ORIGINAL ARTICLE

# EXPLORING THE LIVED EXPERIENCES OF INDIVIDUALS WITH SUBSTANCE USE DISORDER IN PAKISTAN: A QUALITATIVE STUDY ON IMPACTS, CAUSES, TREATMENT CHALLENGES, AND SOCIAL STATUS

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**Background:** Substance use disorder (SUD) presents a significant public health challenge globally, including Pakistan. Despite its high prevalence, there is limited research on the lived experiences of individuals with SUD in Pakistan, particularly in terms of cultural, social, and treatment challenges. **Methods:** This qualitative study explores the experiences of 60 male individuals with SUD in the capital territory of Pakistan. Participants were recruited using snowball sampling and were interviewed using a semi-structured guide covering various aspects of their lives impacted by SUD. Data were analyzed using thematic content analysis, with translation and back-translation processes ensuring accuracy in capturing participants' narratives. **Results:** The study identified four main themes: the impact of SUD on individuals' lives, causes of SUD, treatment experiences, and the social status of individuals with SUD. Participants reported significant financial and social hardships, strained interpersonal relationships, and severe physical and mental health issues. Causes of SUD included emotional distress, peer pressure, and abusive circumstances, while treatment options varied from medical interventions to spiritual healing. The stigma associated with SUD significantly impacted participants' social reintegration and recovery. **Conclusion:** The findings highlight the complex interplay of socio-economic, psychological, and cultural factors influencing SUD in Pakistan. The study underscores the need for culturally sensitive, patient-centered approaches in the treatment and rehabilitation of individuals with SUD. Further research is needed to develop comprehensive strategies that address the specific needs of this population.

**Keywords:** Substance Use Disorder; Pakistan; Qualitative Study; Lived Experiences; Treatment Challenges; Social Stigma; Mental Health; Rehabilitation; Cultural Context; Public Health.

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## INTRODUCTION

Substance Use Disorder (SUD) is a critical public health issue, causing significant harm to individuals, families, and societies worldwide. It encompasses dependencies on substances like alcohol, opioids, and stimulants, leading to serious consequences. The global impact is staggering, with the World Health Organization (WHO) estimating that approximately 35 million people suffer from drug use disorders.[1] This crisis calls for a comprehensive approach, including prevention, treatment, and rehabilitation strategies informed by solid research. In the United States, the opioid epidemic has emerged as a significant public health challenge, with opioid overdoses becoming a leading cause of death.[2] Research indicates that individuals with SUD face various hurdles, including stigmatization, co-occurring mental health issues, and difficulties accessing care.[3] Efforts such as medication-assisted treatment (MAT) and harm reduction strategies have been integral to addressing the opioid crisis in the U.S.[4] Studies highlight the importance of integrating mental health services with substance abuse treatment to improve patient outcomes.[5] Similarly, Europe faces its own set of challenges with SUD. The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) stresses the importance of comprehensive treatment programs to reduce the public health impact of SUD.[6] Countries like Portugal have seen success through decriminalization and harm reduction policies, which have led to decreases in drug-related deaths and improved public health outcomes.[7] Such approaches demonstrate the need for evidence-based interventions tailored to specific contexts. In developing regions, the situation is alarming but often under-researched. In Nigeria, for instance, SUD is linked to socioeconomic factors such as unemployment and poverty, with many turning to substance use as a coping mechanism.[8] In

South Asia, including countries like India and Bangladesh, high rates of substance use are reported, particularly among marginalized communities, exacerbating existing health disparities.[9] These regions require targeted interventions to address the underlying socio-economic drivers of substance abuse.[10] Pakistan, with a population of over 220 million, faces an alarming substance abuse problem. The United Nations Office on Drugs and Crime (UNODC) reports that Pakistan has one of the highest drug dependency rates globally.[11] Despite this, research into the personal experiences of individuals with SUD in Pakistan remains limited. Cultural stigma, inadequate healthcare infrastructure, and limited access to treatment compound the challenges faced by those suffering from SUD.[12] Existing research has largely focused on epidemiological factors, often neglecting the qualitative aspects such as personal narratives and lived experiences, which are essential for developing effective, patient-centered treatment strategies.[13] The stigma surrounding substance abuse in Pakistan further complicates the situation, as it discourages individuals from seeking treatment[14]. Research from other countries, such as Australia and Canada, underscores the importance of integrating patient voices into treatment design, which can improve outcomes.[15] The cultural and systemic barriers to treatment in Pakistan highlight the need for similar approaches that consider patient perspectives and are contextually relevant.[16] SUD in Pakistan not only affects individuals but also has broader social and economic repercussions, contributing to crime, loss of productivity, and increased healthcare burdens.[17] The economic costs of substance abuse in Pakistan are significant, including healthcare expenditures, lost productivity, and law enforcement efforts.[18] Addressing this issue requires a multifaceted approach, tackling both the reduction of substance use and the socio-economic factors that contribute to it.[19] Family dynamics in Pakistan, characterized by strong ties and societal norms, play a crucial role in the treatment process. Family involvement can enhance recovery outcomes, yet it also presents challenges due to the stigma associated with SUD.[20] Despite the high prevalence of SUD in Pakistan, there are promising community-based initiatives. NGOs and local programs have been crucial in providing education, prevention, and treatment services. However, there is a need for increased government support to scale these efforts and ensure their sustainability. This study aims to explore the lived experiences of individuals with substance use disorder in Pakistan, and how do their personal narratives reveal the impacts, causes, treatment challenges, and influence of social status on their condition. Understanding these experiences is critical for developing culturally sensitive interventions that can inform policy and address the growing epidemic of substance abuse in the country. This research seeks to fill the gap in existing literature by providing a nuanced analysis of SUD in Pakistan, contributing to the global understanding of substance abuse and recovery. This study was a part of studies conducted to develop culturally adapted model of cognitive behavior therapy (CBT) for substance abuse in Pakistan. The conceptual framework of study is shown in Figure-1.

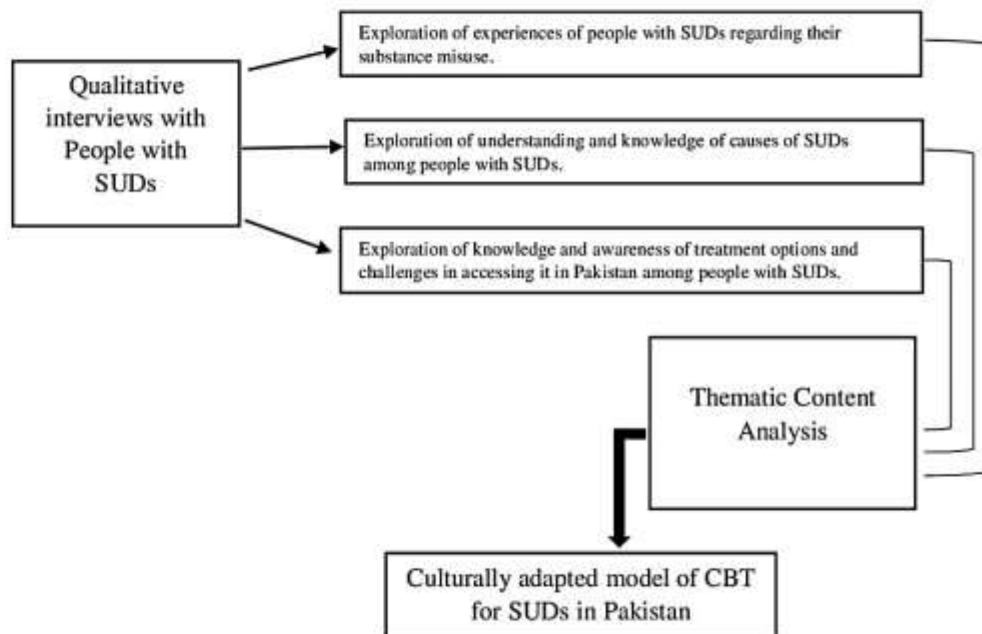


**Figure-1: Illustration of conceptual framework for study**

## MATERIAL AND METHODS

It is a qualitative study conducted in capital outskirts for duration of three months. The study sample included patients with substance use disorder PWSUDs (N = 60) for substance use disorders in the capital territory of Pakistan. The sample was recruited from community. Sample included only males. There was no restriction on inclusion of females, however due to cultural limitations such as not having permission from male family members to take independent decisions, taboo and shame associated with substance misuse, and restrictions on communicating with unknown males, it was not possible to recruit female participants.

Inclusion criteria was the people with a diagnosis of substance abuse disorder in last two years, with the age of 18 years and above. Participants were approached through rehabilitation centers, hospitals, local community, and publicity in local and social media and recruited through snow ball sampling method. Data collection stopped after achieving data saturation at 30 participants.

Two instruments were used in the study, i.e., study, demographic information sheet and interview guide for qualitative interviews with PWSUDs. Both are described in detail below:

Demographic Information Sheet:

It included questions pertaining to age, gender, marital status, number of children if married, highest qualification, onset of substance abuse, substance(s) misusing at present and misused in the past, number of times treatment sought for SUD, history of relapse(s), any other mental or physical ailment.

Interview Guide:

To develop an interview guide for the qualitative study, key themes and research question were identified, and open-ended questions were crafted to explore these areas in depth. The guide was pilot tested by conducting interviews with a small, representative sample, refining questions for clarity, relevance, and effectiveness based on the feedback received. Adjustments were made to the guide before proceeding with full-scale data collection.

It covered the following five areas:

- Effect of substance abuse on patient's life.
- Patients' perception of causes of substance abuse.
- Awareness about treatment options for substance abuse.
- Details of availing treatment for substance abuse.
- Anything which facilitated or hindered treatment of substance abuse.

Questions were designed to derive maximum information about effects of substance abuse on PWSUD's lives, their awareness about treatment options for substance abuse, and difficulties faced in availing treatment for substance abuse.

Before conducting qualitative interviews informed consent was obtained from all participants which included their consent to be audio recorded during the interview. It was ascertained in written form from literate participants (N=39) of study. However, from illiterate participants (N=21) it was ascertained orally in the presence of any of their literate family member or friend. All interviews were audio recorded. Participants were requested to provide as much information as they can on each issue being asked in the questions. Interviews were conducted at mutually convenient place and time, which was coordinated and agreed upon before conducting the interview. On average each interview took an hour to complete. Data was saturated after interviews of thirty patients.

Data was analyzed using six step framework of thematic content analysis. Data analysis was driven by a combination of both theoretical thematic (top-down) and inductive (bottom-up) approaches as it included data regarding specific questions of interview guide along with additional information which emerged during the interviews pertaining to PWSUDs experiences. All data was provided in Urdu (national language) because participants were not proficient in English and Urdu was the only choice to collect data. Therefore, before analyzing data participants' verbatim was first transcribed in Urdu, then translated in English and back translated in Urdu to achieve standard translation as shown in Figure-2. Afterwards, semantic analysis was conducted manually in which codes, sub-themes, and themes emerged from data in a six-step format. It focused on the apparent meaning and interrelationship of the verbatim of the participants. Detail of translation process and each step from six step framework is described below.

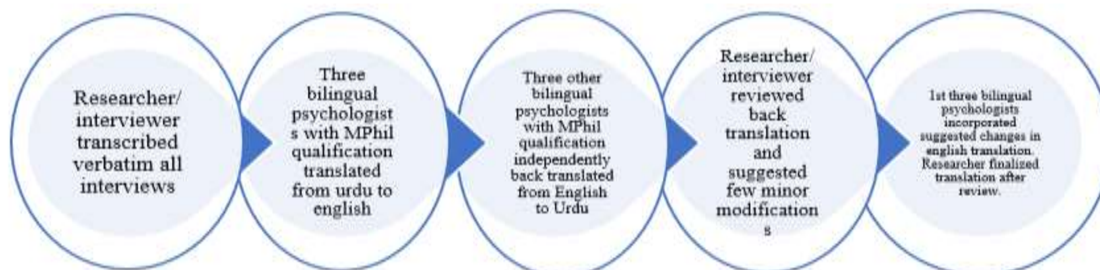


**Figure-2: Process of translation of qualitative interviews from Urdu to English**

At the first step of the six-step framework of thematic content analysis three researchers read and re-read each interview's English translated verbatim several times to familiarize themselves with the information provided in interviews.

In the second step each interview was coded by following line by line open coding method. However, the codes were open, not predetermined which were developed and modified as the researchers worked through the analysis. Team of three researchers who were engaged in the process of coding discussed and compared their codes at the end of each interview coding. As an outcome of the discussion some codes were modified and some new codes were generated. Subsequently, collective and unified codes were assigned to each interview before moving on to the coding of the next interview. After completion of coding for each interview, data which fitted together was organized into meaningful sub-themes. Same process was repeated for each interview data. Finally, sub-themes of all interviews were discussed and compared among the researchers, resulting in overall 20 sub-themes after deletion of duplications and slight modifications

In the third step inter-related sub-themes were divided into four broad themes i.e., Impact of SUD on PWSUD's lives, causes of SUDs, treatment for SUDs, social status of PWSUD. All the themes were descriptive which clearly reflected something specific about the research question of the present study.

Once all sub-themes were arranged under each broad theme, in step four all the relevant data pertaining to each category was incorporated under respective categories. Afterwards, the three researchers read and discussed the data under each theme and its sub-themes. It was ascertained that the themes and sub-themes were inter-related and also represented the data accurately resulting in overall 15 sub-themes, as some of the categories became redundant and eliminated ultimately, and four themes

In step five essence of the main themes, how they relate with the research question, and how sub-themes interact with them was defined as a result three sub-themes were subsumed with other more accurate representative sub-themes. Therefore, at the end of step five there were four main themes; Impact of SUD on PWSUD's lives, causes of SUDs, treatment for SUDs, social status of PWSUD and 12 sub-themes (Table 2).

Step six, i.e., reporting of data is illustrated in the result section.

# RESULTS

## Demographic Information

**Table-1: Participants' demographic information**

| **Participants characteristics (N=60)** | **Values** |
|---|---|
| Age in years Mean (min-max) | 23.7 (19-57) |
| **Gender** | |
| Male | 60 |
| Female | - |
| **Qualification** | |
| Uneducated | 21 |
| Primary | 15 |
| Middle | 12 |
| Matric | 6 |
| Intermediate | 3 |
| Graduate | 3 |
| **Marital status** | |
| Married | 42 |
| Unmarried | 9 |
| Widowed | 3 |
| Divorced | 6 |
| Onset of SUD in years, Mean (min-max) | 13.26 (1-25) |
| Abused substances at present | |
| Cannabis | 27 |
| Marijuana | 18 |
| Opiates | 12 |
| Poly substance | 3 |
| Substances abused in past | |
| Alcohol | 3 |
| Prescription medicines | 9 |
| Naswar | 15 |
| Number of times treatment sought | 1-4 |
| Number of relapses | 1-3 |
| Any other psychological disorder | |
| Depression | 15 |
| Anxiety | 9 |

**Table 2: Themes and subthemes**

| **Themes** | **Sub-themes** |
|---|---|
| **1. Impact of SUD on PWSUD's Lives** | - Financial and social aspects<br>- Interpersonal relations<br>- Physical and mental health<br>- Emotional issues and peer pressure<br>- Abusive circumstances<br>- Recreation and experimentation<br>- Superstitions<br>- Medical treatment<br>- Spiritual healing<br>- Psychological treatment<br>- Realignment in society<br>- Shame and stigma |
| **2. Causes of SUDs** | - Emotional issues and peer pressure<br>- Abusive circumstances<br>- Recreation and experimentation<br>- Superstitions |
| **3. Treatment for SUDs** | - Medical treatment<br>- Spiritual healing<br>- Psychological treatment |
| **4. Social Status of PWSUD** | - Family rejection<br>- Loss of respect<br>- Educational and employment challenges<br>- Shame and stigma |

Individuals with SUDs often faced significant financial difficulties. Many struggled with unemployment and lack of resources, leading to reliance on family support or other means. As their dependency grew, they found it harder to sustain themselves financially, leading to borrowing, begging, or even criminal activities to fund their addiction." I had to borrow money from friends and family just to get my next fix. It got so bad that I started stealing to support my habit." — Patient #12,"I lost my job and my savings were depleted. I ended up begging just to get through the day." — Patient #22."The financial pressure was immense. I was constantly worried about how to get money for drugs." — Patient #26

The financial pressure from substance abuse sometimes drove individuals to engage in crimes or begging to obtain drugs. This lifestyle created additional challenges, including conflicts with law enforcement and threats from drug suppliers. "The shame of begging on the streets and the constant fear of getting caught or hurt by drug dealers made me feel completely lost." — Patient #7 "I started committing petty crimes to support my addiction. It was a dangerous and desperate time." — Patient #18 "I had constant run-ins with the law because of my drug use. It made everything worse." — Patient #30

SUDs frequently strained family relationships. Issues such as financial instability, increased conflict, and the breakdown of communication led to deteriorating bonds. Many individuals reported that their addiction caused family members to distance themselves, leading to isolation, divorce, or homelessness. "My family couldn't handle my addiction anymore. They kicked me out, and I ended up living on the streets." — Patient #3 "I was estranged from my family for years. They couldn't trust me after all the lies and theft." — Patient #11 "The addiction caused so many fights at home. Eventually, my spouse left me and took the kids." — Patient #19

Substance abuse had severe negative effects on both physical and mental health. Health issues such as AIDS and hepatitis C were reported among those who shared needles. Moreover, the overall deterioration in health due to substance abuse often exacerbated psychological distress, creating a vicious cycle where the substance was used as a coping mechanism, further undermining health. "My health went downhill fast. I started having severe health problems and just kept using drugs to numb the pain." — Patient #15 "I contracted hepatitis C from sharing needles. It made my health even worse." — Patient #20 "My mental health was a mess. I used drugs to escape the overwhelming anxiety and depression." — Patient #25

Emotional distress and peer influence played significant roles in initiating substance abuse. Many PWSUDs turned to drugs as a way to cope with life's emotional traumas, such as heartbreak, loss of a loved one, or family issues. Peer pressure also contributed, with some individuals starting to use drugs due to the influence of friends or social groups."I started using drugs after a bad breakup and because my friends were all using. I felt like I had no other way to cope." — Patient #9 "My friends introduced me to drugs as a way to deal with my emotional pain. I didn't realize how quickly it would spiral out of control." — Patient #14 "I was dealing with a lot of personal loss and used drugs to numb the pain. My friends also played a big part in my addiction." — Patient #21

Experiences of abuse, whether at home or school, led some individuals to seek solace in drugs. Traumatic experiences, such as harsh treatment by parents or teachers, created a sense of insecurity and stress that drove them toward substance use as an escape. "The abuse at home made me turn to drugs. It was my way of escaping the pain and stress from my family life." — Patient #5 "I endured a lot of bullying at school, and it pushed me towards drug use as a form of escape." — Patient #16 "I was abused by family members, and using drugs felt like the only way to cope with the trauma." — Patient #23

Curiosity, the desire for new experiences, and the pursuit of pleasure led some individuals to experiment with drugs. What began as recreational use often escalated into dependency, particularly among those seeking thrill and excitement. "It started with just trying drugs for fun, but it quickly became an addiction I couldn't control." — Patient #8"I was curious and wanted to experience new things. What started as experimentation became a full-blown addiction." — Patient #13"I thought I could handle it as a recreational activity, but soon I was completely dependent on drugs." — Patient #24

Some PWSUDs attributed their substance abuse to supernatural causes, such as black magic, evil spirits, or divine will. These beliefs were rooted in cultural superstitions, with individuals feeling that their addiction was a result of curses, predestined fate, or the influence of Jins. "I believed my addiction was caused by a curse. I went to various spiritual healers hoping they'd lift it." — Patient #14 "I thought my drug problems were due to evil spirits. I sought help from traditional healers." — Patient #17 "My family and I thought my addiction was due to black magic. We tried many rituals to fix it." — Patient #29

PWSUDs were generally aware of medical treatments for substance abuse, with many having sought or experienced them. These treatments often involved admission to a hospital or treatment center, where drugs were discontinued, and patients followed

a structured daily routine. However, some individuals faced challenges such as inadequate treatment, high costs, and the distance to medical facilities, leading to unsuccessful outcomes. "I went through a rehab program, but it was so expensive and far from home that I could barely stick with it." — Patient #11 "Medical treatment was helpful, but the costs and travel were major barriers." — Patient #27 "I had some success with medical treatment, but it was hard to stay committed due to logistical issues." — Patient #30

Many PWSUDs turned to spiritual healing as a treatment option, seeking help from spiritual healers or visiting shrines. Practices included wearing amulets, drinking blessed water, or participating in rituals believed to provide relief from substance dependency. Spiritual healing was often seen as a complementary or alternative approach to medical treatment. “I tried spiritual healing by visiting a shrine and using blessed water. It felt comforting, though I wasn’t sure it was working." — Patient #6 "Spiritual healing provided some emotional relief, but it didn't address the physical aspect of my addiction." — Patient #20"I used various rituals and spiritual practices to fight my addiction, but I still struggled with cravings." — Patient #28

While some PWSUDs had heard of psychological treatment for substance abuse, few had sought it. Those who did reported positive experiences with counseling and psychological support, though barriers such as the need for frequent hospital visits and the perception of psychological treatment as ineffective without medication limited its use. "I went to a counselor a few times, and it helped me a bit, but it was hard to see it as a real solution without medication." — Patient #10 "Psychological support was beneficial, but the lack of medication made it less effective for me." — Patient #18 "I appreciated the counseling sessions, but they were not enough on their own to help me overcome my addiction." — Patient #22.

Substance abuse often led to severe social consequences, including family estrangement. Individuals reported being disowned by their families or rejected by loved ones who could no longer trust or support them. This lack of support made it extremely difficult for PWSUD to reintegrate into their previous social and familial roles. "My family disowned me. It was almost impossible to get back into their good graces after all that happened." — Patient #13 "I was rejected by my family and friends. It felt like I was alone in the world." — Patient #21 "The estrangement from my family made reintegration into society extremely challenging." — Patient #30

Even after recovery, PWSUD frequently faced ongoing mistrust and caution from relatives and acquaintances. This persistent stigma hindered efforts to rebuild relationships and regain social standing. "Even after getting clean, people still looked at me like I was a failure. It made reintegrating into society really tough." — Patient #4 "The stigma attached to my past addiction continued to affect how people treated me." — Patient #1 "It was hard to rebuild my reputation and regain trust after my addiction." — Patient #27

Substance abuse resulted in educational setbacks and employment difficulties. Examples included expulsion from college and job loss, with lingering negative effects such as damaged reputations and diminished career prospects. “I lost my job and couldn't finish my studies because of my addiction. It's been hard to get back on track." — Patient #2"My addiction led to dropping out of school and losing job opportunities. It’s been a long road to recovery." — Patient #12 "The impact on my career and education was severe. Rebuilding has been a significant struggle." — Patient #19

There was significant stigma attached to substance abuse, which was often viewed as shameful and disgraceful. Families went to great lengths to conceal the issue to avoid social embarrassment, impacting their willingness to seek help and support for the affected individual. "My family tried to hide my addiction from everyone. They were ashamed and didn’t want anyone to know." — Patient #1 "The shame of addiction made my family avoid talking about it publicly. It was isolating." — Patient #16 "The stigma was so overwhelming that I felt I had to keep everything about my addiction a secret." — Patient #24

Many PWSUD kept their addiction and recovery efforts secret due to fear of judgment and shame. This secrecy prevented them from receiving necessary support and further isolated them from their communities and loved ones. "I kept everything a secret because I was afraid of what people would think. It made getting help even harder." — Patient #16 "The isolation from keeping my addiction a secret made recovery feel even more daunting." — Patient #23 "I was afraid to reach out for help because of the fear of being judged and ostracized." — Patient #29

## DISCUSSION

The financial strain resulting from substance use disorders (SUDs) is a recurring theme in the narratives of people with substance use disorders (PWSUDs). The experiences shared highlight how addiction often leads to significant economic hardship, exacerbating pre-existing vulnerabilities and driving individuals toward criminal activities or beggary to sustain their drug habits. This is consistent with existing literature, which shows that substance abuse often leads to job loss and financial instability.[21] The testimonies reveal a vicious cycle where financial strain leads to further dependence on substances as a coping mechanism, which in turn exacerbates the

financial crisis.[22] Moreover, the participants' experiences with begging and committing crimes underscore the broader social consequences of addiction, such as social stigma and the breakdown of social support systems.[23]The impact of SUDs on interpersonal relationships is profound. Participants reported strained family dynamics, marital breakdowns, and deteriorating relationships with children. This reflects findings from other studies that illustrate how addiction can erode family stability and contribute to family conflict.[24] The experiences shared indicate that addiction often leads to a sense of isolation and rejection from family members, reinforcing the cycle of dependency and contributing to feelings of worthlessness and despair.[25] The narratives also suggest that family support, where present, plays a critical role in the recovery process. For instance, a supportive spouse was noted as crucial in the recovery journey for some individuals.[26] This highlights the importance of family involvement in treatment and the need for supportive interventions aimed at families of PWSUDs.[27] The adverse effects of SUDs on physical and mental health were prominently reported. Participants described severe health problems such as AIDS, hepatitis C, and chronic pain, often compounded by the neglect of physical health in favor of maintaining their drug habit. This is consistent with research indicating that substance abuse significantly increases the risk of various health conditions and complicates the management of these conditions.[28] Mental health issues, including depression, anxiety, and feelings of hopelessness, were also prevalent among participants. This finding is in line with studies showing that SUDs frequently co-occur with mental health disorders, which can complicate treatment and recovery efforts.[29] The participants' reports of experiencing severe withdrawal symptoms and increased dependence on drugs to manage these symptoms underscore the need for integrated treatment approaches that address both substance use and co-occurring mental health issues.[30] Emotional issues, including trauma, loss, and depression, emerged as significant contributors to the development of SUDs. Participants' accounts of substance use as a means of coping with emotional pain and stress highlight the role of unresolved psychological issues in the onset of addiction.[31] Peer pressure and social influences were also cited as contributing factors, particularly among younger individuals. The influence of peers in initiating and perpetuating drug use is well-documented in the literature, suggesting that social and environmental factors play a crucial role in the development of SUDs.[32] Experiences of abuse and neglect in childhood were reported as significant factors in the development of SUDs. The narratives of childhood trauma and harsh parenting practices highlight the role of early adverse experiences in shaping substance use behaviors. This aligns with research showing that childhood abuse and neglect are strong predictors of later substance use problems.[33] The desire for recreational use and experimentation with drugs emerged as another cause of SUDs. Many participants described initial drug use as a form of exploration and pleasure-seeking behavior, which eventually led to dependency. This finding reflects the common pattern of drug experimentation leading to addiction, especially among adolescents and young adults.[34] Participants attributed their substance use to spiritual or religious beliefs, indicating that some used drugs to achieve spiritual experiences or to manage religious or superstitious anxieties. This highlights the need for culturally sensitive interventions that consider the role of spiritual and religious beliefs in the development and maintenance of SUDs.[35] The narratives reveal numerous barriers that PWSUDs face when trying to access treatment. These barriers include financial constraints, lack of availability of specialized treatment facilities, and inadequate healthcare infrastructure. Many participants described the difficulty in finding affordable and accessible treatment options, which is consistent with literature showing that economic factors and lack of resources are significant obstacles to accessing addiction treatment.[36] Furthermore, the stigma associated with substance use disorders often discourages individuals from seeking help. This aligns with findings that stigma can act as a significant barrier to treatment, with individuals fearing judgment or discrimination.[37] Participants also noted that the absence of well-trained professionals and comprehensive treatment programs exacerbates the challenges in accessing effective care. This highlights the need for increased investment in healthcare infrastructure and training to address substance use disorders comprehensively.[38] Comparing the results of our study with global findings, we observe several parallels and differences. Globally, the financial impact of SUDs, including job loss and increased criminal behavior, is well-documented[15]. Similarly, the detrimental effects on family relationships and personal health are consistent with international studies, highlighting the universal nature of these issues. However, our study provides unique insights into culturally specific factors influencing SUDs, such as the role of spiritual beliefs and peer influences, which may vary across different contexts and warrant further exploration in diverse settings.

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## AUTHORS' CONTRIBUTIONS

Authors have the following contributions in the present article: AHA and HF prepared instruments for data collection, collected data for the study,

contributed in data analysis. IA and HF wrote Introduction, and Methods sections of the manuscript. UG compiled, reported and discussed results in the manuscript. SAU and PW analyzed data. SAK reviewed the manuscript. All authors read and approved the final manuscript.

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**Ethical approval and consent to participate**
Ethical approval was ascertained from internal review board of Health Services academy to conduct the present study. Written consent was taken from all the participants of the study prior to their participation in the study.

**Consent for publication**
Not Applicable.

**Competing interests**
I declare that the authors have no competing interests as defined by JAMC, or other interests that might be perceived to influence the results and/or discussion reported in this paper.

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