Factors Predicting Self–stigma among Youths Receiving Substance Abuse Treatment

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Abstract: Self-stigma is a presence of negative evaluation, attitudes, emotions, and thoughts resulting from an individual's identification with a stigmatized group and feeling unacceptable within society. Self-stigma is a significant obstacle to the treatment process in the young with substance abuse. Youths receiving substance treatment often stigmatize themselves, develop negative feelings, lose self-confidence in quitting an addiction, or lack cooperation or avoid treatment. These behaviors lengthen their treatment period, so it is essential to reduce stigma. This study aimed to identify self-stigma and factors predicting this among the youths undergoing rehabilitation in ten substance abuse treatment facilities in Wiwatpolamuang schools, navy camps in the east of Thailand. Simple random sampling was applied to draw 430 voluntary participants. Data was collected using seven questionnaires, which collected data on sociodemographic details, self-stigma in substance abuse, self-esteem, cognitive fusion, family connectedness, friendship intimacy, and personal resources. Descriptive statistics and stepwise multiple regression were used to analyze data.

The findings revealed that the youths receiving drug treatment had self-stigma of substance abuse. Among them, 11.16 % had a low level, 79.07% had a moderate level, and 9.77% had a high level of self-stigma. Stepwise multiple regression analysis showed that cognitive fusion, friendship intimacy, family connectedness, and self-esteem explained 36.7% of the variance in the self-stigma of substance abuse among the youths under treatment, which cognitive fusion was the strongest. The research findings suggested that nurses or health care providers should promote self-esteem for preventing or minimizing self-stigma and focus on creating programs or activities to minimize cognitive fusion.

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Introduction

Substance abuse among the youths has been a significant public health problem, affecting health, economic and social situations worldwide. From a survey report of substance abuse and health status in the United States in 2019, during the past month, around 165.4 million people (60.1%), aged over 12 years, experienced substance abuse, including use of cigarettes, alcohol, or other addictive substances. Around 14.1%, aged 18–25 years, were diagnosed with substance abuse disorders.[1] According to the United Nations Office on Drugs and Crime (UNODC) report,[2]

269 million globally were involved in drug or substance abuse during 2020. Thailand also has a significant problem in substance abuse, particularly among youths, and the problem directly affects Thai society. A 2019 survey revealed that 39% of youth, 15-24 years, experienced substance abuse.[3] More than half of those imprisoned in juvenile protection centers were related to substance abuse.[4] And the number of youths with substance abuse receiving both voluntary and mandatory drug treatment programs increases every year.

Substance abuse, especially that of amphetamine, affects the central nervous system and stimulates the release of dopamine, a neurotransmitter. The drug users feel energetic, euphoric, and more confident while using drugs, so they use the drug more frequently to get pleasure and thus become addicted, affecting their physical, mental, emotional, and social health. Physical deterioration, weakness, emotional disturbance, and psychological symptoms occur if a person is addicted to a substance for a more extended period.[1] They will become lazy in their daily routines, start spending lavishly on buying drugs, become unemployed and lose income, have dysfunctional family relationships, and sometimes become violent.[5] Some may commit crimes to earn money for buying drugs, which may threaten national security.[2] Since substance abuse has adverse effects, the government prioritizes rehabilitation services for addicted people through both voluntary and coercive treatment approaches. The primary goals of these approaches are to rehabilitate capacities, prevent relapse, and enable such people to restore their everyday social life.[5] The experience of being socially rejected by families, friends or coworkers will often cause them to stigmatize themselves.[6]

Review of Literature and Conceptual Framework

The conceptual framework of this study was drawn from Luoma's concept of self-stigma[6] and a literature review related to self-stigma. Luoma[6] posits that self-stigma is a negative thought or feeling towards oneself. The thought and feeling can come from both inside oneself and external sources, including losing self-esteem or being unaccepted or untrusted by society. Stigmatization is a social process in which a person perceives that they have been socially punished and devalued.[6] There are different types of stigma, namely: social stigma, enacted stigma, and self-stigma. Social stigma refers to the process of labeling an individual in a negative process through stereotyping by separating, rejecting, or avoiding them.[7] Enacted stigma is a direct experience with social discrimination, feelings of separation, or rejection. In addition, self-stigma refers to negative thoughts or internal feelings, feeling devalued, and having a loss of self-efficacy.[6]

People with substance abuse are usually labeled as irresponsible, "the so-called junkie," experience social disgust, and are highly self-stigmatized.[8] Two studies showed amphetamine users perceived high-level stigma of 40.9%[9] and 50.40%,[10] and this high perception of self-stigma leads to lower self-esteem in a person. Substance abusers may also feel incapable, hopeless, powerless, with low quality of life, and with low social support or social engagement.[11] Self-stigma is a significant obstacle in treating substance abuse.[8] Youths with self-stigma often have negative feelings, lose self-confidence and are aimless in life. They often reject treatment and return to substance abuse,[12] leading to mental health problems like depression or psychotic symptoms.[8]

Self-stigma comprises of four aspects: self-devaluation, fear of enacted stigma, stigma avoidance, and values disengagement.[13] Self-stigma results from negative self-perception that includes loss of self-respect and negatively perceived social reaction to oneself such as being unaccepted by family or untrusted by society.[6] Internal and external factors related to self-stigma include self-esteem,[11,13,14] cognitive fusion,[15] family connectedness,[16] and intimacy friendship.[10,13] Low self-esteem, guilt, and lower self-respect and self-efficacy

result from such people looking at themselves negatively and such feelings create higher self−stigma. [11,13,14] Family connectedness, intimacy, friendship, and social support are essential facets of youths' social system. These factors need to be present to create self−satisfaction, self−identity, and a sense of self−worth but are often lost or not found when there is a sense of self−stigma. [10,13,16] Cognitive fusion can be directly or indirectly affected by stigma and is a conceptual attachment where people are entangled with their thoughts. In other words, a person's attention is on the content of their mind, that is, their thoughts, memories, assumptions, beliefs, and images, instead of what they are experiencing through their five senses. Thus, a person becomes stuck in their thoughts and becomes "fused" to them. They feel removed from the world outside and their senses, from 'the here and now,' or even from people around them. Cognitive fusion may cause psychological inflexibility that creates mental problems and self−stigma. [15]

Study Aim

To identify self−stigma and factors predicting this among the youths in ten substance abuse treatment facilities in Wiwatpolamuang schools, navy camps in the east of Thailand.

Methods

Design: This was a cross−sectional study using a predictive correlational design and is reported here using the STROBE Statement−Checklist.

Sample and Setting: The sample in this study was the youths receiving treatment for substance abuse at ten Wiwatpolamuang Schools in east Thailand. The inclusion criteria were: between 18 and 25 years, receiving treatment for amphetamine abuse, having no withdrawal symptoms deterring data collection, and consenting to participate in the study. The sample size was determined by power analysis[17] using the

G*Power3 Program.[18] To begin with, the six independent variables were identified, with a power test of .95, an effect size of .052. Since no studies of self−stigma and substance abuse among Thai youths had been undertaken, we used the relationship between the perceived stigma and social support in another study where .22 was used calculating the sample size formula, and the effect size was .052).[10] The statistical significance was set at .05 to estimate the sample size, and 386 participants were required. Ten percent of the sample was added to overcome possible missing information in the questionnaires, and the sample size was required to be 430.

The simple random sampling technique drew potential participants. From the statistics in 2020, there were 800 youths receiving treatment for substance abuse at studied schools. The number of participants was estimated and proportionately selected from ten schools, and the sample was drawn in each school by simple random sampling. After that, the participants were asked for their voluntary participation in the research project.

Ethical considerations: This research project was approved by the Human Ethics Committee of Burapha University, ethics code HS006/ 2563 and approval given by the directors of the ten schools. The researchers informed the participants about research objectives, the process of data collection, time duration, risks and benefits of the study, and their right to refuse or withdraw any time without giving reason or affecting their treatment. Data collection was undertaken only after obtaining informed consent from the participants. The research data are presented only as a collective picture.

Instruments: Seven instruments were collated into a questionnaire in this study and are described below. Two of these, the Self−Stigma in Substance Abuse and the Cognitive Fusion Questionnaire, were translated by the researchers with the permission of developers using a back−translation technique involving three experts. The Thai versions of these instruments demonstrated a good validity with CVI value=1 and .8, respectively. All instruments were piloted with

30 participants who had the same characteristics as the actual participants but were not included in the main study. The Cronbach alpha reliability and the example of each instrument are shown in **Table 1**.

Table 1 Reliability of research instruments in pilot and main study

Research instruments	Reliability values		Example of instrument item
	Pilot study (n=30)	Actual study (n=430)	
Self-Stigma in Substance Abuse Questionnaire	.85	.90	I have the thought that a major reason for my problems with substances is my own poor character.
Cognitive Fusion Questionnaire	.84	.82	My thoughts cause me distress or emotional pain.
Self-esteem Questionnaire	.82	.80	In general, I am satisfied with myself.
Friendship Intimacy Questionnaire	.84	.85	You frequently spend time with your friend.
Family Connectedness Questionnaire	.80	.80	When you have any problems, you always talk to your family members.
Personal Resource Questionnaire	.93	.88	You have a close one who makes you feel safe.

Sociodemographic data questionnaire. This questionnaire obtained age, marital status, education, occupation, monthly income before receiving treatment, and details on substance abuse.

Self-Stigma in Substance Abuse Questionnaire. This questionnaire was developed by Luoma et al.[13] The 40 items assess self-stigma of substance abuse in four aspects, self-devaluation, fear of enacted stigma, stigma avoidance, and values disengagement. The items are assessed on a five-point ranging from 1 "never or almost never" to five "very often." The total score ranges from 40 to 200, and a higher score indicates higher self-stigma. The total score is divided into three levels: low self-stigma (40-93), moderate self-stigma (94-147), and high self-stigma (148-200). The original questionnaire had good validity and Cronbach's alpha coefficient of .86.[13]

Self-esteem Questionnaire: This was developed by Rosenberg and was translated into Thai and modified to be suitable for Thai youths by Silpakit and Silpakit.[19] There are eight items, with four questions signifying positive meaning and four signifying negative meaning. Each item has four scales, from 1 "not strongly agreeable" to 4 "strongly agreeable." The total score ranges from 1-32; a higher score indicates higher self-esteem. The Thai version of the questionnaire had good validity and Cronbach's alpha coefficient of .90.[19]

Cognitive Fusion Questionnaire. This was developed by Gillandersa et al.[20] and comprises seven items. The responses are rated from 1 "not true" to 7 "highly true." The total score ranges from 7-49, with a higher score indicating higher cognitive fusion. The original instrument had good validity and Cronbach's alpha coefficient of .90.[20]

Family Connectedness Questionnaire. This was developed by Resenick et al.[21] and translated into Thai and modified to fit in the context of the Thai youths by Nopparat.[22] It comprises 12 items related to family connectedness, including family intimacy perception of attention and satisfaction of family relation, affection, desire, and feeling of family members. The responses for each item are 1 "strongly disagree" to 5 "strongly agree." The total score range is 12-60. A higher score means higher connectedness of family. The reliability in the youths was good with Cronbach's alpha coefficients of .83-.94.[23, 24]

Friendship Intimacy Questionnaire. This was developed by Buhrmester[24] and translated into Thai by Nateethan et al.[25] It comprises 12 questions related

to friendship intimacy, self−openness, emotional support, and relationship satisfaction. The responses are rated from 1 "strongly disagree" to 5 "strongly agree. The total score ranges from 12−60. A higher score means higher intimacy of friendship. The reliability of the instrument in the youths was good with Cronbach's alpha of .85−.93.[23, 24, 25]

Personal Resource Questionnaire: PRQ 2000. This part was developed by Weinert[26] and translated into Thai by Tungmephon.[27] It has 15 items assessing the perception of five social support and aspects: affection, intimacy, acceptance, and self−esteem, being part of society, facilitation/assistance of others, and receiving assistance and advice. The responses are rated from 1 "strongly disagree" to "strongly agree." The total score is in the range of 15−105. A higher score means higher social support. It had good validity[26, 27] and Cronbach's alpha coefficient of .92 in the youth groups.[28]

Data Collection: Data were collected from April to November 2020 after participants had given their study consent. It took the participants around 30−45 minutes to complete the questionnaires. The filled questionnaires were sealed in an envelope and returned to research teams.

Data Analysis: The data were analyzed by using the SPSS version 26 computer software program. The personal information of the participants was analyzed by descriptive statistics, frequency distribution, percentage, mean, range, and standard deviation. Stepwise multiple regression analysis was used to determine the predictability of the factors. The data of all independents and dependent variables met the basic assumption of stepwise multiple regression analysis.

Results

All participants were men, with an average age of 22.30 years. The majority were single and Buddhist with elementary education. About a half worked as a general employee and earned 5,000−10,000 Thai Baht ($USD150-$300) per month. The participants first became involved in substance abuse at an average age of 16.01 years, and 56.05% had received addiction treatment, and 26.51% took treatment for the second time. The treatment period, on average, was 69.77 days. All participants had used amphetamine, and 76.28% smoked cigarettes, 64.28 smoked marijuana, and 52.79% drank alcohol. The other details are shown in **Table 2**

Table 2 The personal information of the participants (n = 430)

Personal information	Number	Percent
Gender		
male	430	100.00
Age		
16−19 years	54	12.56
20−22 years	156	36.28
23−25 years	220	51.16
(Mean = 22.30, *SD* = 2.21, Min = 16, Max = 25)		
Marital status		
Single	350	81.40
Married	41	9.54
Widow	1	0.23
Divorce	4	0.93
Separated	17	3.95
other	17	3.95

Table 2 The personal information of the participants (n = 430) (Cont.)

Personal information	Number	Percent
Religion		
Buddhist	425	98.84
Christian	1	0.23
Muslim	4	0.93
Education Level		
Not studied/ Below elementary	9	2.09
Elementary school	218	50.70
Junior high school	151	35.12
High school/ Under diploma	51	11.86
Diploma	1	0.23
Occupation		
Unemployed	59	13.72
General employee	223	51.86
Merchant /Personal business	55	12.79
Company employees	54	12.56
Agriculturist	31	7.21
Student	8	1.86
Income before substance abuse treatment		
< $150	119	27.67
$151–$300	211	49.07
$301–$450	71	16.51
$451–$600	23	5.35
>$600	6	1.40
Age at the first drug used		
8–15 years	206	47.91
16–20 years	209	48.60
21–25 years	15	3.49
(Mean = 16.01, *SD* = 2.36, Min = 8, Max = 25)		
Number of substance abuse treatments		
1st time	241	56.05
2nd time	114	26.51
3rd time	35	8.14
4th time	20	4.65
5th time	7	1.63
> 5th time	13	3.02
(Mean = 1.82, *SD* = 1.33, Min = 1, Max = 9)		

Table 2 The personal information of the participants (n = 430) (Cont.)

Personal information	Number	Percent
Day of substance abuse treatment		
0–30 days	75	17.44
31–60 days	139	32.33
61–90 days	120	27.91
91–120 days	96	22.32
(Mean = 61.77, *SD* = 32.13, Min = 1, Max = 120)		
History of substance abuse*		
Amphetamine	334	77.67
Other substances used		
Cigarette	328	76.28
Ice	299	69.53
Alcohol	227	52.79
Marijuana	158	36.74
Heroin	12	2.79
Glue	19	4.42
others	17	3.95

Note: * 1 participant might use > 1 substance

As shown in **Table 3,** The youths receiving treatment for substance abuse had self-stigma of substance abuse on average 120.21 (S.D.=22.73). Most of the participants (79.07%) had self-stigma at a moderate level, and 11.16% had a low level of self-stigma, whereas 9.77% had this at a high level.

Table 3 The self-stigma level of participants (n = 430)

Self-stigma level	Number	Percent
Low self-stigma (40–93 scores)	48	11.16
Moderate self-stigma (94–147 scores)	340	79.07
High self-stigma (148–200 scores)	42	9.77
Total	430	100
(Mean=120.21, SD=22.73, Min=40 Max=190)		

As shown in **Table 4,** the correlation among independent variables was less than .50, which indicated no multicollinearity problem. Cognitive fusion had the strongest correlation with self-stigma.

Table 4 Pearson's correlation coefficient matrix of variables (n=430)

Factors	Mean	SD.	1	2	3	4	5	6
Self-esteem	24.21	3.921	1					
Cognitive fusion	29.77	9.310	-.288***	1				
Family connectedness	41.45	5.814	-.073	.294***	1			
Intimacy friendship to friends	39.64	7.959	-.090*	.163***	.323***	1		
Social support	79.83	12.56	.197***	.091*	.340***	.348***	1	
Self-stigma on substance abuse	120.21	22.738	-.265***	.552***	.320***	.282***	.085*	1

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

In stepwise multiple regression analysis (**Table 5**), cognitive fusion, friendship intimacy, family connectedness, and self-esteem were significant predictors of self-stigma and mutually explained 36.7% of the variance with the cognitive fusion the strongest.

Table 5 Factors influencing self-stigma of substance abuse among the youths receiving treatment for substance abuse (n = 430)

Predictive Factors	*b*	*SE*	β	*t*	*p-value*
Constant	64,008	9,479		6,753	< .001
Cognitive fusion	1,117	.103	.457	10,858	< .001
Friendship intimacy	.448	.117	.157	3,831	< .001
Family connectedness	.497	.165	.127	3,012	.003
Self-esteem	−.638	.234	−.110	−2,727	.007

R^2 = .367; Adjusted R^2 = .361; R = .606; $F_{4, 425}$ = 61.548; p < .001

Discussion

Results of the study showed that the majority of the participants had a moderate level of self-stigma of substance abuse. This differed from a study of youth receiving treatment for amphetamine abuse in an outpatient department at one institution finding that 40-50% had a high-level perception of self-stigma. The studied participants were youths with an average of 22.3 years old, and most (56%) were having substance abuse for the first time.[10] Being in the program was mandatory because they had committed illegal acts, causing them to have negative feelings about themselves, including being ashamed, guilty, and having loss of freedom and detachment from family and their loved ones, and loss of income. The participants' negative experiences like self-devaluation, fear of enacted stigma, stigma avoidance, and value disengagement resulted in self-stigma of substance abuse. The participants received treatment and rehabilitation according to the Fast model. Major activities were providing knowledge, modifying thoughts and behaviors, and enhancing life skills to enable them to understand the process of drug treatment that may assist them to return to everyday life in society.[29] Researchers found that 22.93% of the youth with substance abuse and receiving treatment

for rehabilitation in one institution had a solid attention to quit the drugs. From the above reasons, participants in this study had self-stigma of substance abuse at a moderate level.

Cognitive fusion was positive and the strongest predictor of self-stigma of substance abuse in this study. This was supported by a study of people with multiple sclerosis, where there was a positive correlation between cognitive fusion and self-stigma.[15] Cognitive fusion in acceptance commitment therapy (ACT) essentially affects psychological flexibility.[30] At the same time, the youths with substance abuse who had high cognitive fusion usually lose psychological flexibility so that they cannot open their mind to learn real or new situations. They also believed the reason for being addicted was that they were not good, had no value, and were incapable of quitting the addiction.

In our study, friendship connectedness also significantly predicted self-stigma of substance abuse among the youths receiving treatment. This finding was different from a previous study in Belgium, showing that peer support had a negative relationship with stigmatization among those given mental rehabilitation in health service offices.[31] For adolescents, friends, are the most significant ones during their development process as they are in the period of self-identity. If

youths receiving treatment for substance abuse receive peer support, they may be persuaded to use drugs when they are being educated to be drug-free from the treatment program. As a result, they might admit to uncertainty, and this results in high self-stigma.

Family connectedness significantly predicted the self-stigma of substance abuse in the positive direction among youths receiving treatment. This is quite different from another study that found negative interaction in the family that influenced the internalized stigma among people with psychiatric problems in China.[18] If individuals have high connectedness with their family, they would perceive closeness, intimacy, care and attention, relationship satisfaction, and feeling loved and needed. However, youths with high family connectedness might negatively perceive themselves if they disappoint the family by being drug users. Moreover, the negative thoughts within themselves might develop to become high self-stigma.

In this study, self-esteem also significantly predicted self-stigma of substance abuse among the participants, similar to another study where self-esteem negatively correlated with self-stigma of substance abuse among the youths receiving treatment in health services,[15] and among those who received mental health rehabilitation in Belgium.[31] Study results have found that drug abusers with low self-esteem usually have negative perspectives toward themselves and high self-stigma.[11]

This study revealed that social support did not significantly predict self-stigma in substance abuse among the participants. This finding was inconsistent with those of a previous study, which found a positive relationship between social support and self-stigma of substance abuse among those who received treatment in the health services.[32] However, this study found only a minor relationship and no prediction of social support on self-stigma as the participants received treatment for substance abuse during the data collection period. During the 2-month treatment period, the

sample would have lost communication with their peers, family, or others in society. Although the participants were taken care of in the same manner as their colleagues, they perceived this loss of social support did not affect their self-stigma related to substance abuse.

Limitations

This study was conducted on youths with substance use treated at the rehabilitation centers under the Ministry of Defense. This was compulsory treatment. Thus, generalization is limited to those youths undergoing penal and voluntary treatment programs existing in other parts of Thailand. Future research in other settings and locations is recommended in order to generalize the results. In addition, the association of the two essential variables, friendship and family connectedness, were in the opposite direction as expected. Thus a qualitative study would be helpful to increase the depth of understanding of these phenomena.

Conclusion and Implications for
Nursing Practice

The results of this study can be helpful for professional nurses or others working in substance abuse areas to develop activities or programs to minimize self-stigma related to substance abuse. Such programs need to focus on cognitive fusion and defusion. Promoting self-esteem to reduce the self-stigma on substance abuse also is highly recommended.

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ปัจจัยทำนายการตีตราตนเองของเยาวชนที่เข้ารับการบำบัดสารเสพติด

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บทคัดย่อ: การตีตราตนเอง เป็นการแสดงออกถึงการประเมินตนเองทางลบ มีทัศนคติ และความคิด ที่เป็นผลมาจากการประเมินว่าตนเองเป็นกลุ่มที่มีตราบาป และสังคมไม่ยอมรับ การตีตราตนเองเป็น อุปสรรคสำคัญต่อกระบวนการบำบัดรักษาของเยาวชนที่เข้ารับการบำบัดสารเสพติด เยาวชนที่ติด สารเสพติดที่มีการตีตราตนเองมักมีความรู้สึกด้านลบต่อตนเอง ขาดความมั่นใจในการเลิกเสพสารเสพ ติด ไม่ให้ความร่วมมือหรือพยายามหลีกเลี่ยงการบำบัด ทำให้ต้องใช้ระยะเวลาในการบำบัดยาวนาน มากยิ่งขึ้น การวิจัยครั้งนี้เป็นวิจัยหาความสัมพันธ์เชิงทำนายนี้ มีวัตถุประสงค์เพื่อศึกษาการตีตรา ตนเอง และปัจจัยที่มีทำนายการตีตราตนเองของเยาวชนที่เข้ารับการบำบัดสารเสพติดในโรงเรียน วิวัฒน์พลเมืองจำนวน 10 โรงเรียน เขตพื้นที่ภาคตะวันออกของประเทศไทย จำนวน 430 คน คัดเลือก กลุ่มตัวอย่างโดยใช้วิธีการสุ่มอย่างง่าย เก็บรวบรวมข้อมูลด้วยแบบสอบถามจำนวน 7 ฉบับ ได้แก่ แบบสอบถามข้อมูลส่วนบุคคล แบบสอบถามการตีตราตนเองในการใช้สารเสพติด แบบสอบถาม ความภาคภูมิใจในตนเอง แบบสอบถามการยึดติดทางความคิด แบบสอบถามความผูกพันในครอบครัว แบบสอบถามความผูกพันใกล้ชิดกับเพื่อน แบบสอบถามการสนับสนุนทางสังคม วิเคราะห์ข้อมูล โดยใช้สถิติเชิงพรรณนาและการวิเคราะห์สมการถดถอยพหุคูณแบบขั้นตอน

ผลการวิจัย พบว่า เยาวชนที่เข้ารับการบำบัดสารเสพติดมีการตีตราตนเอง โดยร้อยละ 11.16 มีการตีตราตนเองระดับน้อย ร้อยละ 79.07 มีการตีตราตนเองระดับปานกลาง และร้อยละ 9.77 มีการ ตีตราตนเองระดับสูง ผลการวิเคราะห์ถดถอยเชิงเส้นแบบพหุคูณแบบขั้นตอน พบว่า การยึดติดทาง ความคิด ความผูกพันใกล้ชิดกับเพื่อน ความผูกพันในครอบครัว และความภาคภูมิใจในตนเอง ร่วมกันอธิบาย ความแปรปรวนของการตีตราตนเองของเยาวชนที่เข้ารับการบำบัดสารเสพติดได้ถึงร้อยละ 36.70

ผลการวิจัยชี้ให้เห็นว่า พยาบาลและผู้ให้บริการด้านสุขภาพ ควรส่งเสริมความภาคภูมิใจใน ตนเองอันเป็นการป้องกันหรือลดการตีตราตนเองและให้ความสำคัญต่อการพัฒนาโปรแกรมหรือ กิจกรรมเพื่อลดการยึดติดทางความคิด

คำสำคัญ: การตีตราตนเอง การเสพติดสารเสพติด เยาวชน การยึดติดทางความคิด ความภาคภูมิใจ ในตนเอง

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