



Stigma and help-seeking: The interplay of substance use and gender and sexual minority identity

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HIGHLIGHTS

- Stigma related to substance use and to gender or sexual minority identity impact help-seeking intentions and behaviors.
- Stigma appears to be especially relevant as a catalyst or deterrent of help-seeking behaviors for substance use.
- When identifying with multiple stigmatized groups, the impact of stigma may be context dependent.

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ABSTRACT

Problematic substance use is a global public health concern. However, despite high rates of substance use (SU) and related consequences, rates of treatment seeking remain low. Furthermore, individuals who identify as a gender/sexual minority (GSM) have both increased rates of problematic use and less mental health treatment utilization. Society has stigmatized both SU and GSM identity and created marginalized communities. Individuals who identify with both groups are uniquely situated in that they experience stigma related to both their SU (SU stigma) and their GSM identity (GSM stigma). The objective of this study was to examine how identifying with these stigmatized groups may influence help-seeking behavior for SU treatment. Participants were $N = 171$ individuals with a history of problematic SU recruited on a national scale, including $N = 67$ identifying as GSM. Results from multiple and logistic regression found main effects for SU stigma, such that, more anticipated SU stigma predicted more help-seeking intentions ($\beta = 0.25, p = .04$), and, controlling for SU severity, more enacted SU stigma was associated with a higher likelihood of having sought help in the past ($\text{Exp}\beta = 4.18, p = .001$). However, while we found a main effect for GSM stigma of the same direction when predicting intentions to seek help ($\beta = 0.28, p = .02$), GSM stigma was not associated with past help-seeking behavior. Lastly, the interaction between SU stigma and GSM stigma was not significant. Clinical implications are discussed, as well as future directions for subsequent research.

1. Introduction

Problematic substance use (SU), is a global public health concern among young adults, with prevalence of use peaking among individuals aged 18–25 years (SAMHSA, 2015; UNODC, 2018). Further, problem SU is associated with increased morbidity, mortality, and risky behaviors (Clark, Martin, & Cornelius, 2008; Haegerich, Paulozzi, Manns, & Jones, 2014; White & Hingson, 2014). SU rates are particularly elevated among young adults who identify as a gender or sexual minority (GSM; Allen & Mowbray, 2016; Coulter et al., 2015). Research indicates transgender young adults report more days of alcohol misuse (Coulter et al., 2015), as well as increased use of cigarettes, marijuana, and other illicit drugs when compared to cisgender individuals (Reisner, Greytak,

Parsons, & Ybarra, 2015). Studies indicate sexual minorities (i.e. individuals who have sexual attraction or engage in sexual behavior that varies from the dominant heterosexual culture) have a greater likelihood of lifetime SU disorder diagnoses, as well as earlier SU initiation (McCabe, West, Hughes, & Boyd, 2013), riskier alcohol use, and more problematic other drug use compared to their heterosexual counterparts (Woodford, Krentzman, & Gattis, 2012). For example, bisexual women are 2–7× more likely to smoke cigarettes and engage in illicit drug use than heterosexual women (McCabe, Hughes, Bostwick, & Boyd, 2005). Furthermore, experiencing discrimination increases risk of negative outcomes. For example, transfemale youth who have experienced gender-related discrimination are more than twice as likely to engage in SU and use concurrent with sex, and they are more than three

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times as likely to use multiple drugs when compared to individuals who report lower levels of discrimination (Rowe, Santos, McFarland, & Wilson, 2015).

GSM individuals face unique barriers to help-seeking and may underutilize treatment to an even greater extent than their peers (Allen & Mowbray, 2016; McCabe et al., 2013), with stigma as one potential explanation (Kulesza, Larimer, & Rao, 2013; Livingston, Milne, Fang, & Amari, 2012; Luoma, 2011). In the social sciences, stigma has been defined and conceptualized in various ways. Goffman (1963) defined stigma as “an attribute that is deeply discrediting...turning a whole and usual person to a tainted and discounted one” (p. 3). In other words, stigma occurs when society marginalizes a population that is different than the majority in some aspect of their person.

Researchers have described several types of stigma (Kulesza et al., 2013; Livingston et al., 2012), including enacted, internalized, and anticipated (Smith, Earnshaw, Copenhaver, & Cunningham, 2016). According to Smith et al. (2016), enacted stigma refers to direct acts of discrimination and rejection by members of the larger society. This type of stigma may manifest as differential, or lesser, treatment in a healthcare setting (Kelly & Westerhoff, 2010; Kulesza et al., 2013). Internalized stigma refers to a process in which people who identify with a stigmatized group adopt societal stereotypes and apply them to themselves (Smith et al., 2016). For example, an individual may internalize the societal belief that homosexuality is morally incorrect and consider themselves inherently bad or damaged. Lastly, anticipated stigma is defined as a belief that prejudice and stereotyping will be directed at the self from others in future interactions (Smith et al., 2016). For example, previous experience and knowledge of broader societal views can lead to the anticipation of social rejection (Meyer, 2003).

The stigmatizing attitudes of the public and healthcare professionals can serve as barriers through promoting treatment delay or avoidance, or lowering self-esteem (Corrigan, Larson, & Rusch, 2009; Luoma, Kulesza, Hayes, Kohlenberg, & Larimer, 2014). Thus, the experienced and perceived actions of others can have a powerful effect on the behaviors of individuals considering treatment. It may be, for example, that anticipated stigma influences one's willingness to seek out professional help. While society has stigmatized SU and created a marginalized community, both “addict” and GSM identities are stigmatized in our society. Thus, it is imperative to consider how other intersecting stigmatized identities may interact with SU stigma to impact treatment-seeking behavior in this population.

The minority stress model (Meyer, 2003) offers a framework to understand the impact of identity-based stigma on mental health and well-being. According to Meyer (2003), discriminatory experiences elicit stress and distress in the target, which can lead to poor mental and physical health outcomes. Furthermore, intersectionality frameworks suggest marginalized identities are uniquely nested within broader cultural power dynamics, which may interact to differentially impact concurrent health outcomes (Else-Quest & Hyde, 2016a, 2016b). Identifying as both GSM and as an “addict” constitutes membership in two groups that are marginalized by the larger society. This literature suggests that each of these stigmatized identities cannot be understood individually; rather they take meaning in relation to each other within the individual person (Else-Quest & Hyde, 2016a, 2016b). It may be that the effects of GSM stigma exacerbate the effects of SU stigma, or vice versa.

1.1. The current study

Our objective was to examine the impact of substance-related and GSM-related stigma on help-seeking intentions and past help-seeking behavior in a community sample of young adults with a history of problematic SU. We predicted that (1) GSM participants would endorse greater SU severity than their non-GSM counterparts (2) SU stigma would uniquely predict intentions to seek treatment and previous help-

seeking behavior; (3) GSM stigma would uniquely predict intentions to seek treatment and previous help-seeking behavior; and (4) SU stigma and GSM stigma would interact to predict intentions to seek treatment and previous help-seeking behavior.

2. Materials and methods

2.1. Participants

Recruitment for this voluntary, anonymous survey study was completed using Amazon Mechanical Turk (MTurk; Litman, Robinson, & Abberbock, 2016). This is a widely used and validated recruitment strategy that provides access to a nationally representative sample of community members interested in participating in online survey research (Berinsky, Huber, & Lenz, 2017; Buhrmester, Kwang, & Gosling, 2011). The survey was advertised on MTurk with the title, “Drinking and Drug Use...what are your thoughts on asking for help?”. Participants were informed the survey required completing an online questionnaire about “substance use, mental health, and sexual history.”

Data collection was completed from July 2017 through December 2017. A total of 326 participants consented to complete an initial screening questionnaire to determine their eligibility to receive the full survey. Inclusion criteria included (1) being 18–24 years old (2) being a current US resident, and (3) endorsing current problematic SU. Recruitment was continued until a target sample size was achieved for gender and sexual minority and non-minority identifying participants. A total of $N = 215$ participants met initial screening criteria. Of these, $N = 171$ individuals completed the survey, comprising the final sample. Independent samples t -tests indicated substance use severity did not differ between those who did, and those who did not, complete the survey ($t(213) = -0.85, p = .40$). For a full description of the sample demographics, and demographics delineated by GSM/non-GSM status, see Table 1.

2.2. Procedure

Individuals interested in participating were able to access a link to the survey in the initial MTurk post. All survey materials were presented using Qualtrics software. Participants provided consent to be screened and completed a screening questionnaire assessing demographic and SU information. Problematic SU was operationalized using standardized cut-off values that indicate problematic use: scoring 8 or higher on the Alcohol Use Disorders Identification Task (Babor, Higgins-Biddle, Saunders, & Monteiro, 2001) or a 6 or above on the Drug Abuse Screening Test (Skinner, 1982). Eligible participants received the full survey, on which they completed demographic measures and self-report information. After completing the survey, participants were given national mental health resources and compensated \$2.42. Participants who were not eligible for the full survey were paid \$0.12 for completing the screening questionnaire. The University's Institutional Review Board approved this study.

2.3. Measures

2.3.1. Demographics

Participants reported demographic information including age, race/ethnicity, marital status, income, employment, and level of education. Participants also included information regarding past SU, such as number of overdoses.

2.3.2. GSM identity

Participants were asked to describe their gender identity and sexual orientation. These questions included pre-populated response options (i.e. lesbian, gay, bisexual, queer, straight) as well as an open-ended prompt for participants who felt that none of the provided options applied to them. We then created a dichotomous variable that was

Table 1
Demographics and substance use among the full sample and sub samples.

Variable	Full sample (n = 171)	Among GSM (n = 67)	Among non-GSM (n = 104)	χ^2	t
Age (SD)	22.84 (1.30)	22.85 (1.23)	22.84 (1.35)		−0.07
Gender (%)				20.58***	
Male	45.0	31.3	53.8**		
Female	49.1	53.7	46.2		
Trans binary/non-binary	5.3	13.4	0.0		
Something else not captured here	0.6	1.5	0.0		
Sexual orientation (%)				171.0***	
Heterosexual	60.8	0.0	100.0		
Lesbian/gay/queer	12.9	32.8	0.0		
Something else not captured here	1.2	3.0	0.0		
Bisexual	25.1	64.2	0.0		
Race/ethnicity (%)				6.73	
Hispanic/latino	8.8	7.5	9.6		
White/Caucasian	63.2	62.7	63.5		
Black/African Am.	12.9	9.0	15.4		
Asian or Pacific Islander	6.4	11.9	2.9		
Biracial or multiracial	8.8	9.0	8.7		
Marital status				3.41	
Single	66.1	67.2	65.4		
Married/unmarried, living w/ partner	32.2	31.3	32.7		
Divorced/other	1.8	1.5	2.0		
Income				4.76	
< 30,000	33.9	37.3	31.7		
30,000–69,000	47.9	47.8	48.1		
> 69,000	18.2	15.0	20.1		
Employment				8.10	
Employed full or part time	79.0	74.6	81.7		
Student full or part time	12.3	17.9	8.6		
Unemployed/combination	8.7	7.5	9.6		
Education level				4.48	
High school or less	10.5	9.0	11.5		
Some college or Bachelor degree	82.5	86.6	79.9		
Greater than Bachelor degree	7.0	4.5	8.6		
Substance use variables					
Overdose (%)	21.1	25.4	18.3		1.24
Sought help in past for SU (%)	40.4	32.8	45.2		2.59
SU intentions to seek help (SD)	41.06 (19.15)	36.44 (15.47)	44.04 (20.71)		2.74*
DAST score (SD)	8.18 (6.31)	9.01 (6.36)	7.63 (6.25)		−1.4
AUDIT score (SD)	17.15 (7.57)	15.46 (7.01)	18.23 (7.75)		2.37*
Stigma variables (SD)					
SU enacted	2.20 (1.04)	2.28 (1.10)	2.15 (1.00)		−0.77
SU anticipated	2.49 (1.10)	2.44 (1.07)	2.52 (1.12)		0.45
SU internalized	2.78 (1.11)	2.70 (1.09)	2.82 (1.13)		0.68
GSM-related stigma	27.66 (12.46)	28.42 (11.71)	27.18 (12.95)		−0.64

Note. SD indicates variables for which means and standard deviations are depicted; % indicates percentage. AUDIT = Alcohol Use Disorders Identification Test. DAST = Drug Abuse Screening Test.

* $p \leq .05$.

** $p \leq .01$.

*** $p \leq .001$.

inclusive of all responses that we not “heterosexual” or did not fit strictly into the male/female gender binary (i.e. trans binary, trans non-binary, something else).

2.3.3. Substance use severity

The Alcohol Use Disorder Identification Task (AUDIT; Babor et al., 2001) is a 10-item continuous measure that assesses past year alcohol use and related consequences. Response options are specific to each prompt and summed to create a total score. Possible scores range from 0 to 40, with higher scores reflecting more problematic alcohol use. It has demonstrated good reliability (Shields & Caruso, 2016). Cronbach's alpha for this study was good ($\alpha = 0.84$).

The Drug Abuse Screening Test (DAST; Skinner, 1982) is a 28-item continuous measure that assesses past year drug use. Response options are dichotomous (yes/no), and the total number of ‘yes’ responses are summed to create a total score. Scores range from 0 to 25, and higher scores reflect greater drug use severity. This measure has demonstrated

good reliability and validity (Yudko, Lozhkina, & Fouts, 2007). Cronbach's alpha for this measure indicated excellent reliability ($\alpha = 0.90$).

2.3.4. SU stigma

The Substance Use Stigma Mechanisms Scale (SU-SMS; Smith et al., 2016) is an 18-item measure that assesses experiences of substance-related stigma. The questions are divided across 3 6-item subscales: enacted stigma ($\alpha = 0.91$; e.g. “family members have thought I cannot be trusted”); anticipated stigma ($\alpha = 0.92$; e.g. “healthcare workers will give me poor care”); and internalized stigma ($\alpha = 0.92$; e.g. “I feel ashamed of having used alcohol and/or drugs”). Response options range from 1 = *Never* to 5 = *Very often* and are averaged to create the subscale composite scores. Subscale scores range from 6 to 30, with higher scores indicating more stigma.

2.3.5. GSM stigma

The Everyday Discrimination Scale (Williams, Yu, Jackson, &

Table 2
Correlations among GSM identifying individuals.

Variables	1	2	3	4	5	6	7	8
1. Intentions to seek help	–							
2. Previous help-seeking	0.31*	–						
3. AUDIT	0.14***	0.16	–					
4. DAST	0.15	0.35**	0.40**	–				
5. SU enacted stigma	0.21	0.58**	0.41**	0.57**	–			
6. SU anticipated stigma	0.25*	0.30*	0.50**	0.47**	0.66**	–		
7. SU internalized stigma	0.25*	0.31*	0.15	0.23	0.48**	0.50**	–	
8. GSM Stigma	0.28*	0.28*	0.31*	0.24	0.32**	0.58**	0.32**	–

Note. Correlation statistics are based on Pearson's Product-Moment correlation coefficients. $N = 67$. AUDIT = Alcohol Use Disorders Identification Test. DAST = Drug Abuse Screening Test. SU = Substance use. GSM = Gender or sexual minority.

* $p \leq .05$.

** $p \leq .01$.

*** $p \leq .001$.

Anderson, 1997) assesses experiences of discrimination based on a respondent's gender and sexual identity. Participants are asked to consider, "In your day-to-day life, how often do you anticipate any of the following things happening to you because of your gender or sexual identity?" and respond to 9 items using a 6-point Likert scale ranging from 1 = *Almost every day* to 6 = *Never*. Example items include, "You will be treated with less courtesy than other people are". Items are reverse scored and summed to create a summary score where a higher score indicates more experienced discrimination. This measure has demonstrated good validity and reliability (Kessler, Mickelson, & Williams, 1999; Krieger, Smith, Naishadham, Hartman, & Barbeau, 2005). Cronbach's alpha for this sample was excellent ($\alpha = 0.94$).

2.3.6. Help-seeking intentions

The 15 help-seeking item options were derived from the National Epidemiologic Survey on Alcohol Related Conditions (NESARC; for example see Allen & Mowbray, 2016). Help-seeking intentions were measured on a 7-point scale (1 = *Unlikely* to 7 = *Likely*). Participants were asked to report how likely they would be to seek help for substance-related problems through both formal and informal methods (including self-help groups, detox, psychologist, rabbi, etc.). Scores range from 0 to 105, and higher scores reflect a greater likelihood of engaging in help-seeking behaviors. Cronbach's alpha for this study indicated excellent reliability ($\alpha = 0.94$).

2.3.7. Past help-seeking

Past help-seeking was a dichotomous variable and assessed using the question, "Have you ever sought professional or non-professional help for your substance use?". Response options were "yes" or "no".

2.4. Data analysis plan

Analyses were conducted using SPSS version 24. Data were checked for normality and missingness. Little's missing completely at random (MCAR) test indicated data were most likely missing completely at random, $\chi^2(3410) = 3318.625$, $p = .866$; thus, Expectation Maximization was used to impute missing data (Dempster, Laird, & Rubin, 1977). The items for help-seeking intentions had 1.8% - 9.4% missing data. On the DAST, 7.6% of data were missing, and zero imputation was used to conservatively replace missing values for this measure (Sim, Lee, & Kwon, 2015). For the remaining variables used in this study, < 5% of data were missing. Overall demographic characteristics were assessed using the sample of $N = 171$ individuals described above. In order to explore the impact of multiple marginalized group membership, individuals indicating a non-GSM identity were removed from the sample, and demographics were re-assessed. Bivariate correlations were used to examine associations among variables. Multiple regression was used to predict help-seeking intentions, and logistic regression was used to test our hypotheses regarding past help-

seeking behavior. SU severity measures were included as covariates.

3. Results

3.1. Hypothesis 1: differences in SU variables across groups

Sample characteristics are displayed in Table 1. Independent samples t -tests indicate GSM individuals have significantly lower help-seeking intentions ($M = 36.44$; $SD = 15.47$) when compared to non-GSM individuals ($M = 44.04$, $SD = 20.71$), $t(165.22) = 2.43$, $p = .007$). Contrary to Hypothesis 1, GSM individuals did not endorse higher levels of SU severity. In fact, Non-GSM participants endorsed significantly higher alcohol use severity ($M = 18.23$; $SD = 7.75$) when compared to GSM individuals ($M = 15.46$, $SD = 7.01$), $t(169) = 2.37$, $p = .02$). Furthermore, chi-square analyses indicated no significant differences between groups regarding demographic variables, number of overdoses, past help-seeking experiences, and both SU stigma and GSM stigma.

3.2. Hypothesis 2: impact of substance-related stigma

Our second hypothesis sought to examine the impact of SU stigma on help-seeking intentions and behaviors. For future help-seeking, the decision to analyze the anticipated SU stigma subscale in this model was multiply determined by theory, sample size, and bivariate correlations (displayed in Table 2). The authors of the SU stigma measure recommend analyses be conducted at the subscale level (Smith et al., 2016). Given the link between anticipated SU stigma and help-seeking behaviors, the strength of the bivariate correlations, and restrictions based on sample size, the decision was made to use this subscale as the primary variable of interest. As hypothesized, anticipated SU stigma predicted intentions to seek help ($\beta = 0.25$, $p = .04$, $r^2 = 6.2\%$), such that more anticipated stigma was associated with more help-seeking intentions. All multiple regression results are displayed in Table 3.

For past help-seeking behaviors, the decision was made to use the enacted SU stigma subscale, using the multiple criteria mentioned above. Research suggests higher SU severity may impact help-seeking (Buscemi et al., 2010); thus, we controlled for this factor on step 1 of the logistic regression. In step two, enacted SU stigma was added to the model. Controlling for SU severity, enacted SU stigma predicted a higher likelihood of having sought help in the past ($\text{Exp}\beta = 4.18$, $p = .001$, Nagelkerke $r^2 = 42.6\%$). The addition of enacted SU stigma to the model significantly raised the percent of variance accounted for in previous treatment seeking behavior, $\chi^2(1) = 16.24$, $p < .001$. All logistic regression results are displayed in Table 4.

3.3. Hypothesis 3: impact of GSM-related stigma

In testing our third hypothesis exploring the impact of GSM stigma

Table 3
Summary of multiple regression analyses of variables predicting intentions to seek help.

	Step 1			Step 2		
	B	SE	β	B	SE	β
Regression model 1						
Anticipated SU stigma	3.61	1.75	0.25*			
Regression model 2						
GSM stigma	0.37	0.16	0.28*			
Regression model 3						
Anticipated SU stigma centered	1.85	2.12	0.13**	2.01***	2.12	0.14
GSM stigma centered	0.28	0.19	0.21	0.28	0.19	0.21
Interaction				-0.15	0.14	-0.13

Note. N = 67. SU = Substance use. GSM = Gender or sexual minority.

* $p \leq .05$.

** $p \leq .01$.

*** $p \leq .001$.

on help-seeking intentions, we found that GSM stigma also predicted more intentions to seek help ($\beta = 0.28, p = .02, r^2 = 8.0\%$). However, GSM stigma did not predict past help-seeking behavior ($\text{Exp}\beta = 1.04, p = .10, r^2 = 21.4\%$). Again, we controlled for DAST on step 1, and this variable remained the significant predictor, such that higher SU severity was associated with having sought help in the past ($\text{Exp}\beta = 1.12, p = .02$). The addition of GSM stigma to the model did not significantly change the variance accounted for in past help-seeking behavior, $\chi^2(1) = 2.94, p = .09$.

3.4. Hypothesis 4: interaction of SU stigma and GSM stigma

In order to test our fourth hypothesis exploring how these forms of stigma may interact to influence the outcome variables, we centered our stigma variables and created interaction terms. Step one included both centered predictor variables, and step two included the interaction term. When anticipated SU stigma, GSM stigma, and the interaction term were in the model, the overall model was not significant, and none of these variables were predictive of help-seeking intentions ($ps > 0.05$). We repeated these steps using the interaction between enacted SU stigma and GSM stigma on past help-seeking as the outcome variable. We first entered DAST score in step one to control for SU severity. In step two, we added both the centered predictor variables, and in step three we added the interaction term to the model. The overall model was significant, and enacted SU stigma was the only significant predictor ($\text{Exp}\beta = 4.06, p = .002, r^2 = 44.0\%$).

Table 4
Summary of logistic regression analyses of variables predicting past help-seeking behavior.

	Step 1			Step 2			Step 3		
	B	SE B	Exp(B)	B	SE B	Exp(B)	B	SE B	Exp(B)
Regression model 1									
DAST	0.12	0.05	1.13**	0.00***	0.06	1.00			
Enacted SU stigma				1.43	0.44	4.18**			
Regression model 2									
DAST	0.12	0.05	1.13**	0.11	0.05	1.12*			
GSM stigma				0.04	0.03	1.04			
Regression model 3									
DAST	0.12	0.05	1.13**	-0.01	0.06	0.99	-0.01	0.06	0.99
Enacted SU stigma centered				1.40	0.45	4.04**	1.40	0.46	4.06**
GSM stigma centered				0.03	0.03	1.03	0.03	0.03	1.03
Interaction							-0.00	0.03	0.99

Note. N = 67. DAST = Drug Abuse Screening Test.

* $p \leq .05$.

** $p \leq .01$.

*** $p \leq .001$.

4. Discussion

The current study examined how different types of stigma impact help-seeking behaviors for SU problems among individuals who identify as GSM. There was a strong influence of SU stigma on both prior help-seeking behaviors and intentions to seek help among GSM individuals. However, these data also suggest different types of stigma (anticipated, enacted, internalized) may impact treatment-seeking behaviors differently. In this sample, anticipated stigma was associated with intentions to seek help. This relationship may demonstrate that individuals who are more seriously considering treatment are anticipating having to face more stigmatization in that process (Livingston et al., 2012). On the other hand, this association may indicate that fear of future rejection or persecution may actually motivate help-seeking behaviors. It is important to consider the influence of context in these results. Specifically, there may be differences in the ways that the relationship between the GSM individual and the stigmatizing party impacts intentions to seek help. For example, fear of persecution from friends or family may impact help-seeking behavior differently than fear of stigmatization by mental health professionals. In contrast, enacted stigma was most strongly related to, and predictive of, past help-seeking behaviors. It may be that GSM individuals who sought out help experienced stigmatizing events in those treatment centers (from providers, patients, family; Reisner et al., 2015), or it may be the inverse, and those experiences of stigma led to treatment seeking.

The results suggest that SU severity may be more strongly related to past help-seeking behaviors than experiences of GSM stigma. It may be that SU severity outweighs the effects of GSM stigma in the context of help-seeking for SU disorders, and that the impact of stigma may be contextually bound. Specifically, the role of identity salience may be particularly important when examining stigma related to different components of an individual's self. That is, when seeking help for SU concerns, it may be that stigma related to that identity (e.g. “addict”) becomes most salient and influential. For example, this study was specifically emphasizing SU and SU treatment. It may be that a broader assessment of help-seeking, which includes additional mental health concerns, may lead to a different outcome (Kirkner, Relyea, & Ullman, 2018). For example, the effects of GSM stigma may exacerbate the effects of SU stigma, or their interactive effect may lead to greater overarching health concerns (e.g. depression, sleep loss, interpersonal strain). Despite the fact that one may be more salient in a certain context, it is important to continue to attempt to understand the ways these marginalized identities interact to impact well-being.

This study has important implications for research and clinical practice. The first is that intervention and treatment efforts may benefit

from exploring the function of SU stigma as both a barrier and motivator to treatment. On the other hand, interventions should also aim to better understand GSM stigma's impact on treatment-seeking. For example, if individuals with more intentions to seek treatment are endorsing more anticipated stigma, reducing that stigma may lead to a higher likelihood of following through on those intentions. Furthermore, this study highlights the distinction between action and intention, and emphasizes the utility of examining both in research. Research aimed at understanding help-seeking intentions may better identify barriers that can be addressed to then promote actual help-seeking behavior.

These findings should be considered in light of some limitations. First, this study exclusively utilized measures of self-report. While each measure demonstrates high reliability and validity, future research should consider the inclusion of focus groups, open-ended response options, and a more in-depth analysis of the ways that SU stigma and GSM stigma function independently and interactively to influence treatment seeking intentions and behaviors. Second, our one-time, correlational study design did not allow for a determination of the directionality of these relationships. Future research should analyze how these experiences occur, compound, or interact over time, and in which contexts they do so most noticeably. For example, given the lesser substance use severity reflected in this sample, it may be that participants were more likely to use brief, self-help, or online interventions as opposed to more acute treatment options. As such, they may have had fewer stigmatizing experiences in these environments. Future efforts would benefit from exploring these potential nuances more fully. Finally, this study involved a relatively small sample, and this may have rendered some otherwise significant results, non-significant. A larger sample would allow for the direct comparison of types of stigma, and the impact they have independently (and collectively) on help-seeking.

5. Conclusions

These research findings demonstrate the importance of considering SU stigma and GSM stigma in the treatment of SU disorders. Anticipated and enacted SU stigmas appear to be especially relevant, particularly as a catalyst or deterrent of help-seeking behaviors. Additionally, when identifying with multiple stigmatized groups, the impact of stigma may be context dependent. SU stigma may be especially impactful compared to GSM stigma when considering substance-related treatment seeking behaviors. Finally, these findings suggest that such stigmas should be considered alongside SU severity, as they may have a collective impact on intended and expressed behaviors.

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