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LIVED EXPERIENCES OF PATIENTS WITH SUBSTANCE USE DISORDERS: A PHENOMENOLOGICAL MIXED METHODS STUDY

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ABSTRACT
The objectives of the present study are two folds, 1) to explore the lived experinces of the patients diagnosed with substance use disorders and 2) to investigate levels of psychological distress experienced along with the perceived quality of life and coping startegies used by them. Phenomenological mixed methods approach was applied with two phases and the study was carried out during 1st January to 30th July, 2022. In Phase I, we used qualitative approach of Interpretative Phenomenological Analysis (IPA). Semi-structured interviews were carried out with 6 experts (psychiatrists and clinical psychologists) and 6 patients diagnosed with substance use disorders. The recordings were transcribed and analyzed for themes of lived experinces (Smith et al., 2009) as experienced by the patients and perceived by the experts (Psychiatrists and Clinical Psychologists/Psychologists) treating while probing their experiences. The findings of IPA yielded main factors that influence people to indulge in substance use disorder are peer pressure, family influence, stigma, sexual satisfaction , loneliness, social and cultural contextual factors, and experimentation. In Phase II, we used quantitative approach of cross-sectional design. 200 patients were selected by purposive sampling technique from Shaheed Naveed Rehabilitation Clinic, Pathan Wali, Wazirabad, Punjab. They were screened with Urdu version of Drug Abuse Screening Test (DAST-10, Skinner, 1982; Yudko, Lozhkina, Fouts, 2007). To measure psychological distress, Urdu version (Farooqi, & Habib, 2010) of Depression, Anxiety, Stress Scale (Dass-21, Lovibond & Lovibond, 1995) was used. To measure quality of life and coping strategies, Urdu versions of WHOQOL-BREF (Lodhi, Raza, Montazeri, Nedjat, Yaseri, & Holakouie-Naieni, 2017) and Copying Scale (Hamby, Grych, & Banyard, 2013) were used with patients diagnosed with substance use disorders. The results showed that patients experienced moderate levels of depression (M=17.26, SD=4.71) and anxiety (M=14.10, SD=4.58) and mild level of stress (M=17.32, SD=4.56). The score on coping scale indicated low level (M= 35.0, SD= 7.48) of coping strategies used for appraisal and behaviorally dealing with their issues around drug addiction. Conclusively, the lived experinces of the drug addicts centralized around socio-cultural influences of perceived stigmatization and imbalanced family-peer interactions that arose sensual and curiosity for experimentation with the drugs. They perceived their life to be of average quality and exhibited low coping skills, thus suffered with moderate level of depression and anxiety even in their full remission for substance use disorder in rehabilitation centres. The implications are discussed in the light of the fidnings of the present research.
Keywords: Anxiety, Coping, Depression, Drug Addiction, Quality of Life, Stress.

INTRODUCTION

An estimated 6.7 million people in Pakistan are misusing controlled substances, including prescription drugs. 3.6% of people aged 15 to 64 admitted to having used cannabis at some point in their lives. In Pakistan, there are 860,000 regular heroin users, which is equivalent to 0.8% of the population, and there are 320,000 regular opium users, which is equivalent to 0.3% of the population. Methamphetamine use has skyrocketed in Pakistan in recent years, which has led to an increase in the country's overall prevalence of the drug (United Nations Office on Drugs and Crime, 2013). This

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situation has highlighted importance of exploration of experiences and perceptions about substance use disorders in diagnosed patients.

The Diagnostic and Statistical Manual of Mental Disorders-5 (APA, 2013) defines substance use disorder (SUD) as problematic drug use that results in clinically significant impairment or distress. It is determined whether the severity falls into the mild, moderate, or severe category. According to Jahan and Burgess (2021), substance use disorder (SUD), is a condition that affects both the brain and the behaviour of a person, leading that person to abuse substances such as drugs, alcohol, or medications. Substance use disorders can be caused by abuse of these substances. Cannabis, sedatives, hypnotics, anxiolytics, inhalants, opioids, hallucinogens, and stimulants are among the most commonly used psychoactive substances. It is possible to categorise substances based on the effects they have on the central nervous system. These effects can range from intense feelings of euphoria and increased levels of energy to a profound sense of calm and relaxation. The early stages of substance use disorders are characterised by positive reinforcement, which is when users experience feelings of well-being or euphoria as a result of their substance use. The progression of both the physiological and psychological dependence on a substance is accompanied by a reduction in the dysphoria and symptoms of withdrawal as the dependence on the substance increases.

The quality of life is an important outcome measure that is considered in clinical studies of substances like alcohol and drugs. The absence of a universally accepted definition of quality of life is a barrier to progress in this area. Researchers frequently equate having a healthy status with having a high quality of life; however, there is no definition of quality of life that is universally accepted (Zubaran & Foresti, 2009). However, World Health Organization, considered quality of life as a person's perception of where they are in life in relation to the things that are important to them, such as their goals, expectations, and standards, to be the defining characteristic of quality of life. This perception is based on the person's own goals, expectations, and standards. The quality of one's life is a significant indicator that can be used to determine their state of health. There is a relationship between the quality of the environment and the quality of life in all aspects of a person's existence, including the body, the mind, the community, and the society (WHO, 1996).

The quality of life (QOL) of patients in general hospitals as well as patients in detoxification units was measured and compared in SUD. Between the years 2008 and 2013, a total of 659 patients took part. Patients with substance use disorders had a lower quality of life across all dimensions when compared to the somatic sample (physical, psychological, social, and existential). The suffering caused by mental illness and addiction to substances had a negative impact on the quality of life. At the six-month follow-up, those in the SUD sample showed a moderate improvement in their quality of life, but the improvement was less pronounced for their partner relationships. When providing care for patients who suffer from substance use disorders, medical professionals have a responsibility to take into account every aspect of their patients' QOL (Vederhus, Pripp & Clausen, 2016).

Burnette and Mui (1997) defined psychological distress as a lack of enthusiasm, sleep problems (trouble falling asleep or staying asleep), feeling downhearted or blue, feeling hopeless about the future, experiencing emotional feelings (such as easily crying or feeling like crying), experiencing boredom or having a passing interest in things, and having suicidal thoughts. According to Machado and Klein (2007) abuse of drugs and dependence on them both present in ways that are cognitive, behavioural, and physiological. There is clinical heterogeneity in terms of clinical presentation, severity, vulnerability, sequelae, and comorbidity. This is because these disorders are characterised by such a broad spectrum of symptoms. Because of this, there is a significant amount of suffering, as well as a requirement for assistance in a variety of different areas. It is necessary for professionals who work with addicts to evaluate both the individual's level of substance abuse and their psychological anguish. 107 drug addicts, ranged in age from 22 to 55 years old, with the mean age being 34.84 years old and the standard deviation being 6.44 took part. The research indicated a link between substance abuse and psychopathology in the human brain.

The objectives o the present study is i) to explore the lived experinces of the patients diagnosed with SUD, and (ii) to determine the levels of psychological distress (depression, anxiety and stress), the quality of life, and the effectivity of coping style used by them.

METHODOLOGY

This research applied mixed methods phenomenological approach (Martiny, Toro, & Høffding, 2021) and was conducted during 1st Januaray to 30th July, 2022 in the Department of Psychology, University of Gujrat, with two distinct phases. In Phase I, using a qualitative research design allows for an investigation into the whys and hows of a certain phenomenon (unlike quantitative). The findings of qualitative research are presented in written form as opposed to numerical form, which reflects the subjectivity of the research rather than its objectivity. In order to carry out qualitative research, we made use of interviews that are semi-structured. This research was carried out with the participation of both six individuals struggling with diagnosed substance use disorder and the same number of professionals treating them for their disorder. All participants signed a consent form. The participants were provided with background information on the significance of the study. It was made abundantly clear to each participant that they were free to decline taking part in the activity if they so desired. They were informed that there will not be any costs associated with taking part.

We used Interpretative Phenomenological Analysis (IPA, Smith, 2009) to investigate the experiences of substance abusers as well as professionals working in the field of addiction treatment. Their own narration of the meanings of their lives is essential for the lifeworlds of the participants to be understood. The Interpretative Phenomenological Analysis (IPA) is a research technique that is categorised as phenomenological because it concentrates on the real-world experiences of the people who take part in the study. IPA recognises that the primary means by which research knowledge is obtained is through the relationship that exists between researchers and the participants in the research. IPA conducts interviews with the individuals who are the subject of the research in order to gain a better understanding of what phenomenology actually entails. Data still need to be interpreted in order to determine both the implicit and explicit meanings that can be drawn from them.

i. A great number of readings were taken directly from the transcript. The participant's speech was annotated in the left margin of the paper, and the annotations highlighted parts of the participant's speech that were interesting or significant. Reading the transcript multiple times helped with getting used to it and becoming familiar with it. This helped us better understand the transcript as well as the other individuals who took part in the discussion.
ii. The initial responses consisted of summaries, paraphrases, associations, or interpretations the majority of the time. Data refers to the entirety of the transcript, and separate passages have not yet been transcribed into their own documents.
iii. We determined which topics were pertinent to the research and listed them. After listing them all out, we looked for any connections that might exist between them. There was conversation about every single overarching theme.
iv. The primary sources were analysed to determine whether or not the themes were in line with the findings. The interviewee's responses were taken into consideration when determining how accurate my interpretations were.
v. The final themes were written. These were the concluding statement, and it encapsulated the collective experiences that were gained by the participants.

Our account of reflexivity is the ability to recognise our own positions and values, as well as the ways in which those aspects influenced our analyses of the data, was aided by the tactic of engaging in self-reflection at personal level. During the course of our work with the transcripts, we looked through the data collected to search for developing themes regarding addiction. It was very challenging for us to refrain from attempting to make the experiences of the participants fit into the addiction model that had been previously developed. In order to ensure that our analysis was as objective as possible and as part of the process of reflexivity, we looked back at the context of the final themes. By returning to the data and the contexts in which it was collected, we were able to think about whether or not various data excerpts accurately described the experiences of participants in a way that were more critical and nuanced. We did not choose these excerpts with the intention of proving our ideas or theories on addiction; rather, we used them to determine whether or not they adequately described the experiences of the participants.

In Phase II, we used quantitative approach to determine the patients' levels of psychological distress, as well as their quality of life and copying abilities. It was decided that there would be 200

patients diagnosed with SUD who were in full remission, were purposively selected from Shaheed Neveed Rehabilitation Clinic in Pathan Wali, Wazirabad, Pakistan. They were screened with Urdu version of Drug Abuse Screening Test (DAST-10, Skinner, 1982; Yudko, Lozhkina, Fouts, 2007). To measure psychological distress, Urdu version (Farooqi, & Habib, 2010) of Depression, Anxiety, Stress Scale (Dass-21, Lovibond & Lovibond, 1995) was used. To measure quality of life and coping strategies, Urdu version of WHOQOL-BREF (Lodhi, Raza, Montazeri, Nedjat, Yaseri, & Holakouie-Naieni, 2017) and Copying Scale (Hamby, Grych, & Banyard, 2013) were used with patients diagnosed with substance use disorders.

The authorities at Rehab have given approval for collection of data from 200 substance use disorder patients filled out a (N=200) quantitative research questionnaire. All participants signed a consent form. The participants were asked about their thoughts on the point of the study. It was made abundantly clear to each participant that they were free to decline taking part in the activity if they so desired. They were informed that there will not be any costs associated with taking part. The conduct of the study adhered to all aspects of ethical research practices throughout its entirety, including the collection of informed consent from participants. All of the information that was provided by the participants was kept strictly confidential. All participants were given the option to withdraw from the study at any time they saw fit

RESULTS

The IPA in Phase I, revealed the following themes

Peer Group Influence

The influence of the peer group in substance use followed by SUDs, was reported as a key factor in all the participants and is mentioned as peer group pressure. All the professionals also mentioned peer group pressure. They were introduced to substances by their peer group. Intially, it was meant for the fun and entertainment and to experiment but gradually this led to dependence. In addition the peer group was the source of obtaining the substances.

"*When drug addicts used to sit with their friends, madam, first they would smoke cigarettes, madam, and then they would smoke hashish, madam, so we used to say, "You can't smoke this hashish. Looking at them we also got addicted"* (Participant 3).

"*The reason for this was that I used to sit with my friends, which means that i started smoking cigarettes in school life, and i gradually progressed to marijuana."* (Participant 6).

"*Sitting in a party, like in a party of friends, a friend jokingly asks you to try, from here these things increase"* (Expert 1).

"*And sometimes the company is such that you are sitting in a company, and someone who is used to it, he will look at you, he noticed you are worried, he will say to you, "Try it" and then he slowly get used to it"* (Expert 2).

"Most *of the people who are addicted to drugs are because of their feindships, i.e. their circle of friends is such that they become addicted."* (Expert 3)

"*One friend becomes addicted due to another friend"* (Expert 4)

Loneliness

Some of the participants indicated that they tried substances becuase of the loneliness. They mentioned that taking substances kept them busy and thus helped them to cope with loneliness. Moreever ,they also reported that after taking substances they felt they had a pleasant time .

"*I used to be alone and there was nothing to do, I was bored. When I went to them, they forced me to drink, and then it became a habit. I could not relax without drinking, I felt restless, I longed to die, I was very nervous"* (Participant 2).

"*He goes so far away from the reality that we call as psychosis. To tell you the truth, he does not live in the servitude of anybody in psychosis, he becomes a separate world, plays in this world, talking to himself are a departure from the normal thing"* (Participant 4).

*"When I got addicted, I didn't meet anyone, I stayed hidden so that no one would know, I was lonely" (*Participant *6)*

FamilyIinfluence

In this study the family influence to the individual substance use was evident. Most of the participants were influenced by family. They reported that being male child they were given preferntial treatment by their parents. They were not monitored especially in their childhood. Most of the participants mentioned the male superiority made them stubborn and aggressive as well as their demands were fulfilled also they influenced by family environment. If someone in their home take drug it must leave an impact on them so they did more independently.

"Secondly, my paternal brother is my cousin. At that time, I was thirteen years old, he gave me hashish and I took it for the first time" (Participant 1).

"Madam, my father used to drink in house, my brother used to drink and because of him I turned to marijuana" (Participant 3).

"My father was also drink this, so I didn't find this thing so strange, he used to do it at home." (Participant 4)

"My brother was a party lover …because of him this thing started at home" (Participant 5).

"Mothers have a sympathetic attitude, they help them in taking drugs" (Expert 2)

Experimentation

Mental Health Professionals and participants reported that they used substances in order to taste them, feel high and experience to how felt after taking substances. They mentioned being curious and impulsive and were not scared if trying anything. Furthermore, they never heeded, made instant decisions, and most of the time were not always worried about the outcomes.

"*we also experimented because there was an experimental spirit that seemed to be something new, only when we knew that it would give us peace and the stress level would be reduced, so we would try it. Only some people do it. Then let's leave it whatever we tried on Extreme."* (Participant 4)

"*Some people are curious about this stuff to check what is actually in it to taste."*
(Expert 5)

Sometimes there are some people who come into this field as an enthusiasm, they want to see what is in it, some people have such personality that sometimes they want to take risks and they say just play .and watch" (Expert 6)

Social and Cultural Contextual factors

All the participants in this study were affected by the social and cultural factors of Punjabi society. All the participants and professionals reported that their associations and experiencs of the substance use, followed by SUDs were related to changing social and cultural settings which have reinforced substance use habis as part of their social behaviour. Also society is getting modern day by day and these made drugs trendy in their parties.

"Because I was born in Karachi, there are many such things happening there. People there are party lovers. People there are partying etc. Like lead class. I have friendship with them like designers or models, because of which this is the reason. I had to take the poisoned drug" (Participant 5)

There is also society, which makes a person addicted" (Expert 1)

Sexual Satisfaction

Participants also in this study told me they take drug to gain sexual satisfaction. They do prolonged sex and got more satisfaction after taking drugs. They also told that many women wanted drugs before sexual intercourse. They force them to drink.

There was a woman and I was 13 years old. She was from a rich family….she dragged me near him and i used to drink for her (Participant 2)

I enjoyed sex after taking drug i felt a heaven below.Then i was addicted to taking drug and having sex. (Participant 1)

Then there is a girl, she called me, she called me and she told me that it is a drug, try it, try ice, she made me try it, I drank it, and I liked it. (Participant 4)

Stigmatization

Participants and professionals reported that they face a lot of stigma from society and from family. People abuse them and made fun of them and even did violent behavior to them and they did not even sit with them and called them with different drug names.

"*People used to abuse me, made fun. People go away from where I sit. The behavior with those who were drug addicts was correct, I had disagreements with those who did not do drugs, and friendship was lost. They were not allowed to sit by"* (Participant 2).

"Then wherever he passes in the society. Ahhh! It is not forgiven, not even by family members, not even by relatives. Even if there is a function of the house, then they said to him hide yourself on the side" (Expert 2)

"*Secondly, when he went outside, our society doesn't forgive his great-grandfathers. This guy is doing drugs. His grandfather was to take marijuana, His father also took cocaine. His uncle used to drink alcohol."*(Expert 3)

"*Because of this habit, they beat me a lot, tied me up a lot, locked me in the room, I cried, they didn't open the door, they didn't give me food, they threw me out of the door like dogs. The behavior was that they did not speak correctly, they did not answer correctly, there was a fight on everything, they used to scold me on everything, so for this reason. Their behavior was not very good. When I came home, my eyes were red. My mother used to said to me specially that "I hate you when I see your face."*(Participant 2) .

The mean and standard deviation obtained in Phase II, for the psychological distress, quality of life, and coping strategies used by patients with SUD are given below

Table No. 1 Mean and Standard Deviation for Psychological Distress, Quality of Life and Coping Staretegies used by Patients with SUD (N=200)

Variables	M	SD
Psychological Distress		
Depression	17.26	4.71
Anxiety	14.10	4.58
Stress	17.32	4.56
Quality of Life		
Physical Health	22.62	5.20
Psychological Health	20.75	4.60
Social Relationships	9.95	2.79
Environment	25.89	6.57
Coping	35.0	7.48

Table 1 shows moderate levels of depression (M=17.26, SD=4.71) and anxiety (M=14.10, SD=4.58) and mild level of stress (M=17.32, SD=4.56). The conversion of raw scores into transformed scores for QOL, gave average level of quality as perceived in life by patients with SUD for physical health (Transformed Mean= 56), psychological health (Transformed Mean= 56), social relationships (Transformed Mean= 50), and environment (Transformed Mean= 56). The score on coping scale indicated low level (M= 35.0, SD= 7.48) of coping strategies used for appraisal and behaviorally dealing with their issues around drug addiction, with 36 and above cut off score for high coping.

DISCUSSION

This study makes a contribution the existing body of literature on addiction by focusing not only on the experiences that lead up to an individual's initial addiction, but also on the struggles that addicts face on a daily basis in addition to these experiences. Some of these other primary areas include the specifics of the problem, the ways in which families play a role in the development of addiction, the ways in which peer pressure plays a role, the ways in which addicts are affected by the stigma that exists in society, the ways in which people behave toward addicts, the ways in which social and cultural factors play a role, the ways in which addicts take drugs for sexual activities, and the ways in which addicts use drugs.

Consideration should also be given to the research that focuses on recovery is important, but so is sociological research that links the micro and macro levels of addiction (Anderson, 1994). The application of sociological research methods to investigate the connections between the micro and macro levels of addiction (Banonis, 1989; McIntosh & McKeganey, 2000; Larkin & Griffiths, 2002). Previous phenomenological research (for instance, Shinebourne and Smith, 2009) has concentrated on the process of becoming dependent on illegal substances or alcohol. On the other hand, the current

research is concentrating solely on the factors that contribute to their addiction as well as the challenges they face as addicts.

From IPA, we derived dseven themes, which are as follows: peer pressure, loneliness, family influence, experimentation, stigma, social and cultural contextual factors, and sexual satisfaction. Participants and professionals shared their personal experiences and perspectives regarding the ways in which peer pressure influences them to become addicted, as well as the ways in which they adapt to this influence. When we moved on to the next topic, which was isolation, both the individuals who had struggled with addiction and the professionals in the room discussed the ways in which isolation had played a role in their addiction. The factors affecting the experinces of patients with SUD are summarized in the diagram given below.

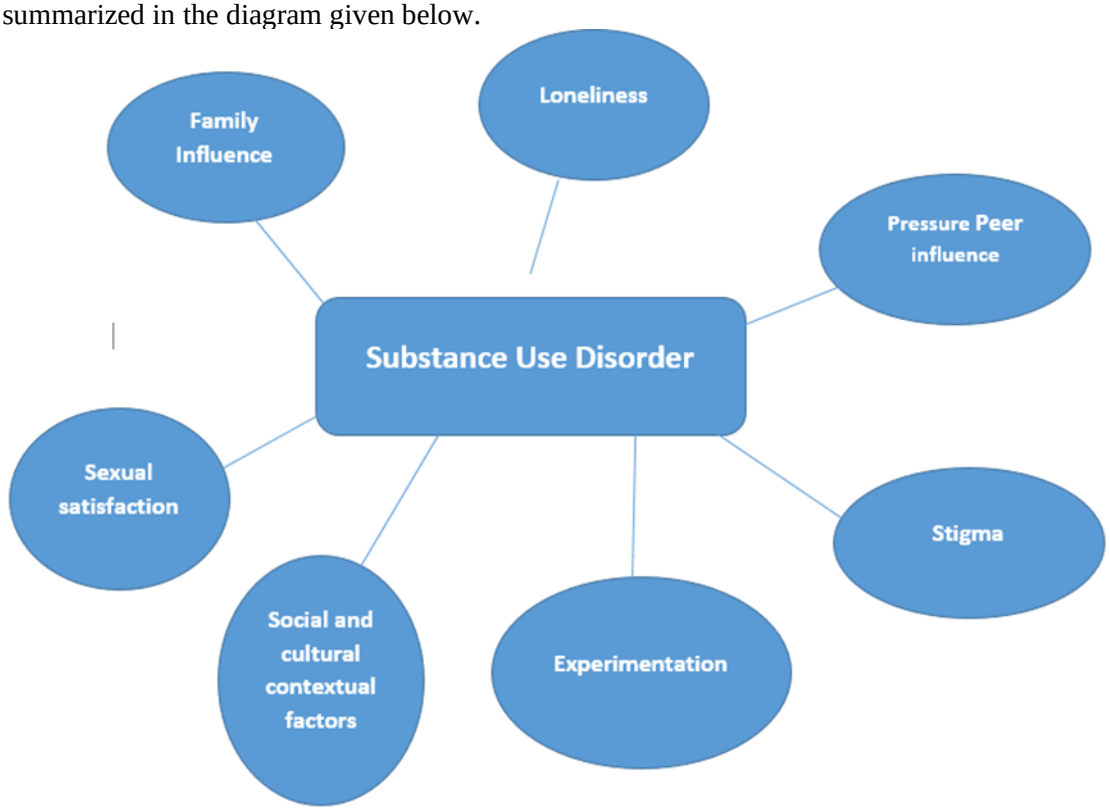

Figure 1: Factors Effecting th Lived Experinces of Pateints with SUD.

Family members who are struggling with addiction are provided with support and encouragement from their families. As we move on to the next topic, experimentation, we see that many people who abuse substances become addicted to them by first trying them out to satisfy their taste curiosity. This is one of the ways that people become addicted to substances. In our other area of research, we investigate the ways in which social and cultural factors, as well as the rituals and practises of society, can have an effect on individuals who are battling substance use disorders. Specifically, we look at how these factors can influence a person's decision to use substances. Sexual satisfaction, and in this section, we're going to look at how drug addicts get sexual satisfaction that lasts for a long time, as well as how some women choose to be addicts so that they can have more sexual satisfaction than they would otherwise have. When we take a look at our last topic, which is stigma, we are able to see how badly people who are afflicted with substance use disorders are treated by our society and how abused they are. We also see how a person's relationships with others and the names they are called can be impacted by the addiction of a family member.

Patients suffering from substance use disorder were assessed in a quantitative study for their levels of psychological distress, quality of life, and copying strategy. Regarding their psychological distress, patients with substance use disorders showed moderate level of depression and anxiety along with average perception for the quality of life they experienced. They applied low level of coping strategies to deal effectively with their problems. These findings are consistent with the results of a

study conducted by Ólafsdóttir, Hrafnsdóttir and Orjasniemi (2018) who reported about of vicious cycle in which patients of SUD are caught. They are stigmatized for bringing shame and guilt to their families for being addicted and thus perceive low quality of life when taking treatment for substance abuse issues. Similarly, Adan, Antúnez, and Navarro (2017) found high score for maladaptive coping in patients with SUD and comorbid major depression in their study.

CONCLUSION

This study finds problems among SUDs patients and factors that influence them to be a addict by using qualitative method. By interpretative phenomenological analysis we found the themes that influence patients with SUD are, peer pressure influence play their main role to influence people to be addict, friends insisted them to try different drugs, family influence also play it's role to influence SUDs patients, if their father, brothers are addict so it will have a negative impact on remaining too and they didn't consider drugs odd. Loneliness also have a significant effect in SUDs patients life to be addicted when they have nothing to do and get bored they must want to do something that's compete their loneliness. Experimentation role is also important. Social and cultural contextual factors also play their important rule in SUDs patients life they see people around them and joined parties which are become trend in new modern generation they used drug as a fashion or trend now so it also highly impact them. sexual satisfaction or need also encourage people to take drug some SUDs patients took drug to get prolonged sex. Stigma the feelings of blaming, dishonor and shaming, which cause mental problems in them. SUDs patients badly treated by their societies and family people abused them and called them with different names also don't like to sit with them. Since, drug dealing is considered a crime, patients with SUD are considered criminals instead of being perceived as humans who are sick, and they are considered sinners.

This study finds out the levels of psychological distress, quality of life and coping strategy among people who live with SUDs with quantitative method. Depression and anxiety is experienced at moderate level while stress is still mild in nature. Their coping strategies are low for effectively dealing with their life. And last but not least, life is perceived to have average quality for them. Therefore, they have high prognosis for relapse and their disorder can be managed neither cured nor treated for long terms.

The findings implied devising a psychosocial intervention plan to be held at community level for reduction of stigmatization against drug addicts and to psychoeductae families for enhanced relationships and wellbeing of the patiwnts. Further, counseling and psychotherapeutic services must be provided to the patients in rehabilitauoon centres for better physical and mental health of the patients with the lessening burden of the psychological distress in patients with SUD.

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