JOURNAL OF PAKISTAN PSYCHIATRIC SOCIETY
(Reviewed Manuscript - Version of Record to Follow)

ORIGINAL ARTICLE:

EXPLORATION OF INTERNALISED STIGMA AND EMOTIONAL DISTRESS AMONG INDIVIDUALS WITH PSYCHIATRIC ILLNESSES

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Submitted: September 30, 2022
Accepted: February 19, 2025

ABSTRACT

OBJECTIVES

To explore the level of internalized stigma and emotional distress in people with different psychiatric disorders including anxiety disorders, mood disorders, and obsessive compulsive disorders.

STUDY DESIGN

Cross-sectional comparative study

PLACE AND DURATION OF STUDY

Department of Psychiatry at the Services Hospital, Lahore, Pakistan from 1st June 2021 to August 2022 (period of one year).

METHOD

A total of 180 participants which comprised 60 with each psychiatric condition (anxiety disorders, mood disorders, and obsessive compulsive disorders) were recruited from psychiatric department (Ward/OPD) using Purposive and convenience quota sampling technique. Internalized stigma was measured using the Internalized Stigma of Mental Illness Inventory (ISMI) Scale, while emotional distress was examined using the Perceived Emotional Distress Inventory (PEDI).

RESULTS

Variations of stigma in different psychiatric populations experiencing mood disorders, anxiety disorders and OCD were observed. It was found that the higher the experience of internalized stigma, higher the levels of emotional distress.

CONCLUSION

The research observed the variations in impact of internalized stigma among individuals with mood disorders, anxiety disorders, and OCD. It was also found that the higher the experience of internalised stigma, the higher were the levels of emotional distress.

KEYWORDS

Anxiety Disorders; Mood Disorders; Obsessive-Compulsive Disorder; Pakistan; Psychological Distress; Stigma.

INTRODUCTION

Stigma, a label that causes an individual to feel oneself divergent from others, is common among individuals with mental illness. Symptoms of mental illness lead suffering individuals to avoid people due to the discriminatory attitudes of others around. It leads to the development of internalised stigma, which is also known as self-stigma.[1]

Self-stigma is a subjective feeling of shame, secrecy, isolation, and devaluation. Psychosocial problems like trouble coping with day-to-day tasks, low quality of life, unemployment, embarrassment, poor socialisation, decreased treatment seeking behaviour, hopelessness, emotional loss, reduced self-efficacy and self-esteem, and limited support seeking are some of the negative effects of internalised stigma. These make suffering individuals distressed.[2]

Perceived Emotional distress is the subjective feeling of sadness, confusion, and worry. It causes major symptoms, such as anxiety, depression, anger expression, social withdrawal, and hopelessness. It varies in intensity and can cause anxiety, inability to relax, loss of focus and concentration, fatigue, and relationship problems, and isolation.[3]

There have been many global studies that link internalised stigma with emotional distress in individuals with psychiatric disorders. However, in developing countries, this link is not uncovered to a greater extent .[4] Researchers have found that societies with higher literacy tend to have more awareness and reporting regarding psychiatric issues than the societies with lower literacy. This is also true for our culture .[5]

A strong link is found between self-stigma and symptoms severity among psychiatric disorders.[6] Researchers found individuals diagnosed with mood disorders, anxiety disorders, or a combination of the two had higher levels of internalised and perceived public stigma. [7] According to the researchers. Individuals with bipolar disease learn to hide symptoms due of societal assumptions.[8] According to Watson et al (2007),[9] acceptance and self-perception of unfavourable stereotypes can lower self-esteem and self-efficacy and cause increased emotional distress. Rüsch et al (2006)[10] identified a close relationship between self-stigma and emotional disturbance as both emerge from societal rejection. Whereas others linked it to emotional distress, depression, helplessness and reduced coping skills.[11] Thus, after studying existing research literature on the construct under study, it may be stated that we need to explore these variables more, especially in our cultural context.

In a study by Rauf and Ali (2016),[12] researchers concluded that the amount of internalised stigma on the subscale of discriminating experience and social withdrawal was higher in females as compared to men. Yet, there is no work exploring differences in the level of internalise stigma and level of distress regarding the three prominent neurotic disorders (anxiety, mood and OCD) and the nature of stigma (as identified through its subscales).[13] The spread of psychiatric disorders is increasing alarmingly. These findings can be further researched to establish plans or techniques to lessen the internal stigma and emotional suffering of those with psychiatric conditions.

This study hypothesized that there would be a difference in the level of internalized stigma and emotional distress among psychiatric disorders (mood disorder, anxiety disorder, and OCD), and there will be a difference between subscales of internalized stigma of mental illness (alienation, stereotype endorsement, discrimination experience, social withdrawal, and stigma

resistance) in psychiatric disorders (mood disorder, anxiety disorder, and OCD), and emotional distress will likely predict the internalized stigma of mental illness.

METHOD

Measures

Demographic Information Sheet: This questionnaire was based on information like age, gender, education, socioeconomic status, marital status, occupational status, psychological diagnosis, and the duration of psychological diagnosis.

Internalised Stigma of Mental Illness (ISMI) Scale (Boyd et al., 2014):[2] ISMI is a 29-items scale. The scale assesses Individuals with psychiatric problems experience self-stigma. It has five subscales: alienation, stereotype endorsement, discrimination experience, social withdrawal, and stigma resistance. A total score of each subscale and total score, both can be obtained by adding raw scores, and responses are given on 4-point Likert Scale and a higher score represents higher level of internalised stigma. The reliability of ISMI ranges from 0.80 to 0.92. The ISMI's test-retest reliability is 0.92, with a Cronbach's alpha of 0.82. In the present research, Cronbach's alpha of Urdu version was 0.84.

Perceived Emotional Distress Inventory (PEDI) (Mosocoso et al., 1978):[4] PEDI was developed by Manolete S. Moscoso and translated by Nida and Rukhsana (2014).[14] PEDI is a 15 items tool that assesses the occurrence and severity of emotional distress on 4-point Likert Scale. The overall score on the scale goes from 0 to 45, with higher scores indicating greater emotional distress. The PEDI Global's alpha coefficient is 0.92. Moreover, the reliability of Urdu-version was 0.92. In the present research, the reliability of Urdu-version was found as 0.77.

Procedure

Ethical approval for the study was sought from the Ethical Review Committee of Bahria University Lahore Campus (ref no. BULC/Psy/2022/29). This quantitative research was conducted over a period of 1 year from 1st June 2021 to August 2022. The data was gathered from the Department of Psychiatry (both inpatients and outpatients) of the Services Hospital Lahore, Pakistan, which is a public facility, and formal permissions for data collection were taken from respective authorities of psychiatric department of the hospital. Purposive and convenience quota sampling technique was used to collect the data from 180 individuals diagnosed with psychiatric disorders. This total number was further divided in three categories i.e., 60 participants diagnosed with mood disorder, 60 with anxiety disorder and 60 with OCD between the age range of 21 to 45 years.

The researcher briefed the participants about aims of the study. All ethical guidelines were followed while conducting the study. Participants were told that their participation is voluntary and they have the right to withdrawal at any point. They were assured about confidentiality

and were informed that the data shared would be used for academic purposes. Written consent was taken from the participants. Afterwards, demographic form and questionnaires and were given to the participants to fill in. If any participant felt distressed or disturbed due to administration of questionnaire, then counselling was provided to relax the participant.

Inclusion and Exclusion criteria

Both male and female participants with at least one year and maximum ten years history of the condition were included in the study. Among anxiety disorders, individuals having generalized anxiety disorder, social phobia and panic disorders were included. In terms of among mood disorders, individuals with major depressive disorder, and Bipolar I and II were included. It was ensured that all participants were stable to provide responses easily, and individuals who were not stable at time of data collection were not included in the sample. The individuals with comorbidity of physical disease and/or psychological conditions like schizophrenia and addiction with mood disorders, anxiety disorder and OCD were excluded.

Data Analyses

Data were analysed using SPSS (Statistical Package for the Social Sciences) version 17. Descriptive statistics were used to summarise demographic variables, and skewness and kurtosis tests confirmed normality (±2 range) of the data ensuring suitability for parametric statistical analyses. One-way ANOVA (Analysis of Variance) examined differences in internalised stigma and emotional distress across psychiatric disorder groups, with Bonferroni post-hoc tests for pairwise comparisons. Linear regression analysis assessed whether internalised stigma predicted emotional distress, reporting R^2, F-values, and 95% confidence intervals. Statistical significance was set at $p < 0.05$. The statistical analyses adhered to appropriate methodological and ethical guidelines to ensure reliability of findings.

RESULTS

Table 1

Demographic Characteristics of Participants

Variables	Categories	F	%
Age			
	21-30	87	48.4
	31-40	54	30.0
	41-45	39	21.6
Gender			
	Male	25	13.9
	Female	155	86.1
Education			
	Illiterate	46	25.6
	Up-till Matric	58	32.2
	Graduation and more	37	20.6
Socio-economic Status			
	Lower	88	48.9
	Middle	92	51.1
Marital Status			
	Single	60	33.3
	Married	117	65.0
	Divorces	03	1.7
Duration of Diagnosis			
	1 to 3 Years	113	62.8
	4 to 6 Years	42	23.3
	7 to 10 Years	25	13.9

Note. N = 180

Table 1 depicts the demographic data of the study participants, where the largest age group was between 21-30 years, constituting approximately half of the participants (48.4%, n = 87), and the majority being female (86.1%, n = 155), while males accounted for 13.9% (n = 25). A significant portion of the study population was illiterate (25.6%, n = 46).

Table 2
Normal Distribution confirmed with Skewness and Kurtosis tests.

	M	SD	Skewness	Kurtosis
Total ISMI	49.047	26.4987	-.248	-1.417
Alienation	15.453	4.0560	-.206	-.430
Stereotype Endorsement	14.860	3.5046	.174	-.799
Discrimination Experience	11.187	3.8432	.329	-.258
Social Withdrawal	14.353	3.7095	-.444	-.666
Stigma Resistance	13.660	3.3395	.306	-.008
Emotional Distress Total	23.487	7.5278	.234	-.339

Before running the parametric test, the normal distribution of data through skewness and kurtosis test were confirmed. It was found that all the variables were normally distributed and there was no issue in normal distribution, which was recommended for parametric test. Some statisticians (George & Mallery, 2010; Gravetter & Wallnau, 2010) narrated that if values of skewness are between +2 / -2, it can be accepted as normal distribution.

Table 3
One-Way Analysis of Variance of Different Domains of Internalised Stigma of Mental Illness (ISMI) and Emotional Distress Based on Patient's diagnosis

	Disorder (Mean ± SD)					
Variables	Mood	Anxiety	OCD	F (2,177)	Sig.	Post-Hoc
ISMI Total[a]	68.52 ± 1.67	63.45 ± 1.65	14.70 ± 0.42	465.88	.000***	1>3, 1>2, 2>3
AL[b]	15.17 ± 0.50	14.55 ± 0.59	16.80 ± 0.44	5.10	.007**	3>2
SE[b]	15.55 ± 0.43	14.22 ± 0.48	14.67 ± 0.43	2.30	.103	-
DE[b]	10.18 ± 0.46	9.23 ± 0.42	13.70 ± 0.40	30.59	.000***	3>2, 3>1
SW[b]	14.52 ± 0.50	12.83 ± 0.53	15.67 ± 0.35	9.40	.000***	3>2
SR[b]	13.10 ± 0.39	12.62 ± 0.32	14.98 ± 0.49	9.43	.000***	3>2, 3>1
ED Total[a]	23.38 ± 0.95	23.65 ± 1.04	23.28 ± 0.82	0.04	.96	-

Note. N = 180 participants. ***. p ≤ .001 level, **. p ≤ .01 level.
AL= Alienation, SE= Stereotype Endorsement, DE= Discrimination Experience, SW= Social Withdrawal, SR= Stigma Resistance, ED= Emotional distress

Table 3 showed significant differences between the three groups ($p < .001$). Participants with mood disorders (M = 68.52, SD = 1.67) reported higher levels of internalised stigma compared to those with anxiety disorders (M = 63.45, SD = 1.65) and OCD (M = 14.70, SD = 0.42). Individuals with OCD (M = 16.80, SD = 0.44) scored higher on alienation than those with anxiety

disorders (M = 14.55, SD = 0.59). Besides these, there were no significant differences between the three groups on stereotype endorsement ($p = .103$).

Individuals with OCD had significantly higher levels of devaluation. Social withdrawal was significantly different across the three groups ($p < .001$). Individuals with OCD experienced more social withdrawal than those with anxiety disorders. Participants with OCD reported higher levels of stigma resistance ($p < .001$) compared to those with anxiety disorders and mood disorders. No significant differences were found between the groups in terms of emotional distress ($p = .96$).

Table 4
Internalised Stigma as Predictor of Emotional Distress

	Emotional Distress		
Predictors	**B**	**β**	**95% CI**
Constant	21.07**		[18.85, 23.29]
Internalized Stigma	.05**	.18**	[.01, .09]
R^2	0.34		
F	5.74**		

**p <.05; B for Unstandardized regression coefficient; *β* for Standardized regression coefficient CI for Confidence interval

Table 4 illustrated that internalised stigma has a significant direct effect on emotional distress ($B = 0.5$, $p < 0.01$, $R^2 = 0.34$, $F = 5.74$) and it explained 34% ($R^2 = 0.34$) of the variance in emotional distress. Internalised stigma was a significant positive predictor of emotional distress ($B = 0.05$, $\beta = 0.18$, $p < .05$), indicating that higher levels of internalised stigma were associated with greater emotional distress. The 95% confidence interval for the unstandardised coefficient ranged from 0.01 to 0.09, which also support the significance of this relationship.

DISCUSSION

The present study investigated the relationship between internalised stigma and emotional distress among individuals diagnosed with mood disorders, anxiety disorders, and obsessive-compulsive disorder (OCD). Results showed variations of stigma in different psychiatric populations, and that there is a relationship between internalised stigma and emotional distress among all three psychiatric populations studied. The analysis illustrated that the higher the experience of internalised stigma, the higher were the levels of emotional distress. This is also supported by previous studies that individuals with different psychiatric disorders suffer different level of self-stigma, and research found that the level of internalised stigma was different among mood and anxiety disorder.[15]

In the Pakistani culture, the society has several beliefs and stereotypes regarding people with mental illnesses. These beliefs exacerbate the stigma linked to mental illness, and as a result, the sufferers confront double trouble: that Mental health ignorance leading to self-destruction, poor coping skills, and emotional disturbance among psychiatric patients. Individuals with psychiatric conditions experience stigma worldwide. But the condition is different for developing countries like Pakistan, where people face different issues which differ in concern with western individuals. One of the major reasons for stigmatisation in our society is a lack of understanding or awareness regarding mental health. People give special consideration to physical health concerns and consider that mental health issues are occurring due to supernatural forces, inadequate religious practices or due to related spirituality.[16]

The current study observed that participants with mood disorders experienced higher levels of internalised stigma than those with anxiety disorders and OCD. This is consistent with prior research showing that people with mood disorders frequently experience strong self-stigmatisation, which is characterised by feelings of shame, worthlessness, and self-blame.[16] Ociskova et al (2014)[17] found that people with depression typically absorb negative stereotypes, resulting in decreased self-esteem and increased social disengagement. This study showed that those with OCD scored higher on alienation than people with anxiety disorders, which is consistent with previous findings. Alienation is the sense of being different or alienated from others, which is typical in people with OCD due to the distressing and sometimes odd nature of compulsions.[18] A study by Stein et al (2010)[19] found that people with OCD commonly see themselves as socially excluded, which increases their sense of isolation.

According to the current study, people with OCD had higher levels of devaluation and social withdrawal than people with anxiety disorders, and the degree of social withdrawal varied significantly between the three groups. These findings are consistent with previous studies indicating that the apparent and often invasive symptoms of OCD render people more vulnerable to stigma and avoidance.[20] This pattern is also seen in mental disorders, where self-perceived stigma promotes isolation.[21]

This research also indicated no significant differences in stereotype endorsement among the three groups. This finding is consistent with prior research demonstrating that people with various mental health disorders may be similarly vulnerable to societal stereotypes.[22] A recent study discovered that people with OCD have higher levels of stigma resistance than people with mood and anxiety disorders. This is similar with prior research, which found that some people with OCD acquire a higher feeling of self-reliance to combat stigma.[20] Robinson et al. (2019)[22] found that people with OCD frequently develop resilience skills, especially when they have access to supportive environments or psychoeducation. This is in contrast to mental disorders, when people are more likely to internalise stigma out of hopelessness.[16]

Findings show that there were no significant differences between the groups in terms of emotional discomfort, that is consistent with prior research, which showed that while stigma differs by diagnosis, emotional distress is a common experience among people with mental health issues.[21] All three groups—mood disorders, anxiety disorders, and OCD—experience severe suffering that impairs their quality of life, regardless of differences in stigma perception or coping techniques (Clement et al., 2015).[19]

Previous studies have consistently highlighted the strong link between internalised stigma and emotional distress. In this study that internalised stigma of mental illness is a predictor of emotional distress and supported by Wood et al (2017)[23] which showed that emotional distress raises the level of anxiety, despair, and psychiatric symptoms, as well as the level of internalised stigma. It was observed that more the internalised stigma, the higher the emotional distress, and thus more the disturbances. According to research, people who absorb societal stigma are more likely to feel anxiety, sadness, and psychological distress. Vogel et al (2017)[24] demonstrated that internalised stigma significantly contributed to emotional discomfort by decreasing self-esteem and raising emotions of hopelessness. Similarly, Corrigan et al. (2016)[25] found that people with greater levels of internalised stigma were more likely to feel emotional discomfort as a result of self-criticism and a negative self-image. These findings support the current study's findings, implying that internalised stigma plays an important role in influencing emotional well-being. So, as the stigma increases, distress also increases. This is true because in culture with low literacy rates, people with mental illness are unable to recognise their state of psychological/ emotional distress and thus do not attend to the alarming signs until lately when it effects their bodily functioning.

Limitations

Being a single centre study with a restricted sample size, may limit its generalisability to the larger psychiatric population. A larger, more diverse sample from multiple centres would provide a better picture of internalized stigma and mental distress with different factors. The link between internalised stigma and emotional discomfort was studied at a certain point in time, which restricted to assess changes in internalised stigma and distress over time, as well as investigate the role of potential mediators such as social support and coping strategies. The cultural differences in the perception of mental illness were not evaluated, which could help shape the relationship between stigma and emotional distress.

This study focused on OCD, anxiety, and other mood disorders; therefore, it may not fully capture the feeling of internalised stigma and emotional distress among those with other psychiatric issues like schizophrenia, somatoform or body dysmorphic, substance related disorders and personality disorders etc.

CONCLUSION

The research observed the variations in impact of internalized stigma among individuals with mood disorders, anxiety disorders, and OCD. It was also found that the higher the experience of internalised stigma, the higher were the levels of emotional distress.

As the findings support the significant association between stigma and emotional distress, which highlight the need for targeted interventions to reduce stigma and improve mental health outcomes. Thus, there is a need for addressing society's attitudes toward mental illness and promoting mental health awareness may help alleviate the detrimental effects of internalised stigma.

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1.	Sibgha Sheikh	Reseacher MS Scholar, Riphah International University Lahore. Consultant Clinical Psychologist	Conceptualized Study, Data Collection, Scrutinized & Analyzed data, Drafted manuscript for Publication and Review
2.	Dr. Khawer Bilal Baig	Department of Professional Psychology Bahria University Lahore Campus	Supervision of Whole research, Manuscript review
3.	Nayab Ashraf	Department of Professional Psychology Bahria University Lahore Campus	Data Analysis, Presentation of result, Review