them. One of the primary drivers of this marginalization is stigmatization.

Stigmatization and social alienation of individuals with alcohol and substance use disorders prevent them from fully engaging in social life, leading to adverse psychosocial consequences such as low self-esteem, depression, feelings of inadequacy, loss of self-confidence, helplessness, social isolation, and loneliness (Sevin & Erbay, 2008). Stigma is commonly categorized into self-stigma, social stigma, and structural stigma (Afyonoğlu et al., 2025). Self-stigma refers to the internalization of negative stereotypes and attitudes, often leading to shame and guilt (Newman & Crowell, 2023). According to Goffman's (2019) conceptualization, individuals involved in the criminal justice system bear a "spoiled identity," reinforcing their exclusion.

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Stigmatization erodes an individual's connection to their family and may increase vulnerability to suicidal tendencies (Şamar et al., 2023; Ünal, 2024). Individuals recovering from alcohol use disorders face challenges across familial, economic, psychological, and social dimensions (Collins et al., 1990; Cukor et al., 2007). Among adults, those unable to contribute economically to their families lose their role as family role models, imposing financial hardships, especially in economically disadvantaged families (Erbay et al., 2016). Coping mechanisms such as spirituality and participation in support groups have been identified as beneficial (Botvin, 2000; DiClemente, 2006).

Protecting individuals with addiction from stigmatization and facilitating their reintegration into society, including strengthening their sense of family belonging, are crucial for recovery (Addiction Research Department, 2020; Ögel, 2020).

Methods

Purpose of the Study

The primary objective of this study is to examine the relationship between stigmatization and family belonging among male drug users and individuals with substance use disorders aged 18 and older who are under probation in accordance with Articles 188, 189, 190, 191, and 192 of the Turkish Penal Code. These articles govern the legal proceedings related to the production, possession, use, import/export, and trade of illicit substances in Türkiye. In line with this primary objective, the study seeks to address the following sub-questions:

1. Is there a relationship between stigma associated with substance use and *family belonging*?
2. Do the mean scores of the *SU-SMS* and its sub-dimensions among substance users vary based on participants' age, whether they receive emotional support from their families, and whether they receive emotional support from institution staff?
3. Do the mean scores of the *FBS* and its sub-dimensions among substance users differ according to participants' age, whether they receive emotional support from their families, and whether they receive emotional support from institution staff?

Data Collection Tools

In this study, the data were collected using a socio-demographic information form, which was designed to capture the independent variables of the participants; the *Substance Use Stigma Mechanisms Scale (SU-SMS)*, which was developed by Smith et al. (2016) and adapted into Turkish by Babahanoğlu and Daşbaş (2021); and the *Family Belonging Scale* (FBS), developed by Mavili et al. (2014). The SU-SMS consists of 18 items, three sub-dimensions (*enacted stigma, anticipated stigma,* and *internalized stigma*), and is structured as a 5-point Likert-type scale. A higher score on the stigma scale implies an increased level of stigma. The FBS comprises 17 items across two subscales (*self-belonging* and *family belonging*). A higher score on the scale indicates that the participants' level of family belonging increases.

Data Analysis

Data were analyzed using SPSS 20.0, and descriptive statistics were used in the analyses. The Kolmogorov-Smirnov normality test revealed that the kurtosis and skewness values were within ±1, and the data were considered normally distributed. To determine whether the sample differed significantly on the *SU-SMS* and *FBS* according to various variables, a t-test was used for paired groups, and one-way analysis of variance (ANOVA) was used for groups of more than two. In cases where there were differences, the direction of the differences was determined using post-hoc multiple comparison tests (Dunnett T and Scheffe) (Köklü et al., 2006). In data analysis consistent with the research objective, Pearson Product-Moment Correlation Analysis was used to determine whether a relationship existed between the SU-SMS and FBS, and if so, its strength and direction. The results obtained from the analyses, which were accepted as a significance level of 0.05, are presented in tables in the "Findings" section.

Population and Sample

The study population consists of adult males who "use addictive volatile or narcotic substances" as defined under Articles 188, 189, 190, 191, and 192 of the Turkish Penal Code and who were placed under probation measures at the Konya Probation Directorate between February 2018 and October 2018. During this period, the number of individuals attending the Konya Probation Directorate ranged between 2,500 and 2,600. Within this population of 2,600 individuals, the data were collected from 360 participants using *simple random sampling*, a subtype of probability sampling. However, 351 male participants were included in the final analysis after data cleaning. This sample size represents the study population. Based on the literature review, it is estimated that a sample size of 335 people would be sufficient for a population size of 2600. In this study, the sample group consisted of 351 people (Coşkun et al., 2012).

The limited participation of women in the data collection process, their absence during certain days and hours, and the necessity to protect their identities are attributed to the heightened stigmatization of women with substance use disorders. This phenomenon aligns with the broader sociocultural context of patriarchal societies, where gender roles exacerbate the stigmatization of women across various domains of life (Yeşilay, 2024).

Therefore, the roles assigned to women in society have been historically shaped by patriarchal norms, which often confine them to traditional expectations such as caregiving, motherhood, and moral propriety. These gendered expectations not only limit women's autonomy and participation in public life but also obscure the visibility of the problems they may face. Women with substance use

disorders (SUDs) are particularly subjected to a heightened degree of stigmatization—not solely due to their addiction, but also because their behavior is perceived as a deviation from socially constructed norms of femininity (Becker et al., 2017).

While men with SUDs are often viewed through a medicalized lens—as individuals in need of treatment—women are more likely to be labeled as morally inadequate, irresponsible, or unfit mothers. This layered stigma contributes to the marginalization of women, hindering their access to healthcare services, reducing the likelihood of seeking support, and ultimately undermining their recovery processes. Therefore, integrating a gender-sensitive approach into addiction treatment and policy-making is crucial in order to improve access to care and to challenge deeply embedded societal biases (Van Olphen et al., 2009).

Findings

As shown in Table 1, 25.6% of the participants were between the ages of 27 and 30, with an average age of 29.48 ± 7.63. Additionally, 51% of the participants had completed secondary school, 51.9% came from a nuclear family structure, 74.9% received emotional support from their families, and 65.8% received emotional support from the institutions they attended for treatment or therapy.

As shown in Table 2, a statistically significant but very weak negative correlation was found between the *FBS* and the *SU-SMS* (r = 0.-22). Additionally, a weak negative correlation was observed between FBS and the *enacted stigma* sub-dimension (r = 0.-41), while a very weak negative correlation was found with the *anticipated stigma* sub-dimension (r = 0.-23). However, no statistically significant relationship was identified between FBS and the *internalized stigma* sub-dimension (p > 0.05). These findings suggest that as participants' sense of family belonging increases, their overall levels of substance use stigma, enacted stigma, and anticipated stigma tend to decrease.

A very weak negative correlation was found between the *self-belonging* sub-dimension of the *FBS)* and the *SU-SMS* (r = 0.-20), while a weak negative correlation was observed with the *enacted stigma* sub-dimension (r = 0.-40) and a very weak negative correlation with the *anticipated stigma* sub-dimension (r = 0.-22). However, no statistically significant relationship was identified between the *self-belonging* sub-dimension and the *internalized stigma* sub-dimension (p > 0.05). These findings indicate that their enacted and anticipated stigma levels decrease as participants' self-identity strengthens.

Similarly, a very weak negative correlation was found between the *family belonging* sub-dimension of the *FBS* and the *SU-SMS* (r = 0.-22), the *enacted stigma* sub-dimension (r = 0.-31), and the *anticipated stigma* sub-dimension (r = 0.-20). However, no statistically significant relationship was observed between the *family belonging* sub-dimension and the *internalized stigma* sub-dimension (p > 0.05). These results suggest that as participants' sense of family belonging increases, their enacted and anticipated stigma levels tend to decline.

Table 1. Demographic and descriptive information of the participants

Socio-demographic Characteristics	Options	N	%
	18-23 years old	75	21.4
Age groups	24-26 years old	71	20.2
	27-30 years old	90	25.6
	31-38 years old	76	21.7
	39 years and older	39	11.1
	Yes	263	74.9
Receiving emotional support from family	No	88	25.1
Receiving emotional support from institutions	Yes	231	65.8
	No	120	34.2
Total		**351**	**100**

As presented in Table 3, the participants' mean score on the *Substance Use Stigma Mechanisms Scale (SU-SMS)* was 44.58, indicating that their overall level of stigmatization was moderate based on the total mean score of the scale. According to the sub-dimensional mean scores, participants experienced varying degrees of internalized, anticipated, and enacted stigma. Additionally, the normality analysis showed that the data were parametric, with Skewness and Kurtosis values ranging between +1 and -1, confirming that the data followed a normal distribution.

As shown in Table 4, the participants' mean score on the *FBS* was 65.68, indicating a high level of family belonging according to the total mean score of the scale. The sub-dimensional mean scores also demonstrated that participants' self-belonging and family belonging levels were above average. Furthermore, the normality analysis confirmed that the data were parametric, with Skewness and Kurtosis values between +1 and -1, which is considered an acceptable range for normal distribution.

As shown in Table 5, a statistically significant difference was found between participants' age groups and their total score on the *SU-SMS* (p < 0.05). When examining the differences between groups, it was observed that participants aged 24–26 experienced significantly higher levels of stigmatization compared to those aged 39 and above. Similarly, a significant difference was identified between participants' age groups and the scale's enacted stigma and anticipated stigma sub-dimensions (p < 0.05). Participants in the 24–26 age group exhibited higher levels of stigmatization than those in the 31–38 age group, consistent with the total scale score findings. However, no statistically significant difference was found between participants' age groups and the internalized stigmatization sub-dimension.

Table 2. Correlation analysis results of the relationship between SU-SMS and FBS (n=351)

Pearson Correlation (n=351)		**1**	**2**	**3**	**4**	**5**	**6**	**7**
1. FBS	r	1						
	p	<0.001						
2. SB-Lower dimension	r	0.94**						
	p	<0.001						
3. FB-Lower dimension	r	0.79**	0.62**					
	p	<0.001	<0.001					
4. SU-SMS	r	**0-.22****	**0-.20****	**0-.22****				
	p	**<0.001**	**<0.001**	**<0.001**				
5. AS-Lower dimension	r	**0-.41****	**0-.40****	**0-.31****	0.66**			
	p	**<0.001**	**<0.001**	**<0.001**	<0.001			
6. ES-Lower dimension	r	**0-.23****	**0-.22****	**0-.20****	0.77**	0.48**		
	p	**<0.001**	**<0.001**	**<0.001**	<0.001	<0.001		
7. IS-Lower dimension	r	0.06	0.09	0-.02	0.70**	0.13**	0.22**	1
	p	0.21	0.07	<0.001	<0.001	<0.001	<0.001	<0.001

** Correlation is significant at the 0.001 level (2-tailed).

Table 3. Scores of the participants on the SU-SMS

			SU-SMS	
Statistical Values	**SU-SMS**	**Enacted Stigma**	**Anticipated Stigma**	**Internalized Stigma**
Mean	44.58	11.03	13.45	20.09
Standard Deviation	±13.70	±4.92	±6.62	±7.47
Minimum	18	6	6	6
Maximum	90	30	30	30
Skewness	.23	1.00	.62	-.33
Kurtosis	-.18	.55	-.62	-1.03

Table 4. Scores of the participants on the FBS

		FBS	
Article Number	**FBS**	**Self-Belonging**	**Family -Belonging**
Mean	65.68	48.21	17.46
Standard Deviation	±11.86	±9.35	±3.48
Minimum	32	19	6
Maximum	85	60	25
Skewness	-.781	-1.02	.07
Kurtosis	.12	.62	.13

The results of the independent samples t-test indicated a statistically significant difference between participants' receipt of emotional support from their families and their total score on the *SU-SMS* (p < 0.05). Specifically, individuals who received emotional support from their families experienced lower levels of stigmatization (Mean = 43.62) compared to those who did not receive family support (Mean = 47.44). Similarly, a significant difference was observed between participants' receipt of emotional support from their families and the enacted and anticipated stigma sub-dimensions of the scale (p < 0.05). As with the total SU-SMS score, the significance level favored participants who received emotional support from their families, indicating lower stigmatization levels in this group. However, no statistically significant relationship was found between receiving emotional support from families and the internalized stigmatization sub-dimension (p > 0.05). These findings suggest that individuals with substance use disorders who receive emotional support from their families experience lower levels of stigmatization compared to those who lack such support.

As presented in Table 5, no statistically significant difference was found between participants' receipt of emotional support from institution staff and their total score on the *SU-SMS* (p > 0.05). This indicates that receiving emotional support from institution staff does not have a significant impact on overall stigmatization levels among individuals with substance use disorders (t = 0.34, p = 0.12). However, a statistically significant difference was observed between participants' receipt of emotional support from institution staff and their scores on the enacted stigma and anticipated stigma sub-dimensions (p < 0.05). The significance level favored participants who received emotional support from institution staff, meaning that these individuals experienced lower levels of enacted and anticipated stigma than those who did not receive such support. No statistically significant relationship was found between receiving emotional support from institution staff and the internalized stigmatization sub-dimension (p > 0.05), which suggests that emotional support from institution staff does not influence internalized stigma levels.

As shown in Table 6, there was a significant difference between the age group of the participants and the total score of the FBS (p < 0.05). Accordingly, a statistically significant difference was found between participants' age groups and their total score on the *FBS* (p < 0.05). According to post-hoc tests, participants in the 18–23 and 39 and over age groups reported higher levels of family belonging than those in the 27–30 and 31–38 age groups. Similarly, a significant difference was observed between participants' age groups

Table 5. Statistical analysis results (ANOVA and t-test) of participants' SU-SMS and selected demographic characteristics

				SU-SMS	
Independent Variable	**n**	**SU-SMS (Mean±SD)**	**Enacted Stigma (Mean±SD)**	**Anticipated S. (Mean±SD)**	**Internalized Stigma (Mean±SD)**
Age Group					
18-23 years old1	75	43.33±12.31	10.72±4.32	13.04±5.98	19.57±7.65
24-26 years old2	71	49.14±13.96	11.70±5.22	15.54±7.32	21.88±6.67
27-30 years old3	90	44.54±14.70	10.81±4.83	14.08±6.83	19.64±5.52
31-38 years old4	76	43.07±14.09	11.38±5.38	11.90±6.08	19.84±7.54
39 years and older5	39	41.69±10.97	10.33±4.73	12.00±6.10	19.35±8.08
F		2.82	0.71	3.66	1.31
p		0.02	0.58	<0.001	0.26
Difference Groups		(2>5) *	-	(2>4) *	-
Receiving Emotional Support from Family					
Yes	263	43.62±13.17	10.44±4.56	13.00±6.66	20.17±7.42
No	88	47.44±17.86	12.77±5.53	14.80±6.35	19.86±7.64
t		0.349	-3.913	-2.221	.334
p		0.023	<0.001	0.027	0.739
Receiving Emotional Support from the Institution Staff					
Yes	231	43.74±12.93	10.46±4.59	12.74±6.33	20.53±7.39
No	120	46.20±14.98	12.12±5.34	14.82±6.99	19.25±7.57
t		0.34	-3.03	-2.81	1.52
p		0.12	<0.001	<0.001	0.12

*Dunnet T **Scheffe

Table 6. Statistical (ANOVA and t-test) analysis results for the FBS and demographic variables

				FBS
Independent Variable	**n**	**FBS (Mean±SD)**	**Self-Belonging (Mean±SD)**	**Family Belonging (Mean±SD)**
Age Group				
18-23 years old1	75	67.84±10.61	49.76±8.21	18.08±3.36
24-26 years old2	71	66.52±11.51	49.11±8.95	17.40±3.43
27-30 years old3	90	63.73±13.27	46.28±10.63	17.44±3.47
31-38 years old4	76	63.48±12.34	46.43±9.51	17.05±3.72
39 years and older5	39	68.79±8.93	51.56±7.10	17.23±3.36
F		2.69	3.67	0.89
p		0.03	<0.001	0.46
Difference Groups		(1.5>3.4) **	(1.5>3.4) **	-
Receiving Emotional Support from Family				
Yes	263	68.58±9.84	50.54±7.61	18.03±3.07
No	88	57.01±13.14	41.26±10.59	15.75±3.54
t		0.34	8.91	5.55
p		<0.001	<0.001	<0.001
Receiving Emotional Support from the Institution Staff				
Yes	231	67.14±11.05	49.45±8.68	17.69±3.51
No	120	62.87±12.87	45.85±10.15	17.02±3.40
t		.34	3.47	1.70
p		<0.001	<0.001	0.08

*Dunnet T **Scheffe

and their scores on the self-belonging sub-dimension ($p < 0.05$). Consistent with the total FBS score, participants in the 18–23 and 39 and over age groups exhibited higher self-belonging levels than those in the 27–30 and 31–38 age groups. However, no statistically significant relationship was found between participants' age groups and their scores on the family belonging sub-dimension ($p > 0.05$).

A statistically significant difference was found between participants' receipt of emotional support from their families

and their total score on the *FBS* (p < 0.05). Specifically, individuals who received emotional support from their families exhibited higher levels of family belonging (Mean = 68.58) than those who did not (Mean = 57.01). Similarly, a significant difference was observed between participants' status of receiving emotional support from their families and their scores on the scale's self-belonging and family belonging sub-dimensions (p < 0.05). As with the total FBS score, the significance level favored participants who received emotional support from their families, indicating stronger self-belonging and family belonging in this group.

A statistically significant difference was found between participants' receipt of emotional support from institution staff and their total score on the *FBS* (p < 0.05). The results indicate that receiving emotional support from institution staff had a positive effect on the family belonging of individuals with substance use disorders (t = 0.34, p < 0.001). Similarly, a significant difference was observed between participants' receipt of emotional support from institution staff and their scores on the self-belonging sub-dimension of the *FBS* (p < 0.05). The significance level favored participants who received emotional support from institution staff, suggesting that these individuals exhibited higher self-identity than those who did not. However, no statistically significant difference was found between participants' receipt of emotional support from institution staff and their scores on the family belonging sub-dimension of the scale (p > 0.05). This finding suggests that receiving support from institution staff does not influence family belonging.

Conclusion and Discussion

Correlation analysis revealed a significant negative correlation between family belonging and stigmatization, indicating that a supportive familial environment may mitigate social stigma. This aligns with prior research demonstrating that stigmatization weakens familial bonds and can precipitate social withdrawal (Beckwith et al., 2015; Dingle et al., 2015; Haslam et al., 2018).

However, the non-significant relationship between family belonging and internalized stigma is particularly noteworthy. Internalized stigma involves the acceptance and integration of negative societal beliefs into the self-concept, which is often resistant to change through external social support alone (Corrigan, 2004; Livingston & Boyd, 2010). While family support can buffer against enacted and anticipated stigma by providing social validation and emotional resources, it may not sufficiently address the deep psychological processes underlying self-stigma. This suggests that interventions targeting internalized stigma require specialized psychological approaches such as cognitive-behavioral therapy, self-compassion training, and psychoeducation (Luoma et al., 2007; Yanos et al., 2015).

Age differences in stigma levels, with younger participants experiencing higher stigma, may reflect developmental and social factors influencing identity and social perception (Yıldırım et al., 2012). Emotional support from family was associated with lower stigma and higher family belonging, reinforcing the protective role of familial support (Arılık, 2019).

Emotional support from institutional staff was linked to lower enacted and anticipated stigma but did not significantly affect internalized stigma or family belonging, highlighting the need for stigma-sensitive training among professionals (Barney et al., 2009; Livingston et al., 2011).

The present study reinforces the notion that perceived social support mitigates internalized stigma by promoting social connectedness and belonging. Frequent social interactions and positive relationships may serve as protective factors against stigmatization (Earnshaw et al., 2013). Empirical evidence further identifies family support as one of the most critical protective mechanisms against the social isolation often experienced by these individuals (Sargent et al., 2002). Accordingly, emotional support from family members appears to reduce stigma, enhance motivation to seek and sustain treatment, and increase the likelihood of long-term recovery.

Beyond the familial context, this study also identified a significant relationship between emotional support from institutional staff and levels of stigmatization. The findings align with research demonstrating that the attitudes and behaviors of healthcare and rehabilitation professionals play a pivotal role in shaping treatment experiences (Demir et al., 2022). As Barney et al. (2009) observed, stigmatization within healthcare settings constitutes one of the main barriers to treatment-seeking behavior. Therefore, efforts to reduce stigma must extend beyond individuals and families to include comprehensive education and sensitization programs for healthcare providers and social service professionals (Yılmaz & Cüceler, 2019).

Similarly, Livingston et al. (2011) and Earnshaw et al. (2013) underscore that positive and nonjudgmental professional attitudes can reduce stigma and promote psychosocial well-being. When institutional staff and family members refrain from moralizing and instead adopt a supportive and empathetic stance, individuals are more likely to engage in treatment and rehabilitation. However, as Room (2005) and Paquette et al. (2018) warn, stigma frequently originates from these very sources—family, friends, and healthcare professionals—thus perpetuating the cycle of social exclusion. Barnard (2007) adds that although labeling these individuals as "victims of society" can protect them from moral condemnation, it may also obscure the recognition of their suffering within their own families. This dynamic underscores the complex moral and relational dimensions of stigmatization in the context of substance use.

With respect to age, no statistically significant differences were found in Family Belonging Scale (FBS) scores. This finding suggests that weakened family communication and belonging are pervasive across age groups, supporting previous studies emphasizing that substance use often disrupts familial cohesion irrespective of life stage (Ögel, 2004; Polat, 2014).

Nonetheless, in certain cases, family awareness of the disorder may lead to increased empathy and stronger relational ties. It indicates that stigma and family belonging are not static but dynamic constructs that can evolve positively through engagement and understanding.

A strong sense of family belonging was also found to be crucial in sustaining treatment motivation and recovery outcomes. This is consistent with prior research demonstrating that individuals who feel valued and accepted within their families exhibit higher levels of psychological adjustment and commitment to rehabilitation (Shlomi, 2010; Yalman, 2019). Moreover, the literature suggests that early experiences of belonging and positive family role models may function as protective factors that reduce vulnerability to substance use later in life. Thus, fostering family cohesion and communication should be considered an essential component of both preventive and rehabilitative interventions.

In this study, *FBS* scores were also significantly associated with the level of emotional support received from families, reinforcing existing evidence that emotional warmth, trust, and open communication enhance both psychological well-being and family belonging (Sargent et al., 2002; Woolhouse et al., 2013). Similarly, participants who perceived emotional support and empathy from healthcare professionals and institutional staff reported higher family belonging and better adjustment. These findings are consistent with those of by Barnard (2007) and Woolhouse et al. (2013). These results collectively suggest that both familial and institutional support systems function as interrelated protective factors that strengthen the individual's sense of belonging, reduce stigmatization, and facilitate recovery.

Ultimately, this study contributes to the broader literature by demonstrating that the mechanisms of stigma and belonging among individuals with substance use disorders are not solely personal or psychological but profoundly relational. Family and institutional contexts act as mediating environments that can either reinforce or alleviate stigma. Interventions aimed at strengthening these relational bonds—through psychoeducation, family-based therapy, and professional empathy training—are therefore vital for promoting recovery, reducing stigma, and improving psychosocial outcomes in this population.

Recommendations

Building upon the study's findings and informed by stigma theory, several recommendations are proposed at the micro, mezzo, and macro levels to address the multifaceted nature of stigmatization toward these individuals. The results of this research underscore that stigma operates not merely as an individual attitude but as a socially embedded process shaped by family dynamics, institutional practices, and structural conditions. Accordingly, effective intervention requires simultaneous engagement across these levels.

Micro Recommendations

At the individual and familial level, the findings highlight the crucial role of accurate knowledge and empathetic understanding in mitigating stigma. Awareness-raising initiatives should be implemented to equip family members and close social networks with evidence-based information about substance use disorders. This emphasizes that addiction is a complex biopsychosocial phenomenon rather than a moral failing. Such interventions can disrupt the "labeling" and "stereotyping" stages of stigma (Link & Phelan, 2001), fostering more compassionate interpersonal interactions.

Furthermore, academic and applied research should continue to explore the mechanisms through which family belonging mediates or moderates stigma, as this study contributes novel evidence that perceived familial support significantly shapes stigmatization experiences. Continued empirical work on these relational dimensions would advance both the theoretical understanding and practical management of stigma within family systems.

Mezzo Recommendations

At the community and institutional level, the findings suggest that stigma reduction requires culturally and contextually tailored educational initiatives. As seen in successful disability and mental health awareness campaigns, similar models should be adopted to target misconceptions surrounding substance use. These initiatives must extend beyond prevention and treatment to emphasize rehabilitation, empowerment, and social reintegration, thereby addressing the "separation" and "status loss" dimensions of stigma.

Professionals working within probation, rehabilitation, and healthcare systems should receive specialized training in stigma-sensitive communication and care. Family-focused psychoeducation and motivational programs are also essential to strengthen positive communication patterns and diminish tendencies toward blame or moral judgment. By reframing addiction as a recoverable health condition and reinforcing families' belief in the possibility of recovery, these programs can transform the social microclimate that often perpetuates stigma.

Macro Recommendations

At the structural and policy level, it is imperative that national development plans and social policy frameworks explicitly incorporate stigma reduction as a public health and social cohesion priority. This aligns with the theoretical understanding that stigma is institutionalized through policies, discourse, and unequal resource allocation (Link & Phelan, 2001). Integrating anti-stigma objectives into probation and rehabilitation systems would ensure a more holistic approach to recovery—one that emphasizes not only abstinence but also social reintegration and identity restoration.

Public institutions should thus go beyond punitive or treatment-oriented frameworks and actively sponsor anti-stigmatization campaigns and evidence-based interventions. Activities that foster inclusion such as sports, cultural and artistic events, and community-based nature programs can function as "contact strategies," reducing social distance and rehumanizing those labeled as "addicts." These initiatives can disrupt the final stage of the stigma process, "discrimination," by normalizing interaction and mutual acceptance within the broader community.

Moreover, this study contributes uniquely to the literature by demonstrating that family belonging operates as both a protective factor and a site of potential stigmatization. Hence, macro-level strategies should integrate family-centered approaches into policy design and funding priorities. Supporting interdisciplinary research on stigma processes, family dynamics, and institutional practices will enable the development of multi-level stigma interventions that address not only individual attitudes but also the structural roots of exclusion.

The intensification of inter-institutional cooperation, particularly involving the Ministry of Health, the Ministry of National Education, the Ministry of Interior, the Ministry of Family and Social Services, and prominent civil society organizations such as the Green Crescent and its affiliated Counseling Centers (YEDAM), is critically important for mitigating the stigma associated with addiction, which remains a central barrier in effective intervention strategies, as well as for ensuring the long-term protection of public health.

The Framework of the Research

Before conducting the study, ethical approval was obtained from the Selçuk University Faculty of Health Sciences Dean's Office Non-Interventional Clinical Research Ethics Committee, with the decision dated 31.10.2018, numbered 1997, and decision number 2018/172. Additionally, to facilitate the research at the Konya Probation Directorate, the necessary permissions were secured based on an official letter from the Ministry of Justice, General Directorate of Prisons and Detention Houses, dated 11.01.2019, and numbered 46985942-773-E.34/5974. All participants provided informed consent and voluntarily agreed to participate in the study. Data collection was conducted following ethical principles and guidelines for voluntary participation.

Author contributions

Conception: R.B.; Design: S.D.; Data acquisition: R.B.; Data analysis: R.B., S.D.; Data interpretation: R.B.; Drafting of the manuscript: R.B., S.D.; Critical revision of the manuscript: R.B., S.D. All authors reviewed the results, approved the final version of the manuscript, and agreed to be accountable for all aspects of this study.

Ethical approval

This study was approved by the Selçuk University Faculty of Health Sciences Dean's Office Non-Interventional Clinical Research Ethics Committee (Date: January 31, 2018, Decision/Protocol No: 2018/172). Informed consent was obtained from all participants involved in this study.

Data availability statement

The data that support the findings of this study are available from the corresponding author upon reasonable request.

Conflict of interest

The authors declare that this study was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

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Generative AI statement

The authors declare that no generative AI or AI-assisted technologies were used in the writing or preparation of this study.

References

Addiction Research Department. (2020). *The effects of drug addiction on family members.* https://www.bhpalmbeach.com/recovery-articles/impact-substance-abuse-and-addiction-families/

Afyonoğlu, M. F., Pak Güre, M. D., Erükçü Akbaş, G., & Uğurlu, Z. (2025). Social workers' perceptions of the stigmatization process for individuals with mental health needs within the criminal justice system in Türkiye: An intersectional analysis. *International Journal of Forensic Mental Health 24*(4), 336-348. **[Crossref]**

Arılık, M. (2019). *Madde bağımlılarının damgalanma sonrası bağımlılık döngüsü* (Thesis No. 541085) [Master's thesis, Hacettepe University]. Council of Higher Education National Thesis Center.

Babahanoğlu, R., & Daşbaş, S. (2021). Madde kullanımı damgalama mekanizması ölçeği: Geçerlilik ve güvenirlik çalışması. *Toplum ve Sosyal Hizmet*, *32*(1), 141-172. **[Crossref]**

Barnard, M. (2007). *Drug addiction and families.* Jessica Kingsley Publishers.

Barney, L. J., Griffiths, K. M., Christensen, H., & Jorm, A. F. (2009). Exploring the nature of stigmatizing beliefs about depression and help-seeking: Implications for reducing stigma. *BMC Public Health, 9*, 61. **[Crossref]**

Becker, J. B., McClellan, M., & Reed, B. G. (2017). Sex differences, gender and addiction. *Journal of Neuroscience Research, 95*(1-2), 136-147. **[Crossref]**

Beckwith, M., Best, D., Dingle, G., Perryman, C., & Lubman, D. (2015). Predictors of flexibility in social identity among people entering a therapeutic community for substance abuse. *Alcoholism Treatment Quarterly*, *33*(1), 93-104. **[Crossref]**

Botvin, G. J. (2000). Preventing drug abuse in schools: social and competence enhancement approaches targeting individual-level etiologic factors. *Addictive Behaviors, 25*(6), 887-897. **[Crossref]**

Collins, S., Ottley, G., & Wilson, M. (1990). Historical perspectives and the development of community services. In S. Collins (Ed.), *Alcohol, social work and helping* (pp. 9-42), Routledge. **[Crossref]**

Corrigan, P. W. (2004). How stigma interferes with mental health care. *American Psychologist*, *59*(7), 614-625. **[Crossref]**

Coşkun, R., Altunışık, R., & Yıldırım, E. (2012). *Sosyal bilimlerde araştırma yöntemleri SPSS uygulamalı*. Sakarya Yayıncılık.

Cukor, D., Cohen, S. D., Peterson, R. A., & Kimmel, P. L. (2007). Psychosocial aspects of chronic disease: ESRD as a paradigmatic illness. *Journal of the American Society of Nephrology, 18*(12), 3042-3055. **[Crossref]**

Demir, B., Kocamer Şahin, Ş., Sancaktar, M., Sargin, E. N., Köse, Z., & Altindağ, A. (2022). Madde kullanım bozukluğunda içselleştirilmiş damgalanmanın klinik özellikler ve tedavi motivasyonu ile ilişkisi. *Bağımlılık Dergisi, 23*(1), 30-36. **[Crossref]**

DiClemente, C. C. (2006). *Addiction and change: How addictions develop, and addicted people recover*. Guilford Press.

Dingle, G. A., Cruwys, T., & Frings, D. (2015). Social identities as pathways into and out of addiction. *Frontiers of Psychology, 6*, 1795. **[Crossref]**

Earnshaw, V. Smith, L., & Copenhaver, M. (2013). Drug addiction stigma in the context of methadone maintenance therapy: An investigation into understudied sources of stigma. *International Journal of Mental Health and Addiction, 11*(1), 110-122. **[Crossref]**

Erbay, E., Oğuz, N., Yıldırım, B., & Fırat, E. (2016). Alkol ve madde bağımlılığı olan bireylerin başa çıkma tutumları. *Türkiye Sosyal Araştırmalar Dergisi, 20*(3), 597-609.

Goffman, E. (2019). *Damga: Örselenmiş kimliğin idare edilişi üzerine notlar* (Ş. Geniş, L. Ünsaldı, & N. Ağırsanlı, Trans.). Heretik Yayınları.

Haslam, C., Jetten, J., Cruwys, T., Dingle, G., & Haslam, S. A. (2018). *The new psychology of health: Unlocking the social cure*. Routledge. **[Crossref]**

Köklü, N., Büyüköztürk, Ş., & Çokluk Bökeoğlu, Ö. (2006). *Sosyal bilimler için istatistik* (2nd ed.). Pegem A Yayıncılık.

Link, B. G., & Phelan, J. C. (2001). Conceptualizing stigma. *Annual Review of Sociology, 27*(1), 363-385. **[Crossref]**

Livingston, J. D., & Boyd, J. E. (2010). Correlates and consequences of internalized stigma for people living with mental illness: A systematic review and meta-analysis. *Social Science & Medicine*, *71*(12), 2150-2161. **[Crossref]**

Livingston, J. D., Milne, T., Fang, M. L. F., & Amari, E. (2011). The effectiveness of interventions for reducing stigma related to substance use disorders: A systematic review. *Addiction, 107*(1), 39-50. **[Crossref]**

Luoma, J. B., Nobles, R. H., Drake, C. E., Hayes, S. C., O'Hair, A, Fletcher, L., & Kohlenberg, B. S. (2007). Self-stigma in substance abuse: Development of a new measure. *Journal of Psychopathology and Behavioral Assessment*, *29*(2), 131-141.

Mavili, A., Kesen, N. F., & Daşbaş, S. (2014). Aile aidiyeti ölçeği: Bir ölçek geliştirme çalışması. *Sosyal Politika Çalışmaları Dergisi, 14*(33), 24-45.

Newman, B. N., & Crowell, K. A. (2023). The intersectionality of criminality and substance use self-stigmas. *Stigma and Health, 8*(2), 212. **[Crossref]**

Ögel, K. (2004). Alkol ve madde kullanım bozukluklarında damgalama. *3P Dergisi*, *12*(3).

Ögel, K. (2020). *Aile: 1. aile ve bağımlılık, 2. aileye yaklaşım*. http://www.ogelk.net/Dosyadepo/aile.pdf

Paquette, C. E., Syvertsen, J. L., & Pollini, R. A. (2018). Stigma at every turn: Health services experiences among people who inject drugs. *International Journal of Drug Policy, 57*, 104-110. **[Crossref]**

Polat, G. (2014). Madde bağımlılığı tedavisinde sosyal hizmet mesleği. *Okmeydanı Tıp Dergisi, 30*(ek sayı 2), 143-148.

Room, R. (2005). Stigma, social inequality, and alcohol and drug use. *Drug and Alcohol Review, 24*(2), 143-155. **[Crossref]**

Sargent, J., Williams, A. R., Hagerty, B. M., Lynch-Sauer, J., & Hoyle, K. (2002). Sense of belonging as a buffer against depressive symptoms. *Journal of the American Psychiatric Nurses Association, 8*(4), 120-128. **[Crossref]**

Sevin, Ç., & Erbay, E. (2008). Madde bağımlılarının tedavi sonrası sosyal yaşama uyumları ve sosyal hizmet uygulamaları. *Bağımlılık Dergisi, 9*(1), 1-11.

Shlomi, H. (2010). *The relationship between childhood family instability, secure attachment, and the sense of belonging of young adults*. University of British Columbia.

Smith, L. R., Earnshaw, V. A., Copenhaver, M. M., & Cunningham, C. O. (2016). Substance use stigma: Reliability and validity of a theory-based scale for substance-using populations. *Drug and Alcohol Dependence, 162*, 34-43. **[Crossref]**

Şamar, B., Taş, M., Kayın, M., & Ünübol, B. (2023). Comprehensive analysis of social stigma of individuals with substance use disorder in Turkey in the context of Erving Goffman's stigma theory. *Journal of Ethnicity in Substance Abuse*, *23*(4), 679-698. **[Crossref]**

Ünal, E. (2024). *Klinik görüşme ve uygulama*. https://avys.omu.edu.tr/storage/app/public/elif.unal/127544/Klinik%20G%C3%B6r%C3%BC%C5%9Fme%20ve%20Uygulama%20-1.pdf

Van Olphen, J., Eliason, M. J., Freudenberg, N., & Barnes, M. (2009). Nowhere to go: How stigma limits the options of female drug users after release from jail. *Substance Abuse Treatment, Prevention, and Policy, 4*(10). **[Crossref]**

Woolhouse, S., Cooper, E., & Pickard, A. (2013). "It gives me a sense of belonging": Providing integrated health care and treatment to people with HCV engaged in a psycho-educational support group. *International Journal of Drug Policy, 24*(6), 550-557. **[Crossref]**

Yalman, E. (2019). Ebeveyn ve akran ilişkilerinin genç kızlarda madde kullanımına etkisi. *İBAD, 4*(2), 372-391. **[Crossref]**

Yanos, P. T., Lucksted, A., Amy, L., Drapalski, A. L., Roe, D., & Lysaker, P. (2015). Interventions targeting internalized stigma among people with serious mental illness: A review. *Psychiatric Rehabilitation Journal*, *38*(2), 97-104. **[Crossref]**

Yeşilay. (2024). *Kadınlar bağımlılık sürecinde yalnız kalıyor.* https://www.yesilay.org.tr/tr/makaleler/kadinlar-bagimlilik-surecinde-yalniz-kaliyor

Yıldırım, E., Akyıl Sokullu, D., & Köknel, Ö. (2012). Alkol bağımlılığında içselşetirilmiş damgalama: Depresif belirtilerle ilişki. *Psikoloji Çalışmalrı*, *32*(1), 1-12.

Yılmaz, M., & Cüceler, S. (2019). Alkol bağımlığı ve damgalanma. *Bağımlılık Dergisi, 20*(3), 167-174. https://izlik.org/JA96WT53EF