EFFECT OF STIGMATISATION ON SELF-CONCEPT AMONG CLIENTS RECOVERING FROM SUBSTANCE USE IN SELECTED REHABILITATION CENTRES IN KIAMBU COUNTY

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DECLARATION

I declare that this document and the research that it describes are my original work and that they have not been presented in any other university for academic work.

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DEDICATION

I dedicate this research to my late dad Mr. Francis Njaga Mwaura, whose guidance and support set me on the right path for my educational life and professional pursuits.

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ABSTRACT

The purpose of this study was to examine the effect of stigmatisation on the self-concept among clients recovering from substance use in Kiambu County, Kenya. The first objective was examine the prevalence of stigmatisation among clients recovering from substance use in selected rehabilitation centres in Kiambu County. The second objective was explore how stigmatisation influences self-concept of clients in selected rehabilitation centres in Kiambu County. Thirdly, the study sought to analyse the relationship between perceived stigmatisation and self-concept among clients in the selected rehabilitation centres in Kiambu County. The final objective was to assess the influence of stigmatisation on self-concept and treatment outcomes. A cross-sectional research design, incorporating mixed methods, guided the collection of data from 113 participants, including individuals in treatment and 12 professionals from accredited rehabilitation centres in Kiambu County. Purposive and random sampling approaches formed the basis for the selection of individuals for the inclusion into the sample. Different validated data collection instruments, including the PSAS - Perceived Stigma of Substance Abuse Scale (PSAS), Recovery Assessment Scale (RAS), and Substance Use Stigma Mechanisms Scale (SU-SMS) provided a foundation for the development and operationalisation of the data collection instrument. A semi-structured interview guide was included to collect qualitative data. Quantitative data was analysed using SPSS version 26 and presented using tables, graphs, and texts. Thematic analysis formed the basis for the processing of identifying recurring themes in the qualitative data. Word clouds and text narratives formed the basis for presenting the qualitative data showing frequency of key themes and verbatim quotes from the participants and interpretations. Pretesting through a pilot study in Mathari Hospital helped assess the validity and reliability of the data collection instruments. To ensure ethical conduct during the research process, it was first important to obtain approval from Nazarene University. Additionally, the researcher obtained informed consent and voluntary participation from the participants. Further, implementing various security measures ensured that all the data was private and confidential. The study found a high prevalence of perceived stigmatisation among clients in rehabilitation. Most of the participants reported feeling judged (66.0%), experiencing negative societal views (79.4%), and facing stigma in personal relationships (65.0%), while 59.8% reported discrimination related to substance use. Despite this, fewer felt ashamed to share their recovery journey (32.9%), with 44.3% feeling comfortable sharing. Perceived stigma showed significant associations with self-concept indicators, including confidence in maintaining recovery ($\tau = .303$, $p = .001$) and belief in goal potential ($\tau = .344$, $p < .001$), while perceived treatment support demonstrated protective effects by reducing stigma-related barriers to help seeking ($\tau = -.279$, $p = .001$). There was a consensus that reducing stigma can potentially lower relapse risk (Mdn=5). However, stigma is common and can harm self-concept, self-worth, and recovery outcomes. As such, it is critical for all stakeholders, including professionals and policymakers to provide a support environment, social support systems, and empowerment to foster the development of a positive identity, which could result in better engagement and outcomes. Rehabilitation efforts should be stigma-sensitive, and more particularly, supportive treatment, which could improve engagement and reduces relapse.

DEFINITION OF TERMS

Treatment Outcomes: A client achieving or failing to achieve the set treatment goals and objectives for substance use problems.

Stigma: The negative perception and labels that cause some members to treat the affected individuals differently and discriminate against them.

Recovery: A client achieving good health or the set treatment goals and objectives, and therefore, live a normal healthy life.

Rehabilitation Centres: Includes Treatment and rehabilitation centres that NACADA accredited rehabilitation centres in Kiambu county providing interventions to help individuals with substance use issues.

Stigmatisation: Negative attitudes, beliefs, and behaviours directed toward individuals with substance use problems, leading to social rejection, discrimination, or internalized shame.

Self-Concept: An individual's perception of himself or herself covering self-efficacy, self-esteem, identity development, authenticity and self-acceptance, perceived personal growth, and social acceptance.

Substance Use: Using cigarettes, alcohol, drugs and substances through oral, inhalation, and injection methods of administration.

ABBREVIATIONS AND ACRONYMS

NACADA	National Authority for the Campaign against Alcohol and Drug Abuse
NACOSTI	National Commission for Science, Technology, and Innovation
NIAAA	National Institute on Alcohol Abuse and Alcoholism
PSAS	Perceived Stigma of Substance Abuse Scale
RAS	Recovery Assessment Scale
SPSS	Statistical Package for Social Sciences
SU-SMS	Substance Use Stigma Mechanisms Scale

CHAPTER ONE
INTRODUCTION

1.1 Introduction

Knowledge about how individuals facing substance use disorder view themselves, their self-concept, and experiencing stigmatisation can deepen insight into their path to recovery. Stigmatisation can greatly influence how one sees themselves and hinder an individual's recovery process. Stigmatisation is the biased and negative judgement, description, and discrimination of an individual or a group of individuals because of their characteristics, such as having alcohol dependence or being in recovery from substance use, in this case (National Institute on Alcohol Abuse and Alcoholism [NIAAA], 2024). Self-concept is the image a person has about themselves, their social, spiritual, or other aspects of their individuality, which influences their worldviews, motivations, and behaviours (Crone et al., 2022).

Recovery is a change process through which individuals with substance use problems stop using substances, improve their health and well-being, and strive to live a better life to realise their full potential (Tooley, 2023). This chapter introduces the study. Exploring extant literature and reports on substance use and stigmatisation and its influence on the self-concept of individuals in recovery from substance use provides a background for this study. The study's problem statement, study purposes and objectives, research questions, as well as the study's scope, delimitations, limitations, assumptions, theoretical and conceptual framework are discussed in this chapter

1.2 Background of the Study

The stigmatisation of individuals in treatment for substance use can potentially affect the recovery journey. Primarily, stigma may inhibit an individual’s efforts to recover from substance because it affects self-concept negatively. Self-concept is how a person understands or views themselves; their self-image, self-esteem, and self-worth are directly associated with an individual’s ability to seek treatment and recover (Anand et al., 2022; Chen, 2024). Different studies, such as one conducted in the United States, concluded that stigmatisation against people with substance use disorders is a prevalent problem, which can have an effect on their self-concept and, therefore affect recovery efforts (Larson, 2019). In another research conducted in China, the researchers concluded that drug addiction stigma results in pronounced depression and anxiety and lower self-acceptance, which can inhibit the recovery process (Li et al., 2025). Anand

et al. (2022), in a study conducted in India, reported similar findings as the study in the US and China, concluding that stigma, including self-stigma, negatively affects self-concept and the recovery process. In Kenya, a study by Gutwa and Obare (2022) resulted in conclusions that echoed the studies drawn from other parts of the world: positive self-concept builds esteem, which can encourage a person to start and sustain treatment and sobriety. Conversely, a negative self-concept may cause feelings of shame and guilt or a lack of motivation to seek and sustain recovery efforts (Gutwa & Obare, 2022). As such, stigmatisation of individuals with substance use problems is a common problem, which could potentially affect their self-concept and then inhibit their efforts to recover and achieve normalcy in their lives.

Different studies from across the world have evaluated the influence of stigmatisation on the self-concept of individuals with substance use problems. For example, a study conducted in the United States, Benz et al. (2021) concluded that fear occasioned by stigma may make the affected individuals less willing to seek help and recover. Another study in the United States concluded that stigma is widely recognized as a barrier to effective substance use treatment, contributing to health disparities (Earnshaw, 2020). Similarly, in a study conducted in Kenya focusing on support assets for individuals in recovery, Kithuri et al. (2016) made similar conclusions, observing that stigmatisation may impede the recovery process for individuals with substance use problems. However, some studies have acknowledged the positive effects of treatment on self-perception, such as Larson (2019) and O'Sullivan et al. (2019), who suggested that therapy, can foster self-kindness and reduce internal shame. Recovery capital, including self-stigma, is vital for sustainable recovery, and increasing recovery resources can mitigate stigma's harmful effects (O'Sullivan et al., 2019). Social support further strengthens recovery by improving self-image (Tooley, 2023).

Generally, the prevalence of alcohol, drugs, and substance use globally, regionally, and locally exacerbates the various associated issues. Substance use is a pervasive public health issue globally, regionally, and locally. Globally, as of 2021, there were approximately 296 million people, in the 15 to 64 years age bracket, that were actively engaged in the consumption of psychoactive substances. Of these, 39.5 million had a drug use problem, and the numbers are expected to continue rising moving into the future (WHO, 2022). The same trends are evident in specific parts of the world. For example, among teenagers, in the Americas and Europe, prevalence rates of alcohol

drinking stood at 43.9% and 45.9%, compared to the global levels at 23.5% (World Health Organization [WHO], 2024).

At the regional level, particularly in Africa, cannabis is widely abused, with prevalence rates ranging from 5.2% to 13.5% (WHO, n.d.). Further, demonstrating the prevalence of alcohol, drugs, and substance use, Mavura et al. (2022) observed that among adolescents in sub-Saharan Africa, the prevalence of substance use is as high as 19.7%, with alcohol and tobacco being the most commonly consumed substances, with prevalence rates reaching 40%. Similarly, in Kenya, substance use remains a significant issue. A report by NACADA (2022) established that key among the different drugs and substances, alcohol and tobacco are the most commonly used substances, with usage rates at 11.8% and 8.5%, respectively. Moreover, about 16.7% of Kenyans, starting from as young as 15, use at least one substance. In Central Kenya, including Kiambu, portable spirits and tobacco have a 3.1% and 10.8% prevalence, respectively (NACADA, 2022). These statistics demonstrate a high prevalence of use of alcohol, drugs, and other substances globally, which considered within the context of the stigmatisation that these individuals face, further demonstrates the seriousness of stigmatisation as an area of concern.

The widespread prevalence of substance use and substance use has deeply affected individuals, families, and communities, driving the need for recovery programs. However, stigma remains a significant barrier in the recovery process. Stigmatisation, defined by negative attitudes, beliefs, and actions toward individuals with substance use, can severely affect self-perception and hinder recovery (Chen & Stuart, 2021; Bielenberg et al., 2021). Individuals with substance use problems have historically faced different challenges, such as discrimination, exclusion, and lack of opportunities in different areas of their lives, which have exacerbated the issues they are already facing in their lives because of their substance use or abuse problems (Amaro et al., 2021; Cazalis et al., 2023; Mburu et al., 2018). Notably, in some instances, individuals with substance use problems may also experience bias, prejudice, stigmatisation and discrimination from healthcare professionals (Macharia et al., 2022; Nieweglowski et al., 2018). When individuals with substance use problems or issues experience stigma, they are less likely to seek treatment and achieve recovery (Ashford et al., 2019; Macharia et al., 2022). Therefore, stigmatisation is a critical issue facing individuals with substance use problems, which can potentially affect their recovery efforts negatively.

Different stakeholders, such as the government and civil society, have expressed concern over substance use's socioeconomic and health effects (Community Education and Empowerment Centre [CEEC], 2023; Muteti & Kamenderi, 2019). Substance use contributes to increased morbidity, comorbidities, mortality, and higher healthcare costs, as well as higher general economic costs (Fardone et al., 2023; Manthey et al., 2021; Muteti & Kamenderi, 2019; NACADA, 2022; WHO, 2022). However, it is important to note that efforts to address substance use has faced numerous challenges, such as stigmatisation of individuals in recovery (Muteti & Kamenderi, 2019; NACADA, 2022). As such, substance use is a prevalent problem that stakeholders should address. However, it is important to acknowledge interventional efforts face significant challenges, which stakeholders should address. While these studies emphasize the importance of addressing stigma and nurturing recovery capital, there is a gap in research focusing on this dynamic in Kenya, particularly in Kiambu County.

1.3 Statement of the Problem

Substance use is a serious global public health concern. It affects a large portion of the global population with serious economic, social, and health negative effects on individuals, families, communities, and the entire healthcare. Despite efforts to implement treatment interventions, there are significant impediments to their effectiveness. One key impediment is stigmatisation. Stigma occasions feelings of shame and rejection, which can negatively affect people's self-concept and self-worth, inhibiting successful rehabilitation. Self-concept, which includes self-esteem, self-worth, and self-image, critically influences the efforts of individuals to recover from substance use. However, there is a paucity of studies assessing the effect of stigmatisation on self-concept among clients recovering from substance use, and their influence on treatment and recovery in the Kenyan context. More specifically, there are few studies focusing on Kiambu County, which has been grappling with alcohol and substance use problems across different demographics Currently, Kiambu County has 39 accredited facilities. As widely reported in the media, the Kiambu County Government and national government have initiated efforts to address substance use in this region. However, there is a scarcity of scholarly works exploring the effectiveness of these initiatives. More specifically, there are no studies in Kiambu County, focusing on stigma, its effect on self-concept, and the effectiveness of the implemented

interventions. As such, this investigation addresses this gap by assessing the effect of stigma on self-concept and the effects on the success of rehabilitative efforts.

1.4 Purpose of the Study

The main purpose of this study was to investigate how stigmatisation affects self-concept and the treatment outcomes for substance users in selected rehabilitation centres in Kiambu County.

1.5 Objectives of the Study

The following specific objectives guided this study:

1. To examine the prevalence of stigmatisation among clients in treatment for substance use problems in selected rehabilitation centres in Kiambu County.
2. To explore how stigmatisation influences self-concept of clients in selected rehabilitation centres in Kiambu County.
3. To analyse the relationship between perceived stigmatisation and self-concept among clients in the selected rehabilitation centres in Kiambu County.
4. To assess the effect of stigmatisation on self-concept and treatment outcomes.

1.6 Research Questions

Derived from the research objectives, the specific research questions that guided this study were:

1. What are the stigmatisation prevalence levels among clients recovering from substance use in selected rehabilitation centres in Kiambu County?
2. How does stigmatisation influence the self-concept of recovering individuals in selected rehabilitation centres in Kiambu County?
3. What is the relationship between stigmatisation and self-concept among clients in selected rehabilitation centres in Kiambu County
4. What is the effect of stigmatisation on self-concept and treatment outcomes?

1.7 Significance of the Study

This study, and by extension, the findings, will contribute to generating knowledge and insights that can help address widespread stigmatisation in substance use recovery, especially in Kiambu County, Kenya. Further, the study will contribute to highlighting the need for appropriate recovery programs with an enhanced scope, including the mental and social support for mental health. Additionally, the study will

provide further insights into how stigma affects self-concept, and therefore, help in addressing factors that could hinder effective reintegration and reduce relapse risk. It will also contribute to filling the current research gap about the specific way in which stigma affects self-concept within the Kenyan context in general, and Kiambu County in particular.

From another perspective, the research will provide insights that could guide targeted interventions and support systems for individuals in recovery. More particularly, the research will provide further insights into the contribution of stigmatisation to discrimination, isolation, and poorer recovery outcomes. The insights generated from this study will demonstrate the link between stigma, self-concept, and therefore, the effectiveness of interventions aimed at enhancing the rehabilitation of individuals with substance-use problems. Finally, the research also contributes context-specific knowledge for Kenya, which can help in informing policy and rehabilitation program development.

1.8 Scope of the Study

The topic that is the focus of this research is the effect of stigmatisation on the self-concept of individuals in recovery from substance use and the effect on the treatment or rehabilitation outcomes. In terms of the geographical area of focus, the study was conducted in Kiambu County. Kiambu County, a metropolitan county bordering Nairobi County, has a reported high prevalence rate of substance use. Further, the county has a notably high number of rehabilitation centres. In addition, the study specifically focused on clients in recovery from substance use, but not diagnosed with substance use disorders (SUDs). The approach mitigated the ethical concerns of working with individuals with severe cognitive challenges that may be present in individuals diagnosed with SUD. Further, the study specifically focused on assessing the relationship between stigmatisation and various aspects of self-concept, targeting individuals in treatment in rehabilitation centres in Kiambu County, from where a representative sample was drawn. Rehabilitation centres in the area draw clients from across the country. The Study was conducted between August 2024 and December 2025. These topical, geographical, temporal, and population areas of focus were deliberately selected to establish a well-defined and coherent scope for the study to ensure high-quality output.

1.9 Delimitations of the Study

This study specifically focused on recovering clients with substance use problems within rehabilitation centres in Kiambu County. The study did not cover other geographical regions or clients diagnosed with SUDs, who could potentially have cognitive challenges, thereby giving rise to ethical considerations in working with this population. Further, the study specifically focused on how stigmatisation affects self-concept and the effectiveness of interventions, which implies that other factors that may potentially affect recovery were not considered.

1.10 Limitations of the Study

Considering and addressing the potential limitations ensures that the study is successful. The notable limitations are clients' willingness to participate in the study because of the sensitivity of the topic, potential language barriers, and self-bias in self-reporting, which was used in data collection. To address these limitations, one of the first strategies was to brief the participants about the research topic, and reassuring them that potential confidentiality and privacy concerns were sufficiently addressed, interpreters used, and used validated tools to foster validity and reliability by mitigating potential self-reporting biases. Finally, by ensuring rigor in conducting the study fostered the generalisability of the findings, conclusions, and inferences to other contexts.

1.11 Assumptions of the Study

Multiple key assumptions guided the study. Primarily, it was assumed that the participants provided honest and accurate responses. Another assumption was that the selected rehabilitation centres provided a representative sample of substance use clients in recovery within the geographical area of focus. Finally, it was assumed that the perceived effect of stigmatisation on self-concept and treatment outcomes is measurable using the adopted data collection instruments. The study also assumed that there is a relationship between stigmatisation and self-concept.

1.12 Theoretical Framework

1.12.1 The Labelling Theory

The labelling theory, by sociologist Becker (1963), was an integral part of this study's theoretical framework. According to Abastillas et al. (2020), scholars on deviance have extensively used this theory. From the perspective of this theory, the labels assigned by society to individuals affects their self-concept and behaviour,

resulting in the manifestation of deviant behaviours (Argueta & Lonergan, 2020; Becker, 1963). Further, labelling exacerbates stigmatisation and social exclusion and reinforces deviant behaviour when the affected individuals internalise the labels and change their self-perceptions (Goldman, 2021). The key concepts of the labelling theory are primary deviance and secondary deviance, which refer to the progression from initial deviance to deviance occasioned by internalised labels (Argueta & Lonergan, 2020).

Accordingly, in this study focusing on the effect of stigma on the treatment and recovery process, the labelling theory provided a basis for assessing the nature and effect of stigma and stigmatisation. For example, different labels associated with substance users, such as addict or junkie, which carry negative connotations, may reinforce stereotypes that individuals with substance use problems are weak or unworthy (Earnshaw, 2020; Sibley et al., 2023). When used, these labels may exacerbate the feelings of shame, guilt, and low self-esteem that individuals with substance use problems experience, thereby increasing the risk of not seeking treatment or relapsing (Ashford et al., 2019). These elements and arguments based on the labelling theory informed a more in-depth and insightful understanding of the effect of stigma on self-concept, and, therefore, the effectiveness of interventions. However, it is important to acknowledge that the theory solely focuses on external factors that may affect stigma, self-concept, and therefore, effectiveness of interventions, which necessitates the consideration and use of other theories.

1.12.2 The Social Identity Theory

The social identity theory is another theory that offered a theoretical lens for assessing and interpreting the relationship between stigma and self-concept, and therefore, the effectiveness of interventions for substance use. The social identity theory proposes that belonging to a particular social group affects their sense of identity and, therefore, their self-concept (Ajewumi et al., 2024; Tajfel & Turner, 1979). From the perspective of this theory, a person will associate with a particular group, such as “recovering addicts”, which, in turn, can bolster their identity and self-concept and improve their likelihood of succeeding in rehabilitation efforts (Naserianhanzaei & Koschate-Reis, 2021). However, when an individual identifies with a stigmatised group, they are likely to experience low self-esteem and inhibit their efforts to recover (Brousseau et al., 2020; Chen, 2024). As such, this theoretical perspective provided the

theoretical basis for evaluating and interpreting the importance of support systems, especially within the group context, and their role in the recovery process (Naserianhanzaei & Koschate-Reis, 2021). Therefore, based on this theoretical perspective, the roles of group membership, including the positive and negative effects, were assessed.

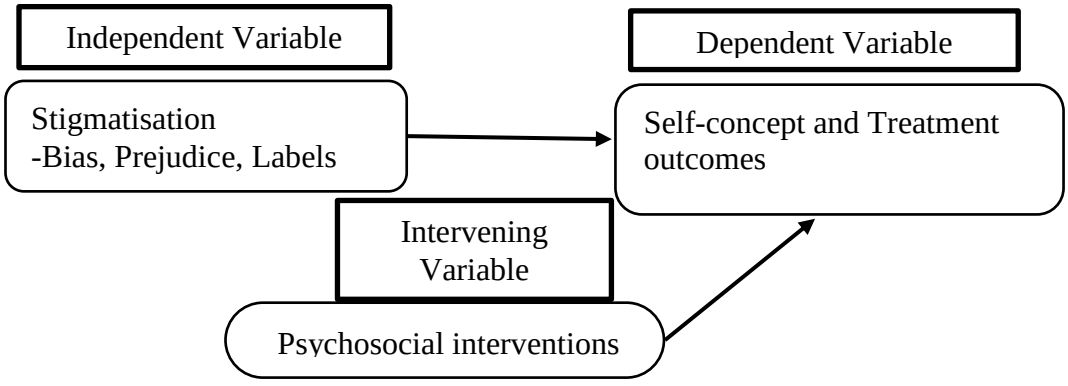
The social identity theory augmented the labelling theory and formed the basis for assessing and interpreting the effect of stigma on self-concept and the potential effect on the treatment and recovery process. The labelling theory provides insights into how labels may encourage or support an individual's exhibition or engaging in deviant behaviour, such as substance use. The social identity theory provides a basis for exploring how groups may be a source of social support and encourage or discourage the effectiveness of interventions based on the specific nature of the group identity. Combined, these theories provide a framework that helped assess and understand the effect of stigmatisation on self-concept and the subsequent effect on the effectiveness of rehabilitation efforts.

1.13 Conceptual Framework

This section provides a description of the conceptual framework guiding this study. A conceptual framework visually depicts the map, or the structure of a study, including the key concepts, variables, and the expected relationships between them. (Varpio et al., 2020). Visually, the conceptual framework helps a researcher to map, present, and therefore, undertake the research process in a structured and purposeful way, providing a clear perspective on how different study elements relate to one another (Van der Waldt, 2020). Figure 1.1 depicts the conceptual framework that guided this study.

Figure 1:1.

Conceptual framework



The independent variable (stigmatisation), and all constituent elements, including bias, prejudice, and labels, affects the dependent variable which is self-concept and the treatment outcomes. Psychological interventions can potentially mitigate the negative effects of stigmatisation on self-concept. Well-structured interventions can potentially mitigate the adverse effects of stigmatisation on self-concept, and therefore, ensure that the treatment and recovery process is more successful. As such, in line with the observations by Varpio et al. (2020) and Van der Waldt (2020), this conceptual framework provides a map for carrying out the study.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This study investigated the effect of stigmatisation on the self-concept and, therefore, the effectiveness of rehabilitative interventions of individuals in treatment for substance use problems in Kiambu County. The research highlighted the potential barriers to individuals with substance use problems access to treatment and recovery, with a particular focus on stigmatisation, which can help improve the implemented measures. The research's specific objectives guided the literature review in this section, with each of the objectives forming the basis for the review of the empirical literature. Accordingly, based on the literature review, it was possible to understand the different constructs and concepts related to the study further. The literature review also formed the basis for identifying and justifying the research gap.

2.2 Empirical Literature Review

2.2.1 Prevalence of Stigmatisation among Clients in Recovery

Recently, there has been an increased focus on substance use as a critical public health issue globally. For example, in one study conducted in Nigeria, Nelson et al. (2024) observed that substance use constitutes the use of different legal and illegal drugs, alcohol, and other substances, which can affect a person's life negatively. Similarly, Mavura et al. (2022) in a study conducted in Tanzania and Mhaidat et al. (2024) in a study conducted in the United States Emirates, observed that overindulgence in alcohol, drugs, and other substances can cause absenteeism, break social relationships, and negatively affect their health, among other effects. Similarly, in a study conducted in Zimbabwe, Maraire and Mariamdaran (2020) observed that it is important to address potential barriers to effective treatment, such as stigmatisation, which will ensure that people grappling with substance abuse issues, their families, and communities live better and more fulfilling lives.

Stigmatisation, including negative attitudes, biases, and beliefs associated with a condition, such as substance use, can cause discrimination and exclusion of the affected individuals (Matsumoto et al., 2021; Nyashanu & Visser, 2022; Sibley et al., 2023). Stigmatisation can be a significant barrier to the treatment and recovery of individuals with different issues, such as mental health disorders or substance use problems (National Institute on Alcohol Abuse and Alcoholism [NIAAA], 2024; Patel

et al., 2024). Kilian et al. (2021), Krendl and Perry (2023), and Magnan et al. (2024) presented similar findings, which demonstrated a high prevalence of stigmatisation and the negative effect on access and use of treatment, and the effectiveness of the interventions. As such, while substance use is a serious problem, stigmatisation can be a significant barrier to successful treatment. These challenges demonstrate the need to formulate and implement measures aimed at addressing stigmatisation to ensure that rehabilitation efforts are more effective.

Further, extant literature has demonstrated that individuals with substance use issues experience different forms of stigma, such as internalised, anticipated, and enacted stigma. For instance, Chen et al. (2022), in their study in the United States, observed that internalised stigma, where individuals internalise societal negative perceptions, leads to diminished self-esteem and feelings of shame. Anticipated stigma, individuals fearing discrimination and rejection because of their condition, discourages them from acknowledging their substance use problem and seeking treatment (Krendl & Perry, 2023). Finally, enacted stigma, individuals experience different forms of stigma and discrimination, is also prevalent, which exacerbates different challenges that people with substance use problems face in different areas in their lives (Murney et al., 2020). These different types of stigmatisations demonstrate that individuals with substance use problems and other issues experience different forms of stigma, which adversely affects their efforts to access treatment and achieve full recovery (Kilian et al., 2021), further demonstrating how common stigma against individuals with substance use issues is in society.

Locally, in Kenya, the same patterns are evident. For example, studies on stigmatisation of substance use clients in Kenya show its prevalence and converge on the significant effect of stigma on individuals' mental health, social inclusion, and access to care. However, differences emerge regarding specific affected groups and intervention needs. More specifically, Jaguga et al. (2022) identify broad societal and healthcare-related stigma as barriers that discourage individuals from seeking treatment, highlighting structural gaps in provider training and substance-focused interventions. Mburu et al. (2018) further emphasise the unique and compounded stigmas faced by women who inject drugs and who experience overlapping social, gender, and health-related stigma, particularly when HIV is involved. While both studies call for systemic interventions, Jaguga et al. (2022) propose broad research and healthcare reforms, while Mburu et al. (2019) stress gender-sensitive. These multi-

faceted harm reduction programs empower women and mitigate gendered drivers of stigma. As such, it is evident that stigmatisation is a prevalent problem negatively affecting individuals with substance use problems, which necessitates the development and use of more targeted interventions.

2.2.2 Stigmatisation's Influence on Self-Concept of Clients in Recovery

Globally, studies have demonstrated the key aspects of self-concept among individuals in recovery from substance use issues. Self-concept is how a person evaluates and understands their identity, self-esteem, and self-worth (Chen et al., 2020), which, for individuals with substance use problems, gives rise to various concerns, such as acknowledging the problem, seeking treatment, and recovering, self-concept significantly influences their behaviours. A positive self-concept is a protective factor that encourages individuals to stop using substances and take actions to enhance their well-being, but a negative self-concept can affect self-esteem negatively, driving them to continue using drugs and other substances (Bourduge et al., 2022). Further, geographical and cultural factors affect self-concept, access to, and use of rehabilitative services (DeLucia et al., 2024). These factors influence an individual's beliefs, feelings, worldview, and self-image, which demonstrates the importance of considering self-concept as a key factor influencing the recovery process for people with Substance use.

An important element of self-concept is how individuals perceive themselves, which can also affect the recovery process. Perception is how a person interprets and makes sense of themselves, environment, substance use, and the associated risks, benefits, and social norms (Zwick et al., 2020). These elements of perception influence an individual's behaviour, such as their likelihood of seeking and using rehabilitative services for substance use problems (Trucco, 2020). A person's perception of substance use as an acceptable social practice can encourage them to indulge in the substances (Lindert et al., 2020; Trucco, 2020). However, if a person perceives substance use as being socially undesirable and detrimental to their health, they are less likely to indulge and use substances irresponsibly (Ottu & Umoren, 2020). Evidently, as Ottu and Umoren (2020) and Kougiali et al. (2021), individuals' perceptions of self, substances, and their environments affect an individual's decision to use or not to use substances and, by extension, seeking and using treatment or rehabilitative services. Other studies, such as Anand et al. (2022) in India, DeLucia et al. (2024) in Florida, and Snoek (2024)

in Finland, also articulated the influence of perception of self and the environment on accessing and using rehabilitative services in line with the findings by other studies.

In African contexts, Maraire and Mariamdaran's (2020) study on Zimbabwean youth found that drug abuse significantly influenced self-control and self-concept, with cannabis as the most commonly abused substance. Similarly, Muswerakuenda et al. (2023) identified that stigma and a lack of psychosocial support, despite the church's role, hindered Zimbabwean youths' recovery, emphasizing the importance of community-based and socially supportive recovery environments. In Kenya, Sitienei et al. (2024) demonstrated that self-control management skills positively influenced recovery from alcohol use disorder at the Iten Wellness Centre, showing that cognitive-behavioural approaches that enhance self-efficacy and personal agency benefit African treatment contexts.

Despite these global and regional insights, a research gap exists in exploring the nuanced self-perceptions and recovery experiences of substance use clients within Kenyan treatment centres, particularly in Kiambu County. While studies like that of Sitienei et al. (2024) provide insights into recovery mechanisms, they do not fully address how individuals perceive their self-concept and identity within these centres, especially considering Kenya's unique socio-cultural and structural influences on recovery. Addressing this gap could result in a better understanding of culturally adaptive interventions that strengthen self-concept in ways that could be more helpful for clients in rehabilitation centres in Kenya, and more specifically, Kiambu County**.**

2.2.3 Relationship between Stigmatisation and Self-Concept among Substance Use Clients in Recovery

The current literature on self-concept and related constructs in individuals with substance use has focused on several key themes. Across different studies, the authors have discussed and demonstrated how stigma and self-esteem are key among the concepts influencing self-concept of individuals with substance use problems. For instance, in one study in India, Anand et al. (2022) used an exploratory design, which formed the basis for assessing the relationship between self-stigma and various dimensions of self-concept. Key among the focus areas in the study were self-regulation and self-efficacy. Anand et al. (2022), from the study, noted that internalized stigma, which is characterised by feelings of shame and self-devaluation, correlates with poor self-regulatory capacities and reduced optimism for future success in recovery efforts.

In yet another study, which was conducted in Germany, Schomerus et al. (2011) used a cross-sectional design, and was able to demonstrate the detrimental effects of self-stigma on self-efficacy. More specifically, as Schomerus et al. (2011) demonstrated, in individuals with alcohol dependence problems, internalised stereotypes erode their belief in their ability to refuse alcohol. The effects of stigmatisation end up causing a weakened self-concept.

In other studies, a review shows findings that bring out the role of stigma in eroding self-esteem. For example, in one study in Turkey, Akhan and Gezgin Yazici (2023) used a cross-sectional study of 223 participants, from which they ascertained that there was a positive correlation between internalised stigma and reduced self-esteem in individuals with alcohol and risky substance use disorder. These findings demonstrated that stigma is associated with serious psychological harm. In another study conducted in Spain, the authors, Fernández-Alarcón et al. (2024), used a longitudinal study conducted with 23 women, from which they established that self-esteem reduces among individuals grappling with substance use problems or substance use disorder, which results in broader psychosocial maladjustments. However, the study by Fernández-Alarcón et al. (2024) also concluded that with targeted interventions, such as self-esteem workshops, clients could have improved self-esteem. Accordingly, despite stigmatisation being a serious concern, with potentially adverse effects on self-concept, interventions can help clients adjust, and therefore, contribute to better outcomes.

Notably, despite the demonstrated consensus about the negative effects of stigmatisation on self-esteem and other elements of self-concept, different studies focus on various elements of self-concept. For instance, Anand et al. (2022) demonstrated that self-regulation, optimism, self-regulation, abstinence and self-efficacy are the crucial factors associated with self-stigma (Anand et al., 2022). From another perspective, Schomerus et al. (2011) and Akhan and Gezgin Yazici (2023) demonstrated that a reduction in self-efficacy and social withdrawal are key among the outcomes of stigmatisation. Evidently, where there is some level of consensus on the harmful effects of self-stigma, different scholars have suggested differing perspectives on the dimensions of self-concept that stigmatisation ends up influencing majorly. Importantly though, the authors demonstrate the effects of stigmatisation is dependent on context and the substance type (Akhan & Gezgin Yazici, 2023; Anand et al., 2022; Schomerus et al., 2011). Generally, these studies show that stigma has an adverse

influence on self-concept, which varies across different contexts and substances. However, at the same time, the studies highlight that the effects on different aspects of self-concept, including self-regulation, self-efficacy, or social withdrawal, vary by context and substance type. Notably, the studies demonstrate that it is important to address internalised stigma in treatment settings, which can potentially improve the psychological well-being and outcomes for recovering clients.

Additionally, research from Asia and the United States shows similar patterns about stigma and clients' recovery from substance use problems. Across different studies, it is evident that authors and scholars put forth arguments that concur that self-stigma harms how individuals see themselves. In turn, the effects could have affected clients' mental health and overall well-being. For example, studies by Hassan et al. (2022) and Saffari et al. (2022) concluded that self-stigma could increase psychological distress, often through feelings of shame and a reduced sense of self-efficacy. More specifically, this issue is especially evident among individuals with opioid use disorder, which comes out in the study by Ma et al. (2024). In their study, they found that self-stigma could discourage people from seeking help or fully engaging in treatment. Shame, in particular, consistently emerges as a major barrier. However, Verona and Branthoover (2022) suggested that self-forgiveness could reduce shame and support recovery. More broadly, stigma affects self-image and has serious mental health consequences. Matsumoto et al. (2021) link stigma to higher levels of depression, anxiety, and post-traumatic stress disorder (PTSD) among individuals with substance use issues. Overall, these findings highlight the importance of addressing shame directly within treatment settings to improve recovery outcomes.

Another common finding is the bidirectional relationship between self-stigma and depression and its effect on self-concept. For instance, Saffari et al. (2022) and Ali (2019), in their studies, demonstrated that depression and self-stigma reinforce each other over time and can potentially affect an individual's self-concept. More specifically, in one study, Saffari et al.'s (2022) conducted a longitudinal study. The results of the study showed that untreated depression could worsen self-stigma, which in turn exacerbates psychological outcomes and the individual's self-concept. This mutually reinforcing cycle demonstrates that it is important for professionals to focus on addressing mental health issues early in substance use patients to prevent long-term stigmatisation and negative self-concept. Additionally, Ma et al. (2024) showed that participation in mutual support groups could help reduce self-stigma by fostering an

environment where individuals feel validated and less isolated, further enhancing their willingness to disclose their substance use and engage in treatment.

However, the studies also have key differences. More specifically, for example, there are notable differences in conclusions about how self-stigma functions in clinical versus non-clinical populations. From the reviewed literature, in one study conducted in the United States, Chentsova et al. (2024) concluded that self-stigma might act as a protective factor and therefore, not engage in substance use. In other studies, the researchers, such as Ma et al. (2024), Verona, and Branthoover (2022) captured self-forgiveness and support systems' role as protective factors in reducing self-stigma. However, in another study, Hassan et al.'s (2022), conclusions demonstrated that the relationship between help-seeking behaviours and clients' psychological well-being is insignificant. The findings suggest support systems and therapeutic interventions are integral to addressing limitations in help-seeking behaviours because they address shame, foster self-forgiveness, and create sustainable change.

Another notable takeaway from the reviewed studies is the relationship between self-stigma and its influence. In one study, Ma et al. (2024) concluded that gender is a major determinant of self-stigma, with women likely to report lower levels of self-stigma than men are. Equally, Saffari et al. (2022) concluded that pre-existing conditions, such as depression, could exacerbate self-stigma in the long term. From another perspective, Verona and Branthoover (2022) observed that self-forgiveness could potentially enhance the efficacy of interventions aimed at addressing self-stigma and its influence on the recovery process among individuals seeking treatment for substance use. Other scholars, such as Chen et al. (2022) and Brezing, and Marcovitz (2016) in studies conducted in the USA, demonstrated that self-stigma varies depending on the type of drugs and substances, with harder drugs being associated with higher levels of self-stigma, but with lower stigmatisation for drugs that are being legalised, such as marijuana. Notably, though, within the Kenyan context, these findings may be limited because marijuana and other hard drugs, such as heroin, remain criminalized.

Regionally, in Africa, and locally, in Kenya, there have also been studies that have explored the relationship between stigma and self-concept. In one study conducted in Egypt by Abd ElRahman Rabea et al. (2023), the researchers made similar conclusions, noting the negative effect of stigma on self-esteem, which self-criticism compounds further. Equally, in another study conducted in Egypt, Ali (2019) observed that shame results from lower self-esteem because of negative self-concept, which

results in compounded psychological distress among younger substance users. Gyamfi et al. (2018) presented similar findings in a study conducted in Ghana and Monnapula-Mazabane and Petersen (2023) in a study conducted in South Africa, who concluded that stigma exacerbates feelings of inadequacy and shame among individuals with substance use problems. Studies conducted in Kenya, such as Kithuri et al. (2016) and Gutwa and Obare (2022), also made similar conclusions, concluded that stigma affects self-concept and self-worth, occasioning feelings of shame and guilt, which can hinder the affected persons' access to and use of rehabilitative services. Notably, from the literature reviewed, there is a scarcity of studies investigating these relationships between stigma, self-concept, and recovery. Even though studies from across the world, regionally, and at the national level demonstrate the dynamics, there is a need for a more contextualised study to address the extant gap and inform the development of more targeted interventions.

2.2.4 Effect of Stigmatisation on Self-Concept and Treatment Outcomes

The demonstrated negative effects of stigma on recovery have necessitated the formulation and implementation of interventions to improve the efficacy of interventions among individuals with substance use problems. The stigmatisation of individuals with substance use problems, as Krendl and Perry (2023) demonstrated, results in exclusion, which can be a barrier to accessing and using rehabilitative services and successful recovery. Similarly, Light and Goldberg (2020) observed that stigmatisation negatively affects an individual's perception and self-concept, which is a barrier to successful recovery. Zeigler-Hill et al. (2017) echoed these conclusions, observing that internalised stigma and low self-esteem are likely to cause an individual to relapse. The negative effect of stigmatisation on self-concept and the efficacy of interventions was also established by Ali et al. (2024) in a study conducted in India, Burgess et al. (2021) in a study conducted in the United States, and Ervin and Litchke (2021), who concluded that implementing interventions to mitigate the potential undesirable effects and foster successful recovery are important.

Other studies, such as Medina et al. (2022), cited community-wide stigma as a critical barrier to successful recovery from substance use. Importantly, like in other studies, Medina et al. (2022) argued for addressing the stigma, fostering recovery, and reducing the likelihood of relapsing. Similarly, Mhaidat et al. (2024), in a study conducted in the United Arab Emirates, concluded that interventions to foster resilience

could mitigate relapse risk. Evidently, there is a consensus in the extant literature that it is important to implement measures to address stigma as a measure for fostering successful recovery, including ensuring gender-specific interventions, in line with the observations by Lochhead et al. (2024), which can help women recovering from substance use. The reviewed literature demonstrates the importance of instituting measures to reduce stigma and promoting support systems to foster successful recovery.

Regional and local studies also present similar findings. For example, in studies conducted in Egypt, Ali (2019) and Elkalla et al. (2023) concluded that stigmatisation could cause internalised shame, which, in turn, negatively affects the psychological well-being of individuals and their intent to access and use interventions. In a study conducted in South Africa and Nigeria, Nyashanu and Visser (2022) and Nelson et al. (2024) made similar conclusions, observing that lack of resources and specialised care services impede help-seeking behaviours and successful recovery. The findings from across the world and regionally are duplicated in studies conducted in East Africa and more specifically, in Kenya. For example, Omollo (2015) observed that trauma and stigma affect help-seeking behaviours and recovery but did not go into a detailed exploration of how stigma affects the risk of relapsing and help-seeking behaviours. In a study conducted in Tanzania, Mbao (2019) captured the significance of demographic factors, the effect of stigmatisation on self-concept, and the efficacy of treatment and rehabilitative interventions. However, while there have been many studies, it is evident, from the reviewed literature that there is a paucity of studies focusing on Kiambu County, which has a high prevalence rate, a high number of accredited rehabilitation facilities, but the problem of substance abuse persists. As such, this study contributes to addressing this gap and providing a deeper understanding of the problem, and therefore, the formulation and implementation of more effective targeted interventions.

2.3 Summary of Review of Literature and Research Gap

The literature review highlights a significant body of work exploring the influence of stigmatisation on the self-concept of individuals with substance use issues. Studies have also extensively documented the various types of stigmas, including internalised, anticipated, and enacted. The studies have also highlighted the effects of the prevalence of stigma on the recovery of clients with substance use problems. These studies consistently demonstrate that stigmatisation diminishes self-esteem, self-worth, and identity, contributing to psychological distress and hindering recovery efforts.

Stigmatisation fosters feelings of shame, guilt, and isolation, which undermine individuals' ability to engage with treatment and maintain recovery. While this body of research offers valuable insights, several gaps remain unaddressed, particularly in specific sociocultural and regional contexts.

Most existing research tends to focus on broad general populations. Such a focus results in studies that do not capture the unique experiences of people living in specific cultural and legal settings like Kiambu County. While some studies touch on differences in gender or help-seeking behaviour, there is still little agreement on how these findings apply across different groups. In Kenya, where cultural views on substance use and stigma can differ from Western or even other African contexts, there is very little local research. This study helps fill that gap by focusing on individuals in recovery within rehabilitation centres in Kiambu County, offering a clearer picture of how stigma actually shows up in their daily lives and how it shapes their sense of self.

Another important gap is the limited understanding of how local factors, such as cultural norms, laws, and societal attitudes, could affect stigma and recovery. In Kenya, the government has criminalised substance use (especially involving drugs like cannabis). In such a situation, where substances are criminalised stigma is even stronger for those trying to recover. This study looked at how these factors interact and influence people's experiences, particularly their self-image, self-esteem, and overall sense of worth during recovery. While previous research acknowledges that stigma affects self-concept, it rarely explores these deeper, more personal dimensions in detail. The study also addresses the unclear link between self-concept and treatment outcomes. Although it is widely accepted that a negative self-view can hinder recovery, there is limited evidence showing exactly how self-concept affects success in structured rehabilitation programs. By examining this relationship in Kiambu County, the study provides insights that can help shape more effective, targeted interventions.

Finally, while some approaches like self-esteem workshops and support groups have been useful in reducing stigma, most existing strategies are quite general. There is a need for more tailored interventions that address deeper emotional and identity-related challenges, especially in under-researched settings like Kenya. This study explores how psychosocial interventions can reduce stigma and strengthen self-concept, offering practical, culturally relevant recommendations for improving rehabilitation programs.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter describes the research methodology. The chapter provides a description of the research design adopted, the mixed methods, to facilitate the collection of data to provide insights into the influence of stigma on self-concept and outcomes. The chapter also provides a detailed description of the study site, target population, sampling procedures, sample size, and the data collection, analysis, and presentation of findings. Finally, within the context of the research design, the chapter includes a discussion of the key ethical and legal considerations, such as informed consent, voluntary participation, privacy, and protection of the data about the participants.

3.2 Research Design

A cross-sectional research design utilising quantitative and qualitative approaches was adopted. The design facilitated an in-depth exploration of the relationship between stigma and self-concept of clients who are in recovery for substance use problems in selected centres in Kiambu County. The cross-sectional approach involved the collection of data from participants at one point in time (Wright, 2013). Under the cross-sectional design, there was no tracking of participants over time, which requires more time and resources. As such, the adopted design, the cross-sectional approach facilitated collection of data from a large number of participants. The approach was therefore primarily appropriate because of time constraints, in addition to aligning with the purpose and objectives of the study. Notably, considering the nature of cross-sectional design, there are opportunities for further research, and more specifically, studies using longitudinal methods to track the effectiveness of interventions for stigma and their effect on the efficacy of treatment interventions. The quantitative approach gathered numerical data from structured questionnaires, while the qualitative component provided deeper insights through semi-structured interviews. This mixed-methods design allows triangulating the findings. Data triangulation, as Alaba et al. (2026) observed, enhances the credibility of findings by combining statistical analysis with nuanced, context-rich narratives from the participants.

3.3 Research Site

The research site for this study was selected rehabilitation centres in Kiambu County. The rehabilitation centres in Kiambu County, which is a metropolitan county,

bordering Nairobi, Machakos, Murang'a, Nakuru, Kajiado, and Nyandarua Counties, have clients from different parts of Kenya and demographic characteristics (Sharon, 2024). According to NACADA (2024), there are 39 accredited treatment and rehabilitation centres in Kiambu County. The large number of facilities in Kiambu County provided a larger base of facilities that supported the realisation of the research purpose. Appendix VI, a table derived from NACADA's website, provides a summary of the accredited rehabilitation centres in Kiambu County. Each of the accredited facilities has a 40-bed capacity for in-patient clients but attends to an even larger number of clients, including outpatient clients. The facilities attend to male and female clients, with a majority of the clients visiting the facilities having alcohol use and misuse problems. All these factors made Kiambu County an ideal study location that is in line with the purpose of this research.

3.4 Target Population

Recovering alcoholics and individuals in Kiambu recovering from other substance use problems aged 18 years and above were the focus population for this study. The participants had to be at least 18 years to ensure compliance with the law and ethical conduct to ensure only adults participated in the study. More specifically, in line with the purpose and objectives of the study, the study focused on individuals currently undergoing rehabilitation in the selected accredited facilities within Kiambu County. The target population were recovering males and females, excluding individuals who have been diagnosed with other mental health issues as comorbidities for SUDs. These individuals are more vulnerable and may potentially have cognitive issues associated with comorbidities of SUDs and other mental health issues. Across the 39 accredited facilities, approximately 1200 individuals meet the criteria for potential inclusion in this study.

3.5 Sampling Strategy

3.5.1 Sample Procedure

This study used a multi-stage sampling technique. First, purposive sampling was used to select accredited treatment and rehabilitation centres within Kiambu County. Purposive sampling ensured that the research is undertaken in accredited facilities, which mitigated potential ethical and legal issues that may arise from working with unaccredited facilities (Hanley et al., 2012). Secondly, a simple random sampling approach was used to select and include individuals undergoing treatment within these

centres. After the selection of individuals in treatment, their names were anonymised and put in a central database. From the database, individuals were randomly picked for inclusion in the study, which reduced the risk of bias that may occur in the selection of participants (Hanley et al., 2012).

3.5.2 Sample Size

Approximately 10 participants were selected from each of the 12 sub-counties of Kiambu County in line with the accredited rehabilitation centres, resulting in a sample of 120 participants (10% of 1200 participants). A sample of 10% is deemed sufficiently representative of a target population (Chow et al., 2017; Martínez-Mesa et al., 2014). An additional 12 participants were drawn from among the professionals in the facilities, which ensured the inclusion of knowledgeable participants, who can provide valuable information regarding stigma and treatment outcomes. One professional was purposefully selected from facilities in each of the 12 sub-counties in Kiambu County. Since the sample size of 10% was achieved, sufficiently representing the population, it allowed for a comprehensive examination of stigma's effect from multiple perspectives.

3.6 Data Collection

3.6.1 Data Collection Instruments

A structured questionnaire was used to gather quantitative data on socio-demographic factors, prevalence of stigma, stigma effect on self-concept, and influence of stigmatisation on self-concept and treatment outcomes. The questionnaire included items from validated scales. Some of the questions included in the data collection instrument were adapted from the Perceived Stigma of Substance Abuse Scale (PSAS), which helped in assessing levels of stigma and participants' perceptions of stigma, in line with the first and the second research objectives. PSAS includes a series of statements that measure different aspects of perceived stigma, based on the extent to which the participant agrees or disagrees with the statements provided in the instrument. Other items were drawn from the Recovery Assessment Scale (RAS), Substance Abuse Self-Stigma Scale, and Substance Use Stigma Mechanisms Scale (SU-SMS) (Giffort et al., 1995; Luoma et al., 2013; Smith et al., 2016), which helped collect data about effect of stigma on self-concept, and its influence on self-concept and recovery outcomes. Following the recommendations in the different standardised tests and assessments, the proper citations for each are provided.

3.6.2 Pretesting of Research Instruments

A pre-test was conducted with 12 participants from Mathari Hospital in Muthaiga, which serves clients from within the capital and the larger metropolitan area, attributes shared with the facilities in Kiambu County. The facility, Mathari National Teaching and Referral Hospital (MNTRH), was selected because it is the national referral hospital for mental health services. The facility serves clients that share near similar demographics as those in Kiambu, a semi-urban residential metropolitan, drawn from different parts of the country. The piloting process was used to test the reliability and validity of the instruments. The pilot study helped identify any ambiguities in the questions and allow for necessary adjustments before full-scale data collection. Feedback from participants in the pilot test informed the revision of the data collection instruments.

3.6.3 Instrument Reliability and Validity

The reliability of the structured questionnaire was evaluated using Cronbach's alpha to measure internal consistency. A Cronbach's alpha value of 0.906, as shown in Table 3.1, was determined, which was higher than 0.7, which is considered acceptable for the subscales of stigma and help-seeking behaviours (Wright, 2013).

Table 3:1.

Reliability of Data Collection Instruments Pilot

Case Processing Summary			
		N	%
Cases	Valid	12	100.0
	Excluded[a]	0	.0
	Total	12	100.0
a. Listwise deletion based on all variables in the procedure.			
Reliability Statistics			
Cronbach's Alpha		N of Items	
.906		20	

Further, different studies, such as Stockton et al. (2021) and Tuliao and Holyoak (2020) demonstrated PSAS's reliability ($\alpha = .80$; $\omega = .80$; $\alpha = .766$) and construct validity, with a unidimensional structure and acceptable model fit (CFI = .961, RMSEA = .067), with improved fit in a six-item version (CFI = .999, RMSEA = .025). Equally, the other

standardised tools, Recovery Assessment Scale (RAS), Substance Abuse Self-Stigma Scale, and Substance Use Stigma Mechanisms Scale (SU-SMS), from which the elements of the data collection instrument were adopted, showed high levels of validity and reliability ((Luoma et al., 2013; Smith et al., 2016). Expert review helped refine the data collection instrument to ensure that it effectively captures the intended themes related to stigma and substance use. The input of the supervisors and peers was sought in the process of developing and finalising the interview guide. Further, the developed instrument was based on tools that have been tested in previous studies. Using tested and validated tools enhanced the validity and reliability of the findings in this study (Hanley et al., 2012). This process enhanced the reliability and validity of the data collection instrument.

3.6.5 Data Collection Procedures

Data was collected over three months. Before starting data collection, the process involved obtaining the Africa Nazarene University's approval after submitting the research proposal and getting an introduction letter to National Commission for Science, Technology and Innovation (NACOSTI). The next phase involved obtaining the NACOSTI data collection authorisation letter, which authorises researchers to collect data in Kenya. Subsequently, from the list of NACADA accredited facilities, the researcher narrowed down the list of potential rehabilitation centres to visit. The process involved purposefully identifying and selecting facilities from each of the 12 sub counties in Kiambu County. Subsequently, the researcher contacted the facilities, sought authorisation, and scheduled a visit to the rehabilitation centres. The researcher then visited each of the selected facilities to distribute questionnaires to the participants. The researcher then scheduled interviews with the counselling professionals. On each of the respective days for the interviews, the researcher visited each of the facilities as agreed for the interviews. The researcher introduced the study, obtained consent, and then conducted the interviews. The interviews were audio-recorded and transcribed for qualitative analysis.

3.7 Data Processing and Analysis

The quantitative data collected through the questionnaires was analysed using the Statistical Package for Social Sciences (SPSS) version 26. Descriptive statistics, specifically, frequencies, percentages and measures of central tendency, were used to summarize the data. Additionally, inferential statistics, such as Pearson's correlation,

Kendall's tau-b, and Spearman's rank correlation coefficient were used to assess the relationship between different variables in line with the research objectives (Wright, 2013). The data was then presented using tables, graphs, and text explaining each of the tables and graphs. The qualitative data from the interviews was analysed using thematic analysis, with themes emerging from the data coded and categorized to identify patterns related to stigma, self-concept, and recovery outcomes. The qualitative data was reported using narrations or text explaining the themes from the analysed data.

3.8 Legal and Ethical Considerations

Appropriate measures were taken to ensure adherence to ethical guidelines and legal requirements. Approval was sought from the Africa Nazarene University and NACOSTI before data collection. Participants were fully informed about the purpose of the study, the voluntary nature of their participation, and the confidentiality of their responses. All data was stored in password-protected devices, including a personal computer, an external hard disk, and a thumb drive. The data will be destroyed after the completion of this study as per the Africa Nazarene University's guidelines. Informed consent was obtained in writing from all participants. Data was anonymised to protect participants' identities, and the report does not include any identifiable personal information. Additionally, the research complied with Kenyan laws governing data protection, the Data Protection Act of 2019 (Nakitare et al., 2025), and the ethical conduct of research involving vulnerable populations, particularly those in treatment for substance use. The researcher engaged in continuous reflexivity to ensure that personal biases and prejudices do not affect the research process.

CHAPTER FOUR

DATA ANALYSIS AND FINDINGS

4.1 Introduction

The study sought to assess the prevalence of stigma among recovering clients, its effect on self-concept and outcomes. This chapter covers a presentation of the findings of the data collection process in line with each of the objectives supporting the research purpose. The findings presentation starts with the response rate and the key demographic information and characteristics about the participants. The subsequent sections present quantitative data on stigma prevalence, effect on self-concept, relationship between stigma and self-concept, and influence of stigmatisation on self-concept and treatment outcomes. The qualitative data is then presented to augment the quantitative data.

4.2 Response Rate

The target sample for this research was 120 respondents from clients in rehabilitation centres. Additionally, 12 professionals were included in the study to provide further insights. Out of the 120 clients approached, only 113 provided responses to the administered data collection instruments, representing a 94.2% response rate. The response rate among the counsellors was 100% because all the professionals who were approached to participate provided responses. However, the data from the clients was further cleaned, with all the responses that had blanks in some of the prompts being excluded. Finally, out of the 113 responses, only 97 were accepted for further processing, accounting for an 80.8% final response rate, within the context of the initial target sample of 120 participants. Rovai et al. (2013) observed that 70% to 80% is a very good response rate, which is higher than between 60% and 70%, which they termed as acceptable. As such, despite the fact that there was a reduction in usable responses after data cleaning, the final sample size remained sufficiently representative to support reliable analysis and interpretation of the study findings.

4.4 Demographics of the Participants

This section includes a presentation of the data about the demographics of the participants, including age, gender, education, substance used, and years in rehabilitation. These elements provide an in-depth understanding of the characteristics of the participants, including the substances or drugs they use, and the period in rehabilitation. Implicitly, these characteristics help to contextualise the study findings and support a clearer interpretation of participant-related influences on the results, such

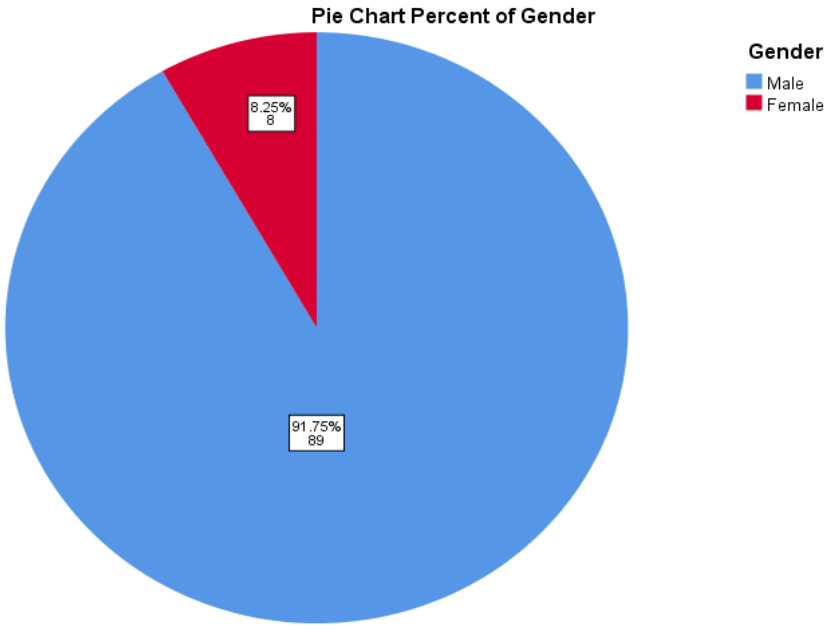
as ascertaining if there are age-differences or gender differences in usage and rehabilitation patterns.

4.4.1 Gender of Participants

As a part of the demographic characteristics, the participants were also asked to provide their gender category. The participants were provided with two options, male and female, and asked to select the option that describes their gender. The responses to this prompt are summarized in Figure 4.1.

Figure 4:1.

Distribution of Participants by Gender



A significant majority of the participants, 91.75% (89) were males. Only 8.25% (8) of the participants were females. These findings highlighted the significantly low number of women enrolled in rehabilitation centres. The findings were consistent with the national patterns, where for example, among males, 1 in 3 males aged between 15 and 65 years; use at least one drug, compared to 1 in 16 females (NACADA, 2022). The patterns evident in the study conducted in Kiambu County aligns with national statistics indicating significantly higher substance use prevalence among males than females.

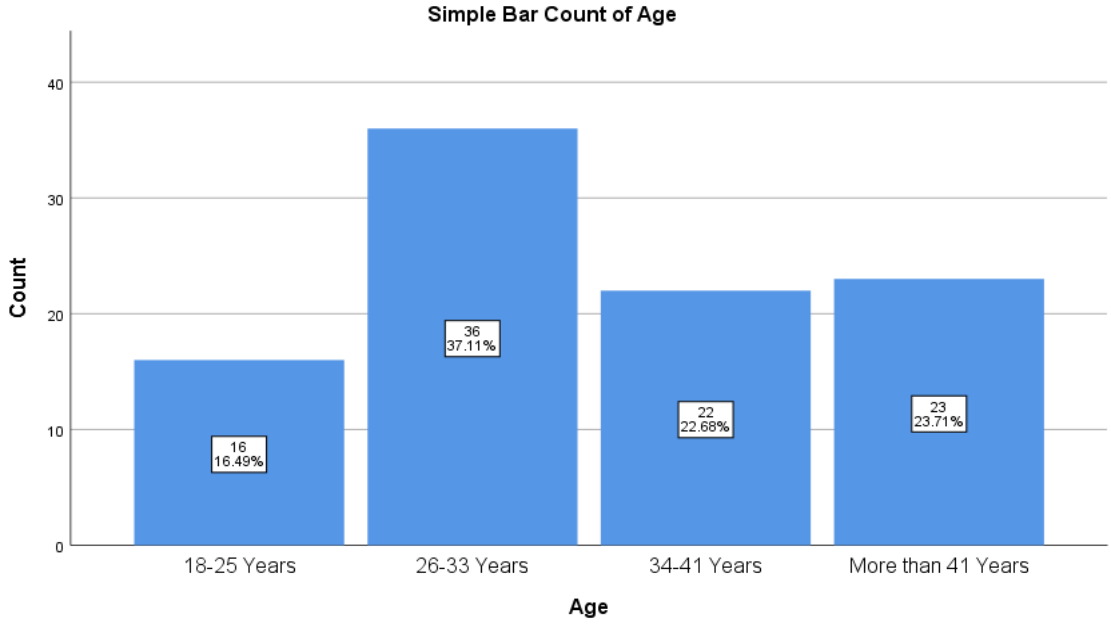
4.4.2 Distribution of Participants by Age

As a part of the research process, the participants were asked to provide their age in terms of age brackets. The age brackets options that were provided in the data collection instrument were 18 to 25 years, 26 to 33 years, 34 to 41 years, and more than

41 years. Figure 4.2 visually presents the distribution of the ages of the participants from the collected responses.

Figure 4:2.

Distribution of Participants by Age



A majority of the participants, accounting for 37.11% (36) fell in the 26 to 33 years, followed by individuals aged more than 41 years, who accounted for 23.71% (23). Participants falling in the 18 to 25 years accounted for 16.49% (16), while those in the 34-41 years accounted for 22.68% (22) of the participants in this study. The findings indicated that a significant number of young people in their prime working years are involved in drugs and substance as adduced from the patterns of the participants enrolled in rehabilitation centres. These patterns are consistent with the reports by NACADA (2022), which showed widespread use of different types of drugs across different age groups, with the highest number of users falling in the 25 years to 35 years age bracket. These patterns indicate that substance use affects individuals across a broad age range but is most prevalent among young adults in their productive years. The implication is that there is a need for targeted prevention and rehabilitation interventions focusing on the most affected age groups.

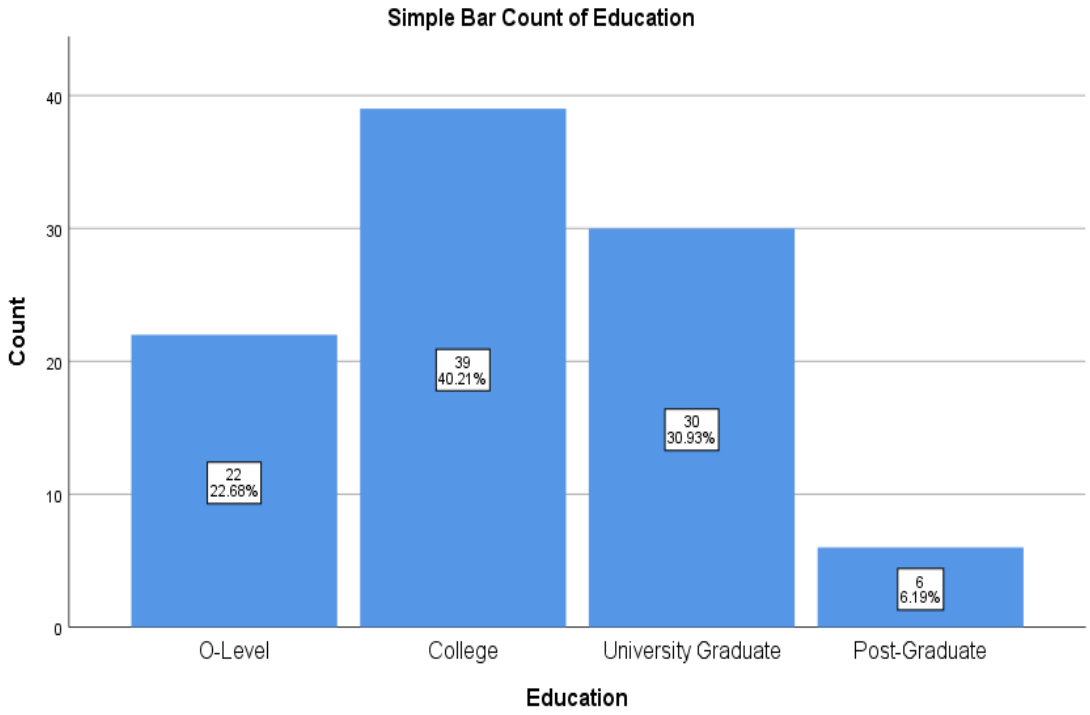
4.4.3 Education Levels of Participants

The participants were also asked to indicate their level of education. Four options were provided, including Kenya Certification of Secondary Education, college,

university graduate, and post-graduate levels. Figure 4.3 summarizes the responses to this prompt.

Figure 4:3.

Participants' Level of Education



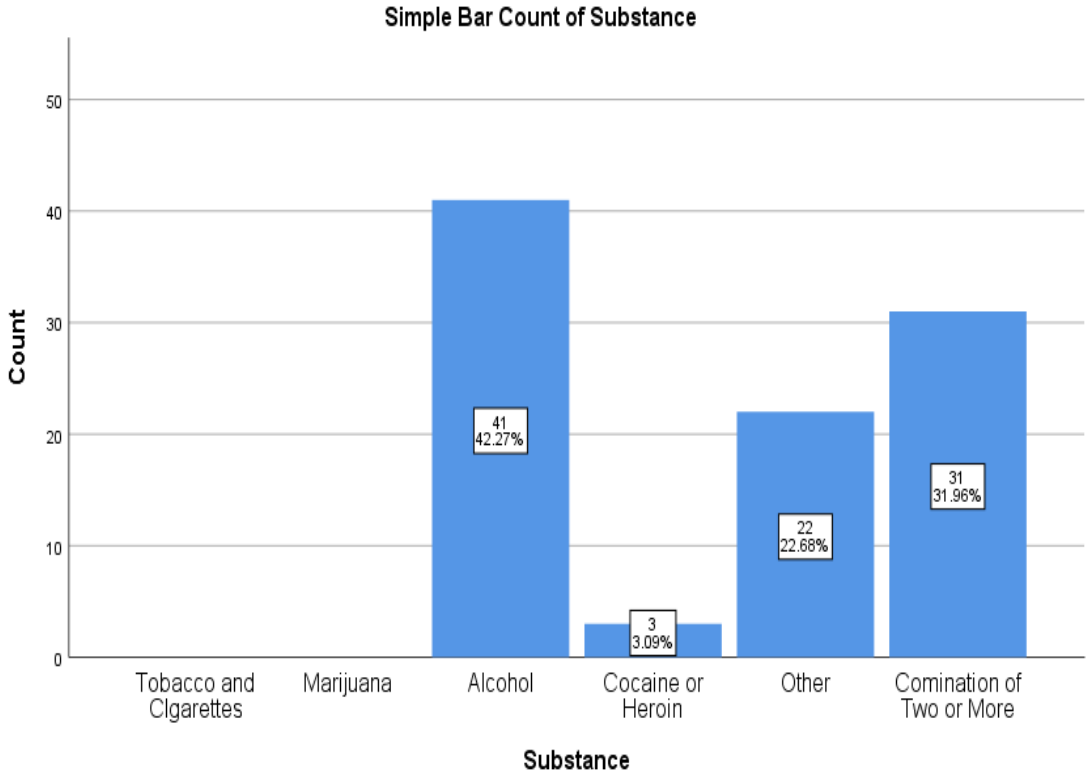
A majority of the participants, 40.21% (39), had a college-level education, followed by university graduates, who accounted for 30.93% (30). Those that had completed their O-level education accounted for 22.68% (22) of the participants. Only 6.19% (6) of the participants had post-graduate qualifications. These findings suggest that substance use and rehabilitation admission cut across different educational levels, which could imply that higher educational attainment does not necessarily protect individuals from substance use-related challenges.

4.4.4 Drugs or Substances Used

As an integral part of the research, the participants were asked to indicate what type of drug or substance they used. The participants were given six options to choose from, including tobacco and cigarettes, marijuana, alcohol, cocaine or heroin, other, and two or more substances. Figure 4.4 summarizes responses from the responses to this prompt.

Figure 4:4.

Distribution of Participants by Substances Used



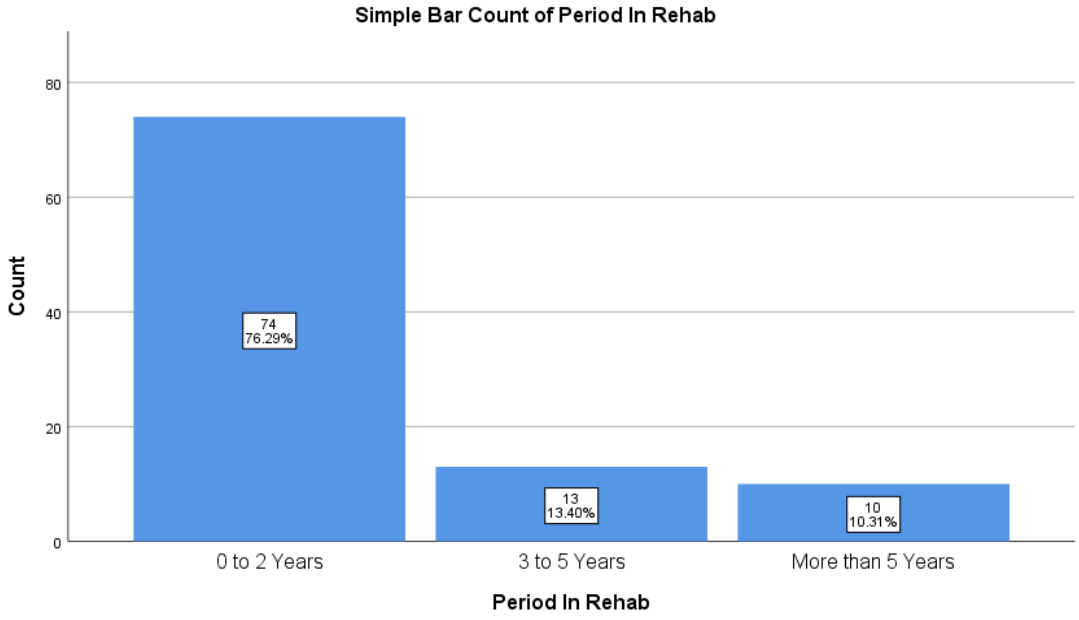
From among the participants in this study, none of the participants indicated that they used tobacco and cigarettes or marijuana alone. A majority of the participants, 42.27% (41) reported using alcohol, followed by those that used two or more drugs and substances, accounting for 31.96% (31). From among the participants, only 3.09% (3) reported using cocaine or heroin, and another 22.68% (22) reported using other drugs. These findings are consistent with national statistics, which showed that alcohol was the most widely used drug (NACADA, 2022). The same patterns are evident for two or more drugs (polydrugs), which came second after alcohol, followed by tobacco, in terms of the most frequently used drugs or substances. However, the responses that no one used tobacco or cigarettes alone contradicts the NACADA (2022) report, which showed that tobacco was among the most widely used substances, especially in the central region. As such, it is evident that while the dominance of alcohol and polydrug use reflects national substance-use trends, the absence of reported tobacco use alone suggests possible underreporting or sample-specific variations. These differences warrant further research to determine the reasons for the variances.

4.4.5 Participants' Cumulative Years in Rehabilitation

Finally, as a part of the demographics, the participants were asked to indicate the period they had been in rehab, not necessarily on a continuous basis, but cumulatively. Figure 4.5 summarises the responses to this prompt.

Figure 4:5.

Participants' Cumulative Years in Rehabilitation



From the responses, a majority of the participants, 76.29% (74), reported to have been cumulatively in rehabilitation for between 0 and 2 years, with zero indicating less than one year. From among the participants, 13.40% (13), had cumulatively been in rehabilitation for between 3 to 5 years, and the rest, 10.31% (10) had been in rehabilitation for more than five years. These findings demonstrate that recovery even in the rehabilitation process results in varying outcomes for each client, with some requiring more time than others require. The findings are consistent with the observations in different studies, which demonstrated clients' duration in rehabilitation is a function of treatment effectiveness, which in turn, depends on availability of resources, specialised care services, stigmatisation, and support systems (Brousseau et al., 2020; Chen, 2024; Nelson et al., 2024). A combination of these and other factors and other individual differences could account for the differences in the length of stay in rehabilitation reported among the participants. Evidently, the variation in rehabilitation duration highlights the individualised nature of recovery. These findings demonstrate that there is a need for flexible, client-centred treatment approaches.

Personalised plans address diverse personal and social factors influencing rehabilitation outcomes, which can enhance the likelihood of successful rehabilitation efforts for clients in recovery.

4.5 Prevalence of Stigmatisation among Clients in Rehabilitation

As an integral part of the research, and in line with the purpose and first of the objectives of the research, the data collection instrument sought to assess the prevalence of perceived stigma among clients in treatment at selected rehabilitation centres in Kiambu County. In the data collection instrument, the statements, "I feel judged by others due to my past substance use (FlJdgd)," "I believe there is a negative perception of individuals in recovery in society (NgtvRec)," "I have experienced discrimination because of my substance use history (DiscSubUse)," "I feel ashamed or embarrassed to disclose my recovery journey to others (ShmDisc)," and "I think stigma affects my relationships with friends and family (StgmRlns)," were used to elicit responses to indicate prevalence of perceived stigma. The participants were to provide a response showing the extent to which they agreed or disagreed with provided statements, with five being strongly agree and one being strongly disagreed. Table 4.1 summarises the responses to the prompts in this part of the data collection instrument.

Table 4:1.

Descriptive Statistics for Prevalence of Stigma

Statistics						
		FlJdgd	NgtvRec	DiscSubUse	ShmDisc	StgmRlns
N	Valid	97	97	97	97	97
	Missing	0	0	0	0	0
Median		4.00	4.00	4.00	3.00	4.00
Mode		4	4	4	1	4
Std. Deviation		1.093	1.150	1.390	1.337	1.256
Range		4	4	4	4	4

As shown in Table 4.1, data were obtained from 97 respondents, and there were no missing responses across all stigma-related items after the data was cleaned. The median scores indicated generally high levels of stigma, with the median for feeling judged, negative views of recovery, discrimination due to substance use, and stigma affecting relationships being 4.00. The lowest median in this scale was for "shame in

disclosing recovery", standing at 3.00, tending towards neutrality. The mode for this scale was 4.00 for most items, which implies that participants have generally experienced different types of stigmatisation. Shame or embarrassment to disclose recovery journey reported a lower mode of one that implied that a significant number of the participants were not ashamed or embarrassed to disclose that they were in rehabilitation. Standard deviations (SD = 1.09–1.39) show moderate variability, meaning participants' experiences of stigma differed across individuals.

Further, Table 4.2 provides a summary of the frequencies and percentages to support Table 4.1 and explain the levels of prevalence of perceived stigma. The different elements, captured in the statements "I feel judged by others due to my past substance use (FlJdgd)," "I believe there is a negative perception of individuals in recovery in society (NegRecov)," "I have experienced discrimination because of my substance use history (DiscSU)," "I feel ashamed or embarrassed to disclose my recovery journey to others (ShmDiscl)," and "I think stigma affects my relationships with friends and family (StigRel)," sought to give an indication of the level of perceived stigma.

Table 4:2.

Levels of Prevalence and Percentages of Stigma

	FlJdgd	**NegRecov**	**DiscSU**	**ShmDiscl**	**StigRel**
	%	%	%	%	%
Strongly Disagree	6.2	7.2	13.4	23.7	8.2
Disagree	7.2	5.2	17.5	20.6	15.5
Neutral	20.6	8.2	9.3	22.7	11.3
Agree	43.3	42.3	34.0	21.6	39.2
Strongly Agree	22.7	37.1	25.8	11.3	25.8
Total	100.0	100.0	100.0	100.0	100.0

The findings show that 66.0% felt judged, and only 13.4% disagreed to some extent, with 20.6% remaining neutral. In response to the prompt, "I believe there is a negative perception of individuals in recovery in society," 79.4% agreed, only 12.4% disagreed, and 8.2% reported neutral views, which aligns with the high mean and median reported in Table 4.1. Further, the findings indicated that 59.8% of respondents reported experiencing discrimination, 31.9% indicated that they had not experienced

discrimination, while 9.3% were neutral, patterns that echo the median and mode reported in Table 4.1. In terms of the participants' shame in disclosing recovery, only 32.9% of the participants agreed, indicating that a majority did not feel shame in disclosing their recovery journey, accounting for 44.3% of the participants, which is also captured in the mode and median in Table 4.1. Only 22.7% were neutral. Finally, a majority, 65.0% agreed that stigma affects personal relationships, compared to 23.7% who disagreed, and 11.3% who provided neutral responses.

Further, from the interviews, the participants were asked to indicate how they have experienced stigma and how it has affected their interactions with others. The data was subjected to a content and thematic analysis. Figure 4.6, a word cloud, summarises the participants' responses.

Figure 4:6.

Word Cloud Showing Themes in Stigma Prevalence.

The qualitative responses provided insights demonstrating that the participants experienced stigmatisation. For example, one of the participants, a middle-aged man, said, "I was addressed as a smoker instead of calling me by my name." Another participant, a man, responded, "I was nicknamed as mlevi." These responses demonstrated that the participants had experienced stigmatisation in different ways, with labelling, judgement, and rejection, emerging as the key themes as represented by the larger words in the word cloud.

The findings demonstrate that perceived judgment, negative societal views of recovery, discrimination, and relationship effects are widely experienced, though feelings of shame in disclosing recovery appear more mixed among respondents, which could be attributed to the participants already being in rehabilitation. The findings were

not surprising, and were consistent with the extant literature. For example, on the one hand, the findings generally demonstrated that the participants reported experiencing stigma, as adduced from the responses to experiencing discrimination because of their drug use and feeling of negative perception. On the other hand, the responses to the statement about feeling ashamed or embarrassed, which shows a different pattern, could imply that the participants, already in rehabilitation, are willing and less afraid of sharing their recovery journey with others in society.

4.5 Assessment of the effect of Stigmatisation on Self-Concept

In line with the second objective of the research, the data collection instrument contained elements that sought to elicit responses showing the extent to which the participants felt stigmatisation affected their self-concept. On the Likert scale, one indicated strongly disagree, with subsequent numbers gravitating towards strongly agree, which was represented by five on the Likert scale. Table 4.3 provides a summary and the descriptive statistics for the effect of stigma on self-concept.

Table 4:3.

Descriptive Statistics for the effect of Stigma on Self-Concept

Statistics						
		StigSelf	PosDiff	RedStig	StigInfl	Empower
N	Valid	97	97	97	97	97
Median		3.00	3.00	4.00	3.00	5.00
Mode		4	1	4	4	5
Std. Deviation		1.450	1.441	1.135	1.350	.957
Strongly Disagree		21.6%	25.8%	5.2%	14.4%	4.1%
Disagree		17.5%	18.6%	8.2%	17.5%	1.0%
Neutral		15.5%	18.6	11.3%	19.6%	7.2%
Agree		25.8%	20.6%	38.1%	27.8%	37.1%
Strongly Agree		19.6%	16.5%	37.1%	20.6%	50.5%

The participants were to select an option that showed the extent to which they agreed or disagreed with the statements, “Stigma has affected my self-esteem and self-worth in recovery (StigSelf)”, “I find it challenging to maintain a positive view of myself due to societal stigma (PosDiff)”, “I believe that reducing stigma would positively affect how I view myself (RedStig)”, “Stigmatisation has influenced my perception of myself

as a person in recovery (StigInfl)", and "I feel empowered to overcome stigma and enhance my self-concept through support systems (Empower)". The data for all the 97 participants from the cleaned data was analysed for all the elements that indicated how the participants felt stigmatisation affected their self-concept. The median for the different elements indicated moderate to high perceived influence of stigma on self-concept. The values ranged from 3.00 to 5.00. The highest median was for the element, feeling empowered [I feel empowered to overcome stigma and enhance my self-concept through support systems] (Mdn=5.00), which showed strong perceived personal agency among participants, especially with a strong support system.

Further, the data showed that participants, as shown in Table 4.4, in this study agreed that reducing stigma improves self-view (Mdn = 4.00, 75.2% of the participants), highlighting the perceived psychological benefits of stigma reduction. For difficulty maintaining positivity and stigma influencing perception, the median showed moderate effect (Mdn=3.00 each). The modes for the different elements showed general agreement (Mode=4.00), except for difficulty maintaining positivity (Mode=1), which showed variations in emotional responses to stigma. Finally, the standard deviations indicated slight to low variability in the respondents' views, with most being consistent regarding empowerment compared to the other constructs. The standard deviations reflect moderate variability in participants' experiences.

The findings suggest that the participants feel that stigmatisation influences different elements of self-concept, with a particular notable perceived influence on self-worth and self-perception. Importantly, in some instances, clients in rehabilitation, retain positive psychological resources when they have a good support system. Further, it was noteworthy that there were variabilities, which imply that the perception of the influence stigma on self-concept varies from one individual to the other. These variabilities could be attributed to various personal and contextual factors. The qualitative responses bring out these variabilities. For example, one of the participants said, "It makes someone lose hope." Another said, "It has strengthened my Alcoholic Anonymous (AA) journey." Finally, another said, "It attacked my self-esteem I became introverted." These differences in the qualitative responses show that indeed, the effect of stigma on self-concept varies from one individual to the other, even when they are enrolled in rehabilitation or are in treatment.

4.6 Relationship of Stigma and Self-Concept in Clients in Treatment

In line with the third objective of the research, to analyse the relationship between stigmatisation and self-concept, a correlation analysis was conducted between the different elements of stigmatisation and self-concept. It was considered more appropriate to include all the elements because the generation of a composite variable resulted in a Cronbach's alpha that was below the acceptable threshold of 0.7. The correlation analysis findings, based on Kendall's tau-b are summarised in Table 4.4.

Table 4:4.

Stigmatisation Relationship to Self-Concept

Correlations							
			Confdnc	Positive	Belief	Flngsprt	Stsfctn
Kendall's tau b							0.16
		Sig.	0.00	0.87	0.025	0.41	0.07
	Ngtvrcvry	Coeff	0.17	-0.08	.231*	-0.01	0.03
		Sig.	0.06	0.38	0.011	0.93	0.73
	Dscrmsbst	Coeff	.24**	0.00	.191*	0.07	.24**
		Sig.	0.005	0.97	0.031	0.45	0.01
	Shame	Coeff	0.06	-0.11	0.088	-0.12	-0.06
		Sig.	0.49	0.20	0.314	0.17	0.49
	StigmaRel	Coeff	0.15	-0.08	.344**	-0.03	0.03
		Sig.	0.09	0.39	0.000	0.74	0.74
		N	97	97	97	97	97

The correlation analysis output showed that feeling judged (I feel judged by others due to my past substance use.) had a significant positive relationship with confidence in maintaining recovery (I feel confident in my abilities to maintain long-term recovery.) (Kendall's $\tau = .303$, $p = .001$; Spearman's $\rho = .350$, $p < .001$) and a weaker but significant association with belief in goal potential ($\tau = .201$, $p = .025$; $\rho = .229$, $p = .024$). These statistics suggest that experiences of judgment may coexist with stronger recovery determination among participants. Further, negative views of recovery (I believe there is a negative perception of individuals in recovery in society.) were significantly associated with belief in goal potential ($\tau = .231$, $p = .011$; $\rho = .258$, $p = .011$), while relationships with other recovery outcomes were weak and non-significant.

Further, discrimination due to substance use demonstrated significant positive correlations with confidence in maintaining recovery ($\tau = .244$, $p = .005$; $\rho = .287$, $p = .004$), belief in goal potential ($\tau = .191$, $p = .031$; $\rho = .218$, $p = .032$), and satisfaction with recovery progress ($\tau = .242$, $p = .006$; $\rho = .287$, $p = .004$). These results imply that individuals reporting discrimination also reported stronger recovery-related motivation and perceived progress.

Notably, shame in disclosing recovery (I feel ashamed or embarrassed to disclose my recovery journey to others.), showed no statistically significant relationships with any self-concept and recovery elements. Finally, perceptions of stigma affecting relationships with family and friends had a moderate and significant positive association with belief in goal potential ($\tau = .344$, $p < .001$; $\rho = .387$, $p < .001$), but no significant links with other recovery indicators. The same patterns were evident in a Spearman's rho analyses. These factors show correlations. Even though the relationships are not statistically significant, the implication is that it is important to consider these factors to ensure that the relationships are explored in an endeavour to understand substance use, and the subsequent development and use of interventions. The p value being greater than 0.005 implies that in addition to the factors being explored, it is likely that there are other contributing factors, necessitating a holistic assessment to understand all factors.

4.7 Influence of Stigmatisation on Self-Concept and Treatment Outcomes

The fourth objective of the study was to assess the effect of stigmatisation on self-concept and treatment and recovery efforts among clients in recovery or in rehabilitation. Table 4.5 first summarises how the participants felt that stigmatisation affected their help seeking behaviour and recovery efforts.

Table 4:5.

Stigmatisation and Effect on Help-Seeking and Recovery Efforts

Statistics						
		Stigma deters seeking support	Stigma as resource barrier	Stigma increases relapse risk	Avoid help due to stigma	Addressing stigma lowers relapse risk
N	Valid	97	97	97	97	97
	Missing	0	0	0	0	0
Median		3.00	4.00	3.00	3.00	5.00
Mode		2	5	4	4	5
SD		1.318	1.429	1.420	1.374	1.159
Range		4	4	4	4	4

From the responses, as captured in the descriptive statistics in Table 4.6, participants reported moderate agreement that stigma deters seeking support (Mdn = 3.00, Mode = 2, SD = 1.32). Further, perceptions that stigma acts as a barrier to accessing resources were relatively high (Mdn = 4.00, Mode = 5, SD = 1.43). The responses indicated moderate agreement that stigma increases relapse risk (Mdn = 3.00, Mode = 4, SD = 1.42). In addition, the participants moderately agreed that individuals may avoid seeking help due to stigma (Mdn = 3.00, Mode = 4, SD = 1.37). The strongest agreement was observed for the statement that addressing stigma lowers relapse risk (Mdn = 5.00, Mode = 5, SD = 1.16). The findings suggest that stigma is widely perceived as a structural and psychological barrier affecting recovery. The moderate standard deviations across items reflect differing individual experiences. These differences suggest stigma affects recovery processes unevenly among participants. The qualitative responses further showed the influence of stigmatisation on self-concept and by extension, help-seeking behaviour and treatment that is more successful. For example, one of the participants observed, “Understanding stigma has helped me self-concept in my recovery and not to relapse.” Another observed, “I will improve my self-concept and reduce relapse possibility,” sentiments that were echoed by another participant, who said, “Constant issues with low self-esteem threatens the sobriety and it may lead to relapse.” These responses show the potential influence of stigma on self-concept and as a risk factor for treatment or rehabilitation failure and relapse.

Additionally, the qualitative responses to the questions seeking to assess how self-concept had changed in recovery and subsequent motivation to achieve better health, show the nature of self-concept and its effect on recovery efforts. Figure 4.7 summarises the key themes.

Figure 4:7.

Stigmatisation and Self-Concept

One of the notable themes was the improvements in self-concepts in recovery. For example, one of the participants pointed out that in recovery, “I am able to think clearly and make plans in my life.” Another observed, “It has helped me break through illusion… and build a new identity.” Another participant, illustrating the improvements, observed, “I view myself as someone with potential.” Other participants captured the negative effects of stigmatisation. A participant said, “It creates self-criticism, shame and hopelessness.” Another one observed, “It attacked my self-esteem, I became introverted.” A female participant, illustrating the negative effects said, “It made me feel like a useless person.” These findings indicate that recovery fosters a more positive self-concept characterized by clarity, confidence, and a renewed sense of identity. However though some experiences of stigmatisation continue to undermine this progress by reinforcing feelings of shame, low self-esteem, and worthlessness among some participants.

CHAPTER FIVE

DISCUSSIONS, CONCLUSIONS, AND RECOMMENDATIONS

5.1 Introduction

In this chapter, the conclusions and recommendations are presented. The conclusions and the recommendations are guided by the research purpose and the specific objectives. The first section covers the conclusions. The second part covers the recommendations.

5.2 Discussions of Findings

5.2.1 The Prevalence of Stigmatisation

The findings show that stigmatisation is common among individuals in recovery. Most respondents said they feel judged (66.0%), believe that society holds negative views about people in recovery (79.4%), and reported that stigma affects their personal relationships (65.0%). In addition, 59.8% said they have experienced discrimination related to substance use. However, when it comes to sharing their recovery stories, many respondents did not feel strong stigma, as only 32.9% reported feeling ashamed while 44.3% said they were not ashamed to share their journey. Overall, these results suggest that stigma remains a major social challenge for people recovering from substance use. Participants experienced stigma through judgment, discrimination, and strained relationships, all of which can influence how they interact with others, seek support, access services, and reintegrate into society.

The finding that stigma affects relationships highlights its broader social effect. Stigma can weaken trust and reduce social support, both of which are essential for long-term recovery. When individuals expect judgment or discrimination, they may withdraw from others or choose not to share their recovery status, limiting their chances of receiving support from family, friends, and the wider community (Kilian et al., 2021). At the same time, the lower number of respondents who reported feeling shame when talking about their recovery may point to some level of resilience or empowerment among those already in rehabilitation programs. Supportive environments and peer networks in these settings can encourage openness and sharing. Overall, the findings reinforce that stigma around substance use disorders is still widespread and continues to shape personal experiences and social relationships. These results are consistent with earlier studies by Kilian et al. (2021), Krendl and Sarah Perry (2023), and Magnan et al. (2024), which also highlight the ongoing presence of stigma and its effect on recovery and social reintegration.

5.2.2 Influence of Stigmatisation on Self-Concept of Clients in Recovery

The findings suggest that stigmatisation has a moderate effect on self-concept among individuals in recovery, with median scores ranging from 3.00 to 5.00 across different indicators. A large majority of participants (75.2%) agreed that reducing stigma would improve how they see themselves (Mdn = 4.00), and an even higher proportion (87.6%) felt empowered to overcome stigma through support systems (Mdn = 5.00). These results show that while stigma can negatively affect self-esteem and self-perception, many individuals in treatment are still able to maintain a positive sense of self, supported by their own resilience and the environments around them. This is also reflected in their willingness to share their recovery journeys.

The qualitative responses support this pattern, with participants describing how their self-concept improved during treatment. For instance, one participant shared, "It helps us accept our condition and seek help," while another expressed the negative effect of stigma by saying, "Stigma has made me feel like less of a man." These experiences highlight both the harmful effects of stigma and the potential for growth and acceptance during recovery.

Overall, these findings align with existing research. Studies such as Ali (2019), Monnapula Mazabane and Petersen (2023), and Gutwa and Obare (2022) show a clear link between stigmatisation and self-concept. Notably though, in this study, some of the relationships were not statistically significant, which could be attributed to other factors mediating the relationship between perceived stigma and self-concept, resulting in varying levels for different people in rehabilitation. Importantly, for example, in line with the labelling and social identity theory, especially the labelling theory, some relationships, such as lack of embarrassment or shame to disclose recovery journey, could be attributable to the focus of the research, people in recovery. This group may have accepted their labels and identity, which makes them less susceptible to the negative effects of stigma, and therefore, no significant effect on their efforts to recover because the stigma has no significant influence on some elements of self-concept (Argueta & Lonergan, 2020; Sibley et al., 2023; Chen, 2024). The study's focus on people in recovery, who have already made the decision to pursue getting better, could explain why they drew motivation from some members of the society viewing them negatively or in a biased manner to pursue and remain committed to achieving recovery.

From the perspective of labelling theory, stigmatising labels attached to individuals with substance use problems may shape how they perceive themselves,

potentially reinforcing negative self-images; however, engagement in treatment can help individuals reinterpret or resist these labels. Similarly, social identity theory suggests that belonging to supportive recovery groups enables clients to reconstruct positive social identities, thereby strengthening self-concept despite societal stigma. Therefore, from the findings it is evident that despite the fact that stigma affects different aspects of self-concept, with support and a good therapeutic environment, the psychological effects of stigma are buffered, and clients are more likely to be resilient.

5.2.3 Relationship between Perceived Stigmatisation and Self-Concept

The findings show that elements of perceived stigma had weak to moderate but significant relationships with self-concept among clients in treatment. Feeling judged was positively associated with confidence in maintaining recovery ($\tau = .30$, $p = .00$; $\rho = .35$, $p < .001$) and belief in goal potential ($\tau = .201$, $p = .025$; $\rho = .229$, $p = .024$). Discrimination due to substance use correlated with recovery confidence ($\tau = .244$, $p = .005$; $\rho = .29$, $p = .00$), goal potential ($\tau = .191$, $p = .031$; $\rho = .218$, $p = .032$), and satisfaction with recovery ($\tau = .242$, $p = .006$; $\rho = .29$, $p = .00$). Negative societal views and relational stigma also related to goal potential ($\tau = .231–.344$, $p \leq .011$; $\rho = .258–.39$, $p \leq .011$). Demographics showed no significant effects (all $p > .05$), highlighting the greater influence of psychosocial stigma on recovery self-concept. The implication is that demographic characteristics have no significant effect on perceived stigma and recovery self-concept. As such, psychosocial experiences of stigma may play a more influential role than demographic differences in shaping clients' recovery perceptions.

The findings from this study partially align with previous literature. This study's findings showed that there is no significant relationship between self-concept and stigmatisation. Current studies have demonstrated that self-stigma negatively affects self-concept among individuals with substance use disorders, contributing to lower self-esteem, reduced self-efficacy, psychological distress, and weakened optimism (Anand et al., 2022; Schomerus et al., 2011; Akhan & Gezgin Yazici, 2023; Fernández-Alarcón et al., 2024). Stigma has also been linked to increased shame, barriers to help-seeking, reduced treatment engagement, and exacerbated mental health challenges such as depression, anxiety, and PTSD (Hassan et al., 2022; Saffari et al., 2022; Ma et al., 2024; Matsumoto et al., 2021). Regional and African studies, including Kenyan research, reinforce these negative associations, highlighting how stigma contributes to feelings of inadequacy, guilt, and reduced access to rehabilitation services (Abd ElRahman

Rabea et al., 2023; Ali, 2019; Gyamfi et al., 2018; Kithuri et al., 2016; Gutwa & Obare, 2022). However, the current study suggests a more nuanced view, showing that stigma can coexist with recovery confidence and goal orientation, especially when mitigated by support systems, self-forgiveness, and therapeutic interventions, highlighting the potential for resilience within treatment contexts, which was also captured in the studies by Verona and Branthoover (2022) and Ma et al. (2024).

Interpreting these findings from the perspective of labelling theory, this relationship can be understood through the influence of socially assigned labels, which shape how individuals interpret themselves and their recovery potential. Unexpectedly, some stigma experiences were positively associated with recovery confidence and goal orientation. The implication from these findings is that individuals in treatment may transform stigmatizing experiences into motivation for recovery, suggesting a process of redefining or resisting negative labels attached to substance use. Similarly, social identity theory helps explain how participation in rehabilitation and recovery groups may foster a more positive collective identity, enabling individuals to reconstruct their self-concept around recovery rather than stigma. Shame related to disclosure showed no significant relationship with self-concept variables, which indicates reduced stigma among individuals already engaged in treatment. Within the context of this particular study, it was evident that among the individuals already in rehabilitation or in treatment, a majority did not feel any form of shame or embarrassment to share their stories and their recovery journey with other people. Finally, demographic factors such as age, gender, education level, substance type, and duration in rehabilitation did not significantly influence stigma or self-concept relationships, implying that psychosocial experiences rather than demographic characteristics primarily shape recovery perceptions.

5.2.4 Effect of Stigmatisation on Self-Concept, and Treatment Outcomes

The findings indicate that stigma is a notable barrier to help seeking and recovery among clients in rehabilitation. Participants moderately agreed that stigma deters support seeking (Mdn = 3.00, SD = 1.32), increases relapse risk (Mdn = 3.00, SD = 1.42), and leads to help avoidance (Mdn = 3.00, SD = 1.37), with stronger agreement that it blocks access to resources (Mdn = 4.00, SD = 1.43) and that addressing stigma could reduce relapse risk (Mdn = 5.00, SD = 1.16). Correlations showed confidence in recovery positively related to perceived relapse risk ($\tau = .255$, p

= .003) and help avoidance (τ = .195, p = .026), while support in treatment negatively related to stigma barriers (τ = −.244 to −.279, p ≤ .005). The results indicate that stigmatisation plays a meaningful role in shaping help-seeking behaviour and relapse vulnerability among individuals in rehabilitation. The strong endorsement of stigma reduction as a protective factor highlights the potential effectiveness of interventions aimed at improving social acceptance and reducing discrimination.

These findings show the need for integrated recovery programs that address both clinical treatment and social stigma to enhance long-term recovery outcomes and reduce relapse risk. One of the notable ways in which stigma inhibits recovery and treatment efforts is limiting access to support services and resources, which instance is also in line with the observations by Macharia et al. (2022) and Nieweglowski et al. (2018), who observed that stigmatisation by professionals may deter people with substance problems from seeking help and pursuing recovery efforts. From the perspective of social identity and labelling theory, these findings suggest that stigmatising labels attached to individuals with substance use problems may reinforce negative social identities and internalized perceptions of deviance (Argueta & Lonergan, 2020; Sibley et al., 2023; Ajewumi et al., 2024; Chen, 2024). When such situations occur, the individuals grappling with substance use problems end up being discouraged from seeking help, which in turn, increases vulnerability to relapse by limiting individuals' willingness to engage with supportive treatment systems

Further, the correlational analysis results echo the findings from current studies, such as Krendl and Perry (2023), Zeigler-Hill et al. (2017), and Medina et al. (2022), who all showed a positive association between addressing stigma and improving self-concept, and by extension, achieving help-seeking behaviour and better outcomes in recovery. However, it is important to acknowledge that the focus on a population of individuals in rehabilitation and recovery implies that some of the participants' insights and experiences from rehab may have affected the identified relationships. Interpretively, from the perspective of social identity and labelling theory, the findings suggest that stigma shapes recovery outcomes in different ways. Stigma can potentially influence how individuals internalise socially assigned labels. Importantly, supportive treatment environments help reconstruct positive social identities and weaken the negative effects of stigmatized identities on help-seeking behaviour and relapse risk (Sibley et al., 2023; Naserianhanzaei & Koschate-Reis, 2021; Chen, 2024). Therefore, the relationship between self-concept exists, but varies from one individual to the other,

and across different elements, which has implications for patients' help-seeking behaviour and recovery and rehabilitation efforts.

From the perspective of labelling theory, stigmatising social labels may discourage help seeking by reinforcing negative self-perceptions and fear of judgement, thereby influencing treatment engagement. Further, strong recovery confidence and goal orientation were associated with greater awareness of stigma-related relapse risks, which implies that the participants, already in rehabilitation or treatment, may have gained helpful insights from being exposed to therapy during treatment. Further, social identity theory helps explain why perceived support within treatment emerged as a key protective factor, as belonging to supportive therapeutic and peer groups enables individuals to develop a positive recovery identity that counters stigmatized social identities. Perceived support within treatment significantly reduced the likelihood of viewing stigma as a barrier to help seeking and resource access. Therefore, positive support systems within rehabilitation settings enhance treatment engagement and mitigate the negative effects of stigma on recovery, which can also potentially reduce the likelihood of relapse.

5.3 Summary of Main Findings

The findings indicate a high prevalence of perceived stigmatisation among individuals in recovery. A majority of participants reported feeling judged (66.0%); believed society holds negative views toward people in recovery (79.4%), and experienced stigma affecting personal relationships (65.0%), while 59.8% reported discrimination related to substance use. However, stigma related to disclosure was lower, with only 32.9% reporting shame in sharing their recovery journey and 44.3% indicating no shame, suggesting some resilience among individuals engaged in rehabilitation. Stigma moderately influenced self-concept, with median scores ranging from 3.00–5.00; 75.2% agreed that reducing stigma would improve their self-view (Mdn = 4.00), and 87.6% reported feeling empowered to overcome stigma through support systems (Mdn = 5.00).

Correlation analysis showed weak to moderate but significant relationships between stigma and self-concept variables. Feeling judged was positively associated with recovery confidence ($\tau = .30$, $\rho = .35$, $p < .001$) and belief in goal potential ($\tau = .201$, $\rho = .229$, $p \approx .025$). Discrimination also correlated with recovery confidence ($\tau = .244$, $\rho = .29$, $p \leq .005$) and satisfaction with recovery ($\tau = .242$, $\rho = .29$, $p \leq .006$).

Participants moderately agreed that stigma discourages help seeking and increases relapse risk (Mdn = 3.00), while strongly agreeing that addressing stigma could reduce relapse (Mdn = 5.00). Support within treatment significantly reduced stigma barriers ($\tau = -.244$ to $-.279$, $p \leq .005$), highlighting the protective role of psychosocial interventions in recovery.

Therefore, the study demonstrated that perceived stigmatisation remains a pervasive experience among individuals undergoing substance use treatment. However, the effects of perceived stigma on recovery are complex rather than uniformly negative as conventionally understood. While stigma influences self-concept and treatment engagement, supportive rehabilitation environments and strong psychosocial support systems can foster empowerment, resilience, and positive recovery outcomes. Therefore, addressing stigma at individual, institutional, and societal levels is an essential factor for improving long-term treatment success for the target populations.

5.4 Conclusions

5.4.1 Prevalence of Stigmatisation among Clients in Rehabilitation

Among the individuals under treatment and rehabilitation in the selected rehabilitation centres in Kiambu County, stigmatisation is prevalent. Stigma is highly prevalent among individuals in recovery. Most participants reported feeling judged (66.0%), experiencing negative societal views (79.4%), and facing stigma in personal relationships (65.0%), while 59.8% reported discrimination related to substance use. Despite this, fewer felt ashamed to share their recovery journey (32.9%), with 44.3% feeling comfortable sharing. Overall, stigma remains a significant social barrier that can influence willingness to seek support, access services, and reintegrate into the community. The prevalence of stigmatisation was evidenced by a majority of the participants strongly indicating that they felt judged, perceived society as having negative attitudes toward recovery, experienced discrimination, and believed stigmatisation affects interpersonal relations between themselves and their families and friends. From the perspective of labelling theory, these experiences suggest that individuals with substance use problems may internalize socially assigned labels associated with deviance or failure, which can reinforce feelings of exclusion and negative social evaluation during recovery. Notably though, from among the elements indicative of prevalence of stigmatisation, many participants reported low levels of shame in disclosing their recovery journey.

This particular finding implies that participation in rehabilitation may reduce internalized stigma and foster acceptance of a recovery identity. For individuals in rehabilitation, there appears to be a growing level of acceptance and willingness to share their recovery journey as part of their evolving social identity, and possibly as a way of encouraging change among others experiencing similar problems. Importantly, the findings indicate that stigma remains a significant psychosocial challenge during treatment and rehabilitation, even within supportive rehabilitation environments, which necessitates the formulation and implementation of targeted stigma-reduction interventions. Such approaches are discussed in detail in the recommendations section.

5.4.2 Influence of Stigmatisation on Self-Concept during Treatment

Further, from the assessment of the influence of stigma on self-concept during treatment and recovery, the study demonstrated that stigmatisation influenced different elements of self-concept in different ways, with the most notable influences being on self-worth and self-perception during recovery. The findings indicate that stigmatisation has a moderate influence on the self-concept of clients in recovery, with median scores ranging from 3.00 to 5.00 across self-concept indicators. A substantial majority of participants (75.2%; Mdn = 4.00) agreed that reducing stigma would improve how they view themselves, while an even larger proportion (87.6%; Mdn = 5.00) reported feeling empowered to overcome stigma through support systems. These results suggest that although stigma can negatively affect self-esteem and self-perception, many individuals in rehabilitation maintain a positive self-concept due to personal resilience and supportive treatment environments, as also reflected in participants' qualitative accounts of both the negative emotional effect of stigma and the motivation it can provide to seek help and sustain recovery. Therefore, for the participants, it was evident that stigma contributes to some clients experiencing challenges in maintaining positive self-evaluation, with variations across individuals. Notably, participants demonstrated strong feelings of empowerment and personal agency, which was particularly evident in situations where there are good support systems, such as rehabilitation and social support systems.

5.4.3 Relationship between Stigmatisation and Self-Concept

The study found significant relationships between several stigma dimensions and self-concept indicators, confirming that stigma and self-concept are interconnected during recovery. Stigma is significantly related to self-concept among clients in treatment, although the relationships are weak to moderate in strength. Feeling judged

was positively associated with confidence in maintaining recovery ($\tau = .30$, $\rho = .35$, $p < .001$) and belief in goal potential ($\tau = .201$, $\rho = .229$, $p \leq .025$). Similarly, discrimination related to substance use was significantly correlated with recovery confidence ($\tau = .244$, $\rho = .29$, $p \leq .005$), goal potential ($\tau = .191$, $\rho = .218$, $p \leq .031$), and satisfaction with recovery ($\tau = .242$, $\rho = .29$, $p \leq .006$). In addition, negative societal views and relational stigma were associated with goal potential ($\tau = .231–.344$; $\rho = .258–.39$, $p \leq .011$). These results suggest that experiences of stigma are meaningfully linked to how individuals perceive their recovery abilities and future goals. Importantly, demographic factors showed no significant effects ($p > .05$), indicating that psychosocial experiences of stigma play a more influential role than demographic characteristics in shaping recovery-related self-concept.

5.4.4 Effect of Stigmatisation and Self-Concept and Treatment Outcomes

From the investigation of the relationship between self-concept and treatment outcomes, the study concludes that self-concept plays a meaningful but selective role in treatment engagement and recovery outcomes. Participants perceived stigma as a barrier to accessing resources, seeking help, and maintaining recovery, with many believing that stigma increases relapse risk. The findings indicate that stigma significantly affects psychosocial interventions and recovery outcomes among clients in rehabilitation. Participants moderately agreed that stigma deters support seeking (Mdn = 3.00, SD = 1.32), increases relapse risk (Mdn = 3.00, SD = 1.42), and leads to help avoidance (Mdn = 3.00, SD = 1.37), while stronger agreement was observed that stigma blocks access to resources (Mdn = 4.00, SD = 1.43). Importantly, participants strongly agreed that addressing stigma could reduce relapse risk (Mdn = 5.00, SD = 1.16), highlighting the perceived importance of stigma reduction in treatment outcomes. Correlational results further showed that confidence in recovery was positively related to perceived relapse risk ($\tau = .255$, $p = .003$) and help avoidance ($\tau = .195$, $p = .026$), while support within treatment was negatively associated with stigma barriers ($\tau = -.244$ to $-.279$, $p \leq .005$). These findings suggest that stigma can undermine the effectiveness of psychosocial interventions by discouraging help-seeking and increasing relapse vulnerability, whereas supportive treatment environments can mitigate these effects and enhance recovery outcomes.

5.5 Recommendations

5.3.1 Recommendations for Rehabilitation Centres

From the insights gained from the findings of the study, rehabilitation centres can institute various measures and programs to foster better outcomes for clients grappling with substance use problems and issues. These institutions should ensure that:

a. Rehabilitation programs integrate structured stigma-reduction interventions, including psychoeducation, cognitive restructuring, and identity-rebuilding therapies, to address stigma (Lochhead et al., 2024; Naserianhanzaei & Koschate-Reis, 2021; Sitienei et al., 2024).
b. There is a focus on strengthening peer-support programs and group therapy approaches, as social support was shown to enhance empowerment and protect self-concept.
c. Treatment approaches remain client-centred and individualised or personalised to meet the need of each client. This approach is based on acknowledging variability in stigma experiences and recovery journeys.
d. There is an incorporation of self-concept enhancement strategies such as self-esteem training, strengths-based counselling, and resilience-building interventions like mindfulness and self-compassion.

5.3.2 Recommendations for Mental Health and Addiction Professionals

At the professional level, counsellors and therapists can support individuals seeking treatment and rehabilitation for drugs and substance use problems and issues. Counsellors and therapists:

a. Should adopt stigma-sensitive care practices that avoid reinforcing negative labels associated with substance use disorders.
b. Should actively assess stigma experiences during treatment and incorporate coping strategies into therapy plans.
c. Should focus on strengthening clients' perceived support systems, as support significantly reduces stigma-related barriers to treatment engagement.
d. Should implement training programs for addiction professionals, which should include modules on stigma awareness, social identity reconstruction, and recovery-oriented communication.

5.3.3 Recommendations for Policy Makers and Public Health Stakeholders

At a macro environment level, policy makers and other public health stakeholders also have an important role in fostering better outcomes for individuals with drug and substance use problems. To this end, policy makers and other public health stakeholders should:

a. Develop and implement public awareness campaigns to challenge negative societal perceptions of individuals in recovery and promote substance use disorders as treatable health conditions rather than moral failures.
b. Develop and implement policies that promote community reintegration programs that reduce discrimination against individuals recovering from substance use disorders.
c. Ensure that the government and health agencies take initiatives to support anti-stigma initiatives within communities, workplaces, and healthcare institutions to improve treatment accessibility and reduce relapse risks.

5.3.4 Recommendations for Community and Family Systems

Notably, one of the things that emerged from the research is that a strong support system can ensure better outcomes for individuals in treatment or rehabilitation. It is therefore critical to ensure a good support system in and outside the rehabilitation centres. At the community level, members of the community and communities, holistically, can also support treatment and rehabilitative efforts to ensure better outcomes for individuals with substance use problems.

a. Community education programs should be implemented to encourage supportive attitudes toward individuals undergoing rehabilitation.
b. Families should be involved in treatment through family therapy and psychoeducation programs to reduce relational stigma and strengthen recovery support networks.
c. Community-based recovery support groups should be expanded to sustain positive self-concept beyond institutional rehabilitation.

5.6 Areas for Further Research

Importantly, considering the findings from this study, there is a need for further research to provide an in-depth understanding of the status of alcohols, drugs, and substance use in Kiambu, including the protective and risk factors, treatment and treatment effectiveness, and other pertinent areas relevant to the topical areas. As such,

a. Future studies should explore stigma experiences among individuals not yet enrolled in rehabilitation to compare internalized stigma levels before treatment engagement.
b. Longitudinal research is recommended to examine how stigma and self-concept evolve across different stages of recovery.
c. Further research should investigate the unexpected positive associations between stigma experiences and recovery motivation to better understand resilience mechanisms.
d. Studies incorporating qualitative methods could provide deeper insight into personal narratives of stigma and identity transformation during recovery.

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APPENDICES

Appendix I: Data Collection Instruments

Dear participant,

Thank you for agreeing to participate in this study. This study seeks to assess the effect of stigmatisation on how you view yourself and the potential effect it could have on your recovery. Your responses will help us to complete the study and potentially contribute to the formulation and implementation of policies and other measures to help people with similar issues to achieve recovery goals. Your identity and information will remain confidential and will not be used for any other purposes other than this research. The information will subsequently be disposed in line with the university's policies. Follow the provided instructions and be as honest as possible in your responses. The first section captures important demographic information. The other sections have information related to stigmatisation and self-concept and their relationship to recovery efforts.

Select the option that applies to you

Section I: Demographics

1. What is your age?

☐ 18-25 Years

☐ 26-33 Years

☐ 34-41 Years

☐ More than 41 Years

2. What is your gender

☐ Male

☐ Female

3. What is your level of education?

☐ O-Level

☐ College

☐ University graduate

☐ Post-graduate

4. Which substance do you commonly use? (Select all that apply)

☐ Tobacco and cigarettes

☐ Marijuana

☐ Alcohol

☐ Cocaine or heroine

☐ Other

☐ A combination of two or more substances

5. For how long have you been in rehabilitation or tried to recover?

☐ 0 to 2 years

☐ 3 to 5 Years

☐ More than 5 years

In the subsequent sections, indicate the extent to which you agree or disagree with the statement by selecting one of the following options 1 to 5, where they represent 1- strongly disagree, 2- disagree, 3- neutral, 4- agree, and 5- strongly agree**.**

Section II: Prevalence of Stigmatisation

Question	**5**	**4**	**3**	**2**	**1**
I feel judged by others due to my past substance use.					
I believe there is a negative perception of individuals in recovery in society.					
I have experienced discrimination because of my substance use history.					
I feel ashamed or embarrassed to disclose my recovery journey to others.					
I think stigma affects my relationships with friends and family.					

Section III: Levels of Self Concept

Question	**5**	**4**	**3**	**2**	**1**
I feel confident in my abilities to maintain long-term recovery.					
I have a positive view of myself as a person in recovery.					
I believe in my potential to achieve my goals post-recovery.					
I feel accepted and supported in expressing my true self within the treatment Centre.					
I am satisfied with the progress I have made in improving my self-concept since starting recovery.					

Section IV: Effect of Stigmatisation on Self-Concept

Question	5	4	3	2	1
Stigma has affected my self-esteem and self-worth in recovery.					
I find it challenging to maintain a positive view of myself due to societal stigma.					
I believe that reducing stigma would positively affect how I view myself.					
Stigmatisation has influenced my perception of myself as a person in recovery.					
I feel empowered to overcome stigma and enhance my self-concept through support systems.					

Section V: Effect of Stigma on Outcomes

Question	5	4	3	2	1
Stigma has deterred me from seeking help or support for my recovery journey.					
I perceive stigma as a barrier to accessing necessary resources for maintaining sobriety.					
I feel vulnerable to relapse when facing stigma related to my substance use history.					
Stigmatisation has increased my reluctance to reach out for help during challenging times in recovery.					
I believe addressing stigma would decrease the risk of relapse among individuals in recovery.					

Section VI: OPEN ENDED QUESTIONS (Interview Guide)

Part I: Levels of Stigmatisation

1. Can you share any specific instances or experiences where you felt stigmatized due to your past substance use within the treatment Centre?
2. How has the stigma surrounding substance use affected your interactions with other clients or staff members in the treatment Centre?

Part II: Self-Concept Perception

1. In what ways do you believe your self-concept has evolved or changed since beginning your recovery?

2. Can you elaborate on how your self-perception influences your motivation and progress in maintaining sobriety within the treatment Centre?

Part II: Relationship between Stigmatisation and Self-Concept

1. How do you think the stigmatisation you have experienced effects your thoughts and feelings about yourself as a person in recovery?

2. In your opinion, how can addressing societal stigma contribute to a more positive self-concept and overall well-being during the recovery process?

Part IV: Effect of psychosocial intervention on Help-Seeking Behaviour and Recovery

1. Have you ever felt hesitant to seek help or support for your recovery journey due to concerns about stigma? If so, please describe the reasons behind this hesitation.
2. How do you perceive the connection between stigma, self-concept, and the likelihood of relapsing in the context of your recovery within the treatment Centre?

Appendix II. Consent to Collect Data

Dear participant,

Thank you for agreeing to participate in this study on the effect of stigma on self-concept of individuals in recovery from substance use and the effectiveness of rehabilitative efforts. By signing this consent form, you acknowledge that you have been briefed about the nature of the study, your duties, responsibilities, and the measures that will be taken to protect your privacy and confidentiality of the collected data. You agree that your participation in this study is voluntary, and is not due to any form of coercion or inducements. Thank you.

Participant Signature: …….

Researcher: Elizabeth Njaga

Appendix III: NACOSTI Authorisation Letter

REPUBLIC OF KENYA

NATIONAL COMMISSION FOR SCIENCE, TECHNOLOGY & INNOVATION

Ref No: 453325

Date of Issue: 05/June/2025

RESEARCH LICENSE

This is to Certify that Miss., Elizabeth Njeri Njaga of Africa Nazarene University, has been licensed to conduct research as per the provision of the Science, Technology and Innovation Act, 2013 (Rev.2014) in Kiambu on the topic: EFFECT OF STIGMATISATION ON SELF-CONCEPT AMONG CLIENTS RECOVERING FROM SUBSTANCE USE: A CASE OF SELECTED REHABILITATION CENTRES IN KIAMBU COUNTY for the period ending : 05/June/2026.

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See overleaf for conditions

Appendix IV: Introduction Letter

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2nd May, 2025

TO WHOM IT MAY CONCERN

RE: RESEARCH PERMIT: ELIZABETH NJAGA STUDENT NO. 18S03EMCP001

Elizabeth Njagi Reg. No. (18s03emcp001) is a Bonafide postgraduate student at Africa Nazarene University in the School of Humanities and Social Sciences – Counseling Psychology department. She is pursuing a Master's degree in Counseling Psychology. This program entails Coursework and Thesis. She has successfully completed coursework and defended her thesis proposal entitled:

"Effect of Stigmatisation on Self-Concept Among Clients Recovering From Substance Use: A Case of Selected Rehabilitation Centres in Kiambu County".

Any assistance accorded to her to facilitate data collection and complete her thesis will be highly appreciated.

Faithfully,

Prof. Orpha Ongiti
Dean of Postgraduate Studies & Director Institute of Research.

Appendix V: Study Site Map