

**INFLUENCE OF PERCEIVED STIGMA AND  
PSYCHOLOGICAL DISTRESS ON QUALITY OF LIFE OF  
PATIENTS WITH PSYCHOACTIVE SUBSTANCES  
DISORDER AT FEDERAL NEURO-PSYCHIATRIC  
HOSPITAL BARNAWA KADUNA**

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**ABSTRACT:** Patients with psychoactive substance use disorder often face significant challenges beyond the direct effects of substance use itself. Therefore, this study explores the influence of perceived stigma and psychological distress on the quality of life of patients with psychoactive substance use disorder at the Federal Neuropsychiatric Hospital Barnawa, Kaduna (FNPHK). The study instruments were completed providing informed consent. Substance Use Stigma Mechanism Scale (SU-SMS), Kessler Psychological Distress Scale (K-10), and The World Health Organization Quality of Life Scale (WHOQOL-BREF) scores were collected and analysed using SPSS version 27. Hypothesis one indicated that enacted stigma ( $\beta = -0.218$ ,  $t = -2.388$ ,  $p = .019$ ), anticipated stigma ( $\beta = -0.315$ ,  $t = -3.354$ ,  $p = .001$ ), and internalized stigma ( $\beta = -0.390$ ,  $t = -4.389$ ,  $p < .001$ ) were significant negative predictors of quality of life. Hypothesis two revealed that psychological distress significantly predicts quality of life [ $F(1, 77) = 7.025$ ,  $p = .010$ ,  $R^2 = .084$ ], and hypothesis three indicated a significantly negative impact of both perceived stigma and psychological distress [ $F(3, 75) = 20.708$ ,  $p < .001$ ,  $R^2 = .453$ ] on quality of life among psychoactive substance use disorder patients

**Keywords:** Stigma, Psychological Distress, Quality of Life, Psychoactive Substances Disorder, Federal Neuro-Psychiatric Hospital Barnawa

## **INTRODUCTION**

Psychoactive substances have long played a substantial role in public health and human society in general. In several African countries such as Nigeria, Ghana, and South Africa, these substances are considered significantly relevant socially, politically, culturally, and economically. They have been used in many industries for various therapeutic reasons (UNODC World Drug Report, 2023). Despite their relevance and acceptability, numerous negative multidimensional factors have been associated with their abuse. Recently, the use of these psychoactive substances has become a major national issue and a public health problem with possible detrimental consequences for economic development (UNODC World Drug Report, 2023).

There is ample evidence linking substance use to reduced Quality of Life (QoL; Zubaran & Foresti, 2009). Castro et al. (2007) argue that smokers, for example, show greater impairment in quality of life in all areas, as well as more symptoms of anxiety and depression. Another variable that influences the QoL of psychoactive substance abuse patients is perceived stigma (Ajayi et al., 2019). According to the European Monitoring Centre for Drugs and Drug

Addiction (2023), psychoactive substance abuse is one of the most highly stigmatized disorders in Nigeria. Discriminating against patients with psychoactive substance abuse causes severe psychological distress, such as fear, anger, or disgust, and it directly affects victims' quality of life. Historically, perceived stigma and psychological distress have been two major barriers to quality of life for people who use psychoactive drugs. Perceived stigma is defined by Weiss and Ramakrishna (2006) as a social process or personal experience characterized by exclusion, rejection, blame, or devaluation that results from experience or reasonable anticipation of adverse social judgment about a person or group.

The influence of perceived stigma on quality of life among patients abusing substances across the world and in Nigeria cannot be overlooked. Studies have shown that mental illness-related stigma and discrimination are linked to many negative effects, including diminished self-efficacy, increased feelings of guilt and shame (Corrigan et al., 2009), decreased social functioning, lower quality of life, and increased distress, depression, and anxiety (Can & Tanriverdi, 2015). In addition, patients who abuse psychoactive substances also face psychological distress, and psychological distress has been found to be associated with the QoL of patients with psychoactive substance abuse.

Psychological distress and impaired quality of life have been reported for people with substance use disorders (SUDs) and those with behavioural addictions (Ruiz et al., 2020), and these phenomena (i.e., high psychological distress and low quality of life) have been associated with more severe substance use. Psychological distress is associated with impaired health and greater healthcare expenditures. This may lead to serious health problems for people with SUDs. For example, psychological distress has been associated with increased mortality (Barry et al., 2020).

Research in Nigeria has explored stigma and depression linked to substance use, highlighting its impact on quality of life and susceptibility to mental health issues like anxiety and PTSD (Ruiz et al., 2020). Despite these findings, gaps in Nigeria's healthcare persist, particularly in addressing stigma and psychological distress among patients with substance use disorders. Existing studies have primarily focused on medical perspectives, neglecting non-medical individuals and substantial patient populations at the Federal Neuro-Psychiatric Hospital Kaduna (FNPHK). To fill this void, this study aims to assess whether FNPHK patients face comparable challenges to those observed elsewhere, aiming to enhance understanding and support for affected individuals.

### **Objectives of the Study**

The aim of this study was to examine the influence of perceived stigma and psychological distress on quality of life among patients with psychoactive substances disorder at FNPHK; specific objectives include:

- i. To examine how perceived stigma will predict quality of life among psychoactive substance abuse patients.
- ii. To determine the extent to which psychological distress will predict quality of life among psychoactive substance abuse patients.
- iii. To examine the extent to which stigma and psychological distress will jointly influence the quality of life of patients with Psychoactive substance disorders.

## Statement of Hypotheses

The following hypotheses were tested:

- i. Perceived stigma will significantly predict the quality of life among psychoactive substances patients in FNPHK.
- ii. Psychological distress will significantly predict the quality of life among psychoactive substances patients in FNPHK.
- iii. Perceived stigma and psychological distress will jointly predict the quality of life among psychoactive substances patients in FNPHK.

## METHOD

### Design

This study adopted a cross-sectional survey design, which involves gathering and analyzing data from a population of interest at one specific point in time. The two independent variables used in this study were perceived stigma and psychological distress, while the dependent variable was quality of life among patients abusing psychoactive substances at Federal Neuro-Psychiatric Hospital Barnawa Kaduna.

This study included all stable and available participants (i.e., patients) who were undergoing treatment and rehabilitation for substance use and abuse at the Federal Neuro-Psychiatric Hospital Kaduna. The participants were sampled through purposive sampling technique. Relevant sociodemographic information, such as age, marital status, and religion, was obtained and described in detail.

### Instruments

The Substance Use Stigma Mechanism Scale (SU-SMS) was developed by Laramie & Valerie (2016). It is designed to measure the mechanisms underlying substance use stigma and consists of 18 items. The SU-SMS focuses on three key mechanisms of stigma. It utilizes a 5-point Likert scale response format, with higher scores indicating greater endorsement of substance use stigma. The scale also allows for the creation of sub-scores based on the source of the stigma. The psychometric properties of the SU-SMS indicate good internal consistency, with Cronbach's alpha coefficients ranging from 0.85 to 0.96 for the different mechanisms. Test-retest reliability was also good, with intraclass correlation coefficients ranging from 0.73 to 0.91. The SU-SMS has demonstrated good construct validity, meaning it measures what it is intended to measure, correlates well with other measures of substance use stigma, and distinguishes between different levels of stigma.

The Kessler Psychological Distress Scale (K-10) was developed by Kessler et al. (1992) and is used as a measure of nonspecific psychological distress to assess well-being in individuals. It consists of 10 items assessing the frequency of symptoms such as feeling nervous, hopeless, or worthless in the past 30 days. The K-10 has shown good psychometric properties, including reliability, with high internal consistency (Cronbach's alpha coefficients ranging from 0.83 to 0.93).

The K-10 has been validated in Nigeria in a study by Seun-Fadipe & Mosaku (2017) on sleep quality and psychological distress among undergraduate students of a Nigerian university. The Cronbach's alpha was 0.87, and it showed significant discriminant validity with depression and anxiety (Pearson's moment correlation coefficients were 0.284 and 0.263, respectively). Similarly, another study by Adayonfo & Akanni on Psychological Distress Among Nigerian Undergraduate Students demonstrated significant discriminant validity of the K-10 between cases with psychological distress and those without ( $t$ -test = 2.007).

The World Health Organization Quality of Life Questionnaire BREF (WHOQOL-BREF) is a self-report questionnaire containing 26 items rated on a 5-point Likert scale. Domain scores are scaled positively, where higher scores indicate greater quality of life (WHO, 1998). The Cronbach's alpha reliability in a study conducted by Gholami et al. (2014) was 0.82, indicating high internal consistency, consistent with the current study where a Cronbach's alpha of 0.91 was achieved for the total domain.

### Procedure

The researcher obtained a letter of introduction from the Department of Psychology and applied to the ethical committee of the hospital for permission to conduct research. After approval from the FNPHK ethical committee, the researcher conducted the study at the facility. Participants were briefed about the study's purpose and objectives. Those interested were provided with questionnaires containing a consent form at the beginning and were given sufficient time to complete it. Data collection lasted two days, after which the researcher debriefed participants and sorted the data to ensure only correctly completed questionnaires were used for analysis.

### Statistical technique used

The data collected in this study were analysed using the Statistical Package for Social Sciences version 27. The demographic characteristics of the participants were analysed using descriptive statistics such as frequencies, percentages, means and standard deviations. Inferential statistics such as regression analyses, analysis of variance (ANOVA) and independent sample  $t$  tests were used to test the hypotheses. Hypotheses one and three were tested using multiple linear regression analysis, while hypothesis two was tested using linear regression analysis.

### RESULTS

**Table 1: Multiple regression analysis of perceived stigma on quality of life among psychoactive substances patients in FNPHK**

Variables	R	R <sup>2</sup>	df	F	$\beta$	t	Sig.
(Constant)						24.078	0.000
Enacted Stigma					-0.218	-2.388	0.019
Anticipated Stigma	0.690	0.477	3,76	23.070	-0.315	-3.354	0.001
Internalised Stigma					-0.390	-4.389	0.000

*a. Dependent Variable: WHOQOL*

Multiple regression analysis was used to examine the influence of enacted stigma, anticipated stigma, and internalized stigma on quality of life. The overall model was significant [ $F(3, 76) = 23.070, p < .001, R^2 = 0.477$ ]. The  $R^2$  value of 0.477 indicates that 47.7% of the variance in

quality of life can be explained by the three types of stigmas included in the model. enacted stigma ( $\beta = -0.218, t = -2.388, p = .019$ ). The negative beta coefficient indicates that as enacted stigma increases, quality of life decreases. For every one standard deviation increase in enacted stigma, quality of life decreases by 0.218. Anticipated stigma ( $\beta = -0.315, t = -3.354, p = .001$ ) was a significant negative predictor of quality of life. For every one standard deviation increase in anticipated stigma, quality of life decreases by 0.315. Internalized stigma ( $\beta = -0.390, t = -4.389, p < .001$ ) was a significant negative predictor of quality of life. For every one standard deviation increase in internalized stigma, quality of life decreases by 0.390.

**Table 2: Simple linear regression of psychological distress and quality of life among psychoactive substance-treated patients in the FNPHK**

Variable	R	R <sup>2</sup>	df	F	$\beta$	t	Sig.
(Constant)	0.289	0.084	1,77	7.025		13.519	0.000
Psychological distress					-0.289	-2.650	0.010

a. *Dependent Variable: WHOQOL*

A simple linear regression analysis was conducted to investigate the predictive ability or influence of psychological distress (measured by the Kessler scale) on quality of life (measured by the WHOQOL). The regression model was statistically significant [ $F(1, 77) = 7.025, p = .010, R^2 = .084$ ]. The  $R^2 = .084$  indicates an 8.4% variance in quality of life explained by this model. This indicates that psychological distress has a significant influence on or can predict quality of life, albeit to a modest degree.

Specifically, psychological distress ( $\beta = -.289, p = .010$ ) was a significant negative independent predictor of quality of life. This indicates that a one-unit increase in the Kessler scale score was associated with a 0.414 unit decrease in the WHOQOL score. This suggests that as psychological distress increases, quality of life decreases. However, it is important to note that while the relationship is statistically significant, the model explains only a small portion of the variance in quality-of-life scores.

**Table 3: Hierarchical regression analysis of perceived stigma and psychological distress among psychoactive substance patients in the FNPHK**

Model	Variable	R	R <sup>2</sup>	$\beta$	t	Sig.	B	Std. Error
1	(Constant)	.453			23.086	0.000	84.917	3.678
	Enacted Stigma			-0.220	-2.383	0.020	-0.317	0.133
	Anticipated Stigma			-0.314	-3.329	0.001	-0.439	0.132
	Internalized Stigma			-0.390	-4.346	0.000	-0.660	0.152
2	(Constant)	.467	.467		18.064	0.000	89.657	4.963
	Enacted stigma			-0.206	-2.244	0.028	-0.298	0.133
	Anticipated stigma			-0.295	-3.119	0.003	-0.413	0.132
	Internalized stigma			-0.377	-4.210	0.000	-0.638	0.152
	Kessler			-0.124	-1.411	0.162	-0.178	0.126

Hierarchical multiple regression analysis was conducted to examine the joint and contributory influence of enacted stigma, anticipated stigma, internalized stigma, and psychological distress on quality of life (WHOQOL).

In Step 1, using the three types of stigma as predictors, the model was statistically significant [ $F(3, 75) = 20.708, p < .001, R^2 = .453$ ]. All three predictors were significant individually: enacted stigma ( $\beta = -.220, p = .020$ ), anticipated stigma ( $\beta = -.314, p = .001$ ), and internalized stigma ( $\beta = -.390, p < .001$ ). This step accounted for 45.3% of the variance in quality of life.

In Step 2, with the addition of psychological distress (Kessler), the model remained statistically significant, with a slight increase in  $R^2$  [ $F(4, 74) = 16.234, p < .001, R^2 = .467$ ]. Enacted stigma ( $\beta = -.206, p = .028$ ), anticipated stigma ( $\beta = -.295, p = .003$ ), and internalized stigma ( $\beta = -.377, p < .001$ ) remained significant predictors, while psychological distress ( $\beta = -.124, p = .162$ ) was not a significant predictor. This step accounted for 46.7% of the variance in quality of life.

The model suggested that enacted stigma, anticipated stigma, and internalized stigma were significant independent predictors of quality of life, all of which negatively predicted quality of life. Internalized stigma had the strongest negative impact, followed by anticipated stigma and then enacted stigma. The addition of psychological distress in Step 2 did not significantly improve the model's predictive power.

## DISCUSSION

The results from hypothesis one reveal that psychological distress and quality of life jointly predict quality of life among psychoactive substance patients. Consistent with other studies, such as the one carried out by Corrigan and Watson (2002), discrimination and prejudice towards individuals with mental illnesses are common in various settings, including the workplace, healthcare, and social interactions, which also negatively affect quality of life.

Similarly, the findings from the data analysis of the anticipated subscale of perceived stigma were consistent with those of other studies. For example, the study by Quinn & Chaudoir (2009) focused on the impact of anticipated stigma on the mental health of individuals living with HIV/AIDS. The researchers found that individuals who anticipated stigma were more likely to experience symptoms of depression and anxiety, as well as lower self-esteem and poorer quality of life.

Furthermore, in a study by Link et al. (2014), the researchers examined the impact of anticipated stigma on the help-seeking behaviours of individuals with mental health conditions. The study revealed that individuals who anticipated discrimination or negative attitudes from others were less likely to seek help for their mental health concerns and were more likely to delay treatment or avoid disclosing their condition.

Moreover, the findings from the data analysis of the internalized subscale of perceived stigma are consistent with those of Link et al. (2001), who found that internalized stigma can lead to feelings of shame, guilt, and worthlessness among individuals with mental illness, which can in turn exacerbate symptoms of depression and anxiety. Furthermore, Puhl and Brownell (2006) focused on internalized stigma in individuals with obesity. The researchers found that individuals who internalized weight-based stigma were more likely to experience depression,

anxiety, and poor quality of life and were less likely to engage in healthy behaviors such as exercise and healthy eating.

The results from hypothesis two reveal that psychological distress and quality of life jointly predict quality of life among psychoactive substance patients. Consistent with other studies, such as the one carried out by Muller et al. (2016), which showed that 75% of drug users indicated that their quality of life was "weak" or "bad", where depression has shown a strong association with poor quality of life. Moreover, lack of physical activity among drug users has been associated with very poor quality of life, and underrating an individual's weight was associated with poor quality of life. Similarly, a study carried out by Abrahamson et al. (2015) determined the factors associated with the quality of physical and mental life in a sample of addicted patients, and the results showed that the abuse of narcotic substances led to deterioration in physical health, such as physical pain, anger, impaired social functioning, and decreased quality of life among addicted individuals. The symptoms of anxiety and depression associated with addiction lead to an increase in the severity of problems in addicted individuals, which has a negative impact on their quality of life.

Furthermore, the study by Saatcioglu et al. (2008) examined the nature of the relationship between quality of life and severity of depression and anxiety for addicts, and whether quality of life differs between addicted individuals with and without depression and anxiety. The results of the study found that the quality of life in the areas of physical, psychological, and environmental health differed significantly between groups of patients, with the exception of social relations. The quality of life was lower in patients with depression and higher in addicted patients with less anxiety and depression. Similarly, the results of hypothesis two are consistent with the study results of Marcon et al. (2013) and Armstrong et al. (2013), which demonstrated a strong negative relationship between quality of life and depression, anxiety, and suicidal ideation for drug addicts. The studies also showed that drug addicts have different psychological, physical, social, and emotional needs than healthy individuals; behavioural changes resulting from drug abuse, as well as problems in relationships with family and friends, etc. The studies also concluded that the increase in the duration of substance use leads to a deterioration in quality of life. Additionally, a study by Earnshaw et al. (2013) found that substance use stigma was associated with higher levels of psychological distress and lower levels of well-being among individuals with substance use disorders. This study underscores the importance of addressing stigma as a social determinant of health.

### **Limitations of the Study**

The following limitations were observed in the course of this study:

- i. Some of the patients were reluctant to participate, and the few who agreed to participate spent much time responding to the copies of the research instrument.
- ii. Some of the participants left some questions unanswered. Most patients who were admitted to the front of the taxology ward might be highly suspicious and vigilant in the course of completing the questionnaire.

### **Contributions to Knowledge**

The following key findings have contributed to the current knowledge:

1. Research has shown that perceived stigma, or the belief that one is being discriminated against or judged negatively by others because of their substance use disorder, can have a significant impact on an individual's quality of life. This stigma can lead to feelings of shame, isolation, and low self-esteem, all of which can contribute to psychological distress and poor quality of life.
2. Psychological distress, such as anxiety, depression, and other mental health issues, is common among individuals with substance use disorders. This distress can both be a cause and a consequence of substance use and can further worsen quality of life by impacting relationships, work, and overall well-being.
3. Research has highlighted the complex interplay between perceived stigma, psychological distress, and quality of life among individuals with substance use disorders. For example, stigma may lead to increased psychological distress, which in turn can negatively impact quality of life. Conversely, high levels of psychological distress may also increase perceptions of stigma and further degrade quality of life.

### **Conclusion**

The role of perceived stigma and psychological distress on the quality of life among patients with psychoactive substances at FNPHK has been illuminated by the findings of this study. The study demonstrated the significant influence of perceived stigma and psychological distress on the quality of life among patients with psychoactive substances, supporting findings from studies conducted outside this country on the influence of perceived stigma and psychological distress on quality of life. The researcher concluded that individuals who exhibit perceived stigma symptoms such as enacted stigma, anticipated stigma, and internalised stigma are more likely to experience poor quality of life, while individuals with psychological distress disorders such as anxiety disorder, depression, and post-traumatic stress disorder (PTSD) are also more likely to experience low quality of life.

### **Recommendations**

The following recommendations were made as follows:

1. It's important for healthcare providers to address and mitigate the perceived stigma experienced by patients with psychoactive substance disorders. This could involve creating a safe and welcoming environment for patients to seek treatment without fear of judgement.
2. Mental health professionals should also assess and address the psychological distress experienced by patients with substance use disorders. This could involve providing adequate support and counselling services to help patients cope with their emotions and improve their overall quality of life.
3. Collaboration between mental health professionals, psychoactive substance abuse treatment providers, and support groups may be beneficial in offering comprehensive care to patients with substance use disorders, who are also experiencing psychological distress.



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