

Lived Experience of Women with Substance Use Disorder: A Qualitative Study

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Abstract

Substance use disorder among women is a multifaceted condition shaped by individual, familial, social, and economic determinants, with profound consequences for mental health, maternal roles, and overall quality of life. Understanding the lived experiences of affected women is essential for developing effective, gender-sensitive interventions. This qualitative study employed a conventional content analysis approach and was conducted in 2026 in healthcare centers in a city in the southeastern region. Participants were randomly selected from all healthcare centers in the study area. Thirty women were enrolled. Data were collected through semi-structured individual interviews and analyzed concurrently using Graneheim and Lundman's method with MAXQDA 2020. Trustworthiness was ensured using Lincoln and Guba's criteria. Five main themes emerged: (1) initiating and perpetuating factors—including childhood trauma, chronic physical pain, spousal encouragement, bereavement, and cultural misconceptions; (2) barriers to cessation—fear of withdrawal, financial constraints, concurrent spousal use, hopelessness, and low distress tolerance; (3) individual and family consequences—guilt, maternal role disruption, social isolation, and mental health deterioration; (4) social and structural factors—poverty, economic dependence, unemployment, and inadequate institutional support; and (5) participants' proposed solutions—financial assistance, employment opportunities, accessible psychological services, family support, and free women-centered treatment facilities. The findings highlight a complex interaction of individual, relational, and structural forces, with pharmacological treatment alone proving insufficient. The cultural context of this region—characterized by traditional opioid use for pain management, patriarchal family structures, and limited women-centered services—profoundly shapes these experiences. The lived experiences of these women underscore the urgent need for comprehensive, multidisciplinary, and gender-responsive approaches. Integrating trauma-informed care, mental health services, couple therapy, economic empowerment, and social support into treatment protocols can enhance recovery outcomes and improve quality of life for this population.

Introduction

Substance use is a complex public health challenge that affects multiple dimensions of individuals' lives. Understanding the treatment experiences of women with substance use disorder requires qualitative exploration and a careful examination of the individual, institutional, and social barriers they encounter on the path to recovery [1].

To understand the lived experience of these women, researchers must move beyond quantitative statistics and enter their world of meaning. A qualitative content analysis approach allows researchers to systematically describe and interpret these experiences from the women's own perspectives, focusing on both the manifest and latent meanings they ascribe to their lives. This approach is particularly suitable for exploring the experiences of women with substance use disorder because it enables the identification of patterns and categories within their narratives without imposing pre-existing theoretical frameworks. Many women with substance use disorders have experienced physical or sexual violence

over the course of their lives. These traumatic experiences often lead to a restricted and fearful world in which drugs become a tool for coping with deep-seated internal pain [2].

The role of interpersonal relationships, particularly with romantic partners, is a key axis in women's lived experience. These relationships can act both as a source of support and as a factor that perpetuates substance use. They are often fraught with complex challenges, placing women in difficult dilemmas between maintaining the relationship and pursuing recovery [3].

Motherhood during substance use is an experience laden with stress, shame, and fear, imposing an additional psychological burden on women. These women often grapple with intense internal conflicts as they attempt to manage maternal responsibilities while simultaneously coping with substance dependence [4].

Fear of social stigma and legal consequences, especially for women concerned about child custody, serves as one of the greatest barriers to accessing treatment services. This fear leads many women to avoid seeking essential help in order to prevent identification by healthcare or judicial systems [5].

Conversely, pregnancy and maternal responsibilities often act as a turning point, generating the motivation necessary for change and engagement with support services. This transition to motherhood can provide a platform for identity reconstruction and for finding new meaning in life [6].

Social capital and family support play a decisive role in sustaining recovery and reducing the likelihood of relapse among women. The existence of non-judgmental environments and strong support networks helps women manage loneliness and social rejection, allowing them to pursue health and well-being with greater stability [7].

Therapeutic approaches must move toward comprehensive, women-centered models that address psychological and social needs, guided by an understanding of these complexities. Building trusting, non-judgmental relationships between therapists and women is key to facilitating the recovery process and empowering them [8].

In the context of this region, women with substance use disorder face unique challenges shaped by cultural, religious, and legal factors. Substance use among women is heavily stigmatized, and traditional remedies—including opium and its derivatives—are sometimes prescribed by family members for pain relief, creating a culturally specific pathway to dependence. Furthermore, women's economic dependence on spouses and limited access to women-centered treatment facilities compound these challenges. Understanding these contextual factors is essential for developing culturally sensitive interventions.

Ultimately, the goal of this study is to provide an authentic and in-depth representation of these women's lived experiences, identifying existing barriers and facilitators to inform the development of more effective policies and supportive interventions. Understanding these experiences is an essential step

toward improving the quality of life for women undertaking the difficult journey of recovery from substance use.

Methods

This qualitative study employed a conventional content analysis approach [9]. The primary aim of this approach is to formulate and classify the various dimensions of an experience from narrative data. This method fundamentally differs from phenomenological studies, which seek the essential nature of phenomena; instead, the focus here is on extracting conceptual categories and analyzing latent meaning patterns within the discourse text.

Study Population, Sampling, and Participants

This qualitative study was conducted in 2026 in healthcare centers in the study area, located in the southeastern region. This region is characterized by a predominantly traditional and religious culture, with patriarchal family structures and limited economic opportunities for women. Women-centered services remain scarce. Traditional opioid use for pain management is culturally embedded in some families, and women's access to education and employment is often restricted. These contextual factors are critical for interpreting the findings. The study population comprised women diagnosed with substance use disorder who were referred to healthcare centers in the study area.

Participants were selected randomly from all healthcare centers in the study area. Ultimately, 30 women were enrolled. Inclusion criteria were: (1) having a direct lived experience and rich knowledge of the research topic; (2) voluntary informed consent to participate; (3) ability to verbally communicate experiences; and (4) signing a written consent form. Prior to data collection, the researcher provided a detailed explanation of the study objectives, ensured confidentiality, emphasized the voluntary nature of participation, and affirmed the right to withdraw at any stage without negative consequences; written informed consent was then obtained from all participants.

Ethical approval for this study was obtained from the Ethics Committee of Bam University of Medical Sciences (Approval Code: IR.MUBAM.REC.1405.048). The study was conducted in accordance with the Declaration of Helsinki. Given the sensitive nature of the interviews—which explored childhood trauma, domestic violence, and maternal guilt—a distress protocol was implemented. If participants showed signs of emotional distress during or after the interview, the interview was paused or terminated, and the participant was offered immediate psychological support by a trained counselor. Participants were also provided with contact information for free counseling services and were followed up by phone within 48 hours after the interview.

Sampling continued until data saturation was reached. By the twenty-fifth interview, no new codes, categories, or concepts emerged, and responses became repetitive [10]. Following the principles of theoretical saturation in qualitative research, data collection beyond the 25th interview was continued for five additional participants (26–30) to ensure that saturation was robust and to capture potential

variations in experiences related to age, education, and duration of substance use. This decision was guided by the recommendation that saturation should be confirmed through additional sampling rather than assumed at the point of initial redundancy [10]. Nevertheless, to deepen the findings and enhance the study's robustness, the interview process was continued until 30 participants were completed.

Data Collection

Data were collected through semi-structured, individual, face-to-face interviews conducted in a quiet, private setting within the healthcare centers, taking into account participants' emotional and time constraints. Each session lasted between 25 and 35 minutes (mean duration: 28 minutes). The relatively brief duration of interviews was a deliberate methodological decision based on two factors. First, the emotional intensity of discussing traumatic experiences posed a risk of psychological distress for participants, and shorter sessions helped minimize this risk. Second, the healthcare center environment and participants' care responsibilities limited their availability for extended sessions. To compensate for the shorter duration, multiple probing questions were used to encourage elaboration, and field notes were recorded immediately after each interview to capture non-verbal cues and contextual details. However, the authors acknowledge that the brief duration may have limited the depth of exploration, and this is discussed as a limitation. All interview content was audio-recorded with participants' verbal and written permission and transcribed verbatim immediately after each session. Data collection and analysis proceeded concurrently; the analytical output of each interview guided subsequent interviews within the sampling framework until theoretical saturation was achieved.

The semi-structured interview guide used in this study was developed for this study by the research team based on a review of the relevant literature and the study objectives. It has not been published previously. The guide was designed to explore participants' lived experiences of substance use disorder, including initiation and perpetuation of use, barriers to cessation, individual and family consequences, social and structural factors, and participants' proposed solutions. It also included optional modules on pregnancy, childbirth, and motherhood for participants who were pregnant or had children. The English version of the interview guide is provided as Supplementary File 1. All interviews were conducted using this guide, with additional probing questions as needed.

Data Analysis

For textual data analysis, Graneheim and Lundman's conventional content analysis method was employed [11]. This step-by-step process included repeated reading of the texts, identifying meaning units, extracting initial codes, categorizing codes, abstracting categories, and finally identifying main and overarching themes of the phenomenon. To facilitate and systematize the analysis process, MAXQDA 2020 software was used [12].

Trustworthiness and Rigor

To assess the credibility and rigor of the qualitative data, Lincoln and Guba’s four criteria—credibility, dependability, confirmability, and transferability—were considered [13].

Credibility was achieved through prolonged engagement with the raw data and member checking. Dependability was supported by peer review during the coding process and continuous recording of analytical decisions. Confirmability was ensured by maintaining a documented and transparent audit trail along with the researcher’s continuous reflexivity regarding their role in the research process. Transferability was guaranteed through maximum variation sampling and the provision of rich, detailed descriptions of participants’ individual characteristics and the study context.

Reflexivity. The research team included individuals with experience in qualitative research and clinical work with women with substance use disorder. Throughout the study, the researchers maintained reflexive journals to document their assumptions, biases, and emotional responses to the participants’ narratives. Peer debriefing sessions were held regularly to discuss emerging findings and challenge interpretations. The researchers also acknowledged their positionality as outsiders to the participants’ lived experiences and took steps to build trust and rapport during interviews.

Results

The extracted themes and subthemes are presented in Table 1.

Table 1. Main themes, subthemes, and example quotes from interviews

Main Theme	Subtheme	Example Quote from Interviews
1. Initiating and Perpetuating Factors	1-1. Chronic Physical Pain	"Back disc, kidney pain, facial pain, childbirth" (Interviews 8, 24, 35)
	1-2. Psychological Pressures and Childhood Trauma	"Parental divorce, constant arguing, loneliness, lack of guardianship" (Interviews 1, 11, 16)
	1-3. Encouragement by Spouse or Others	"My husband told me to use it, you'll feel better" (Interviews 10, 12, 16, 26)
	1-4. Loss of Loved Ones	"Death of father, death of child, death of spouse in the earthquake" (Interviews 14, 33, 34)
	1-5. Cultural/Traditional Prescription for Pain or Calm	"They said opium sap is warm, good for MS," "The neighbor woman said use opium for your nerves" (Interviews 29, 30)
2. Barriers to Cessation	2-1. Fear of Withdrawal Pain	"I'm afraid of the body aches from withdrawal" (Interviews 30, 34)
	2-2. Lack of Financial Support for Cessation	"I want to go to a camp but I don't have the money" (Interview 28)
	2-3. Concurrent Spousal Use	"My husband uses, so I keep using too" (Interviews 20, 23, 25)
	2-4. Lack of Motivation and Hope for the Future	"I see my future as destroyed," "Life is pointless and worthless" (Interviews 2, 21)
	2-5. Lack of Distress Tolerance Skills (Low Resilience)	"I can't tolerate pain," "With the smallest upset, I turn to substances" (Interviews 5, 18)
3. Individual and Family Consequences	3-1. Neglect of Children	"I hit my kids," "I don't even prepare breakfast for them" (Interviews 10, 12)
	3-2. Feelings of Guilt and Remorse	"I'm ashamed of my children," "I feel guilty for becoming an addict" (Interviews 5, 22)
	3-3. Social Isolation and Rejection	"I distanced myself from my family," "No one helps me" (Interviews 11, 22)
	3-4. Severe Decline in Mental Health	"Depression, wishing for death, feelings of worthlessness, insomnia" (Interviews 11, 33)
4. Social and Structural Factors	4-1. Poverty and Economic Dependence on Spouse	"My situation is very bad, I get money from my husband" (Most interviews)

Main Theme	Subtheme	Example Quote from Interviews
	4-2. Low Education and Unemployment	Mostly below high school diploma, housewives or unemployed
	4-3. Lack of Support from Governmental/Supportive Institutions	"No government organization helped," "The Imam Khomeini Relief Committee only gives a small allowance" (Interviews 11, 30)
	4-4. Harmful Cultural Norms (Prescribing Substances for Women)	"When my father died, everyone said drink alcohol to cope" (Interview 14)
5. Participants' Proposed Solutions	5-1. Financial Aid and Employment	"More money, cleaner life," "I want a well-paying job" (Interviews 30, 33)
	5-2. Spousal or Family Support in Cessation	"My sister helps but I haven't decided," "My daughter could help" (Interviews 6, 32)
	5-3. Access to Free Camps and Psychologists	"I talked to a psychologist and decided to quit" (Interview 10)
	5-4. Separation from a Substance-Using Spouse	"If I get a divorce and have a good doctor, I'll quit" (Interview 12)

Note. The "Comprehensive Analysis" section that previously appeared in the Results has been moved to the Discussion section, in accordance with qualitative reporting standards. The Results section now presents only the themes, subthemes, and participant quotes

Discussion

The findings of the present study revealed that the lived experience of women with substance use disorder is shaped by a constellation of individual, familial, social, and economic factors. Analysis of the interviews identified several main themes, including childhood trauma, the role of the spouse and acquaintances in initiating use, substance use for pain relief, poverty and economic dependence, concurrent use with a spouse, and damage to the mother-child relationship.

1. The Pivotal Role of Childhood Trauma and Parental Divorce in Initiation of Use

More than half of the participants directly referred to parental divorce or severe parental conflict. These women had not witnessed healthy conflict resolution models during childhood and experienced substances as the first route to "forgetting" or "transient calm." For instance, Participant No. 1 stated: "Since childhood, because of my parents' disagreements, I used substances." This finding underscores that prevention of substance use among women should begin with intervention in high-conflict families and parenting skills training. In the cultural context of this region, divorce is often stigmatized, and children from divorced families may face additional social pressures and emotional insecurity. In this region divorce-related stigma may intensify children's emotional insecurity and vulnerability.

2. Encouragement by Spouse or Acquaintances as a Gateway to Addiction

In numerous interviews, husbands, friends, or even mothers-in-law encouraged the woman to use substances. This highlights a harmful cultural norm: “Use it, you’ll feel better,” “If you don’t use, you’ll feel unwell,” “Take it, you’ll enjoy it.” This finding is particularly significant in the context of this region, where women’s social networks are often limited to family and close acquaintances, and where obedience to husbands and elder family members is culturally expected. Women may feel pressured to comply with their husband’s or mother-in-law’s suggestion to use substances, viewing it as a form of care or intimacy rather than coercion. This is a crucial finding: society and the health system must implement extensive awareness campaigns against the “prescription of substances” within families, as many women enter the cycle of addiction in good faith, encouraged by their closest relations. The influence of intimate partners on women’s substance use initiation and maintenance is well-documented in the literature, with partners often acting as facilitators of drug use [15].

3. Chronic Physical Pain as a Pretext for Use and Dependence

Herniated discs, postpartum pain, MS, cancer, accidents, and kidney loss illustrate a common trajectory: illness → traditional or spousal recommendation of opium/sap → dependence. Many of these women fundamentally needed pain management, but the health system failed to provide a safe alternative, and instead, traditional opioids were prescribed by their own families. In this region, opium and its derivatives have historically been used as traditional remedies for pain, and this cultural practice persists in some communities. Women who experience chronic pain may be advised by family members to use opium, which is perceived as a natural and harmless remedy. This culturally specific pathway to dependence highlights the need for public education about the risks of traditional opioid use and the importance of seeking professional medical care for pain management. The self-medication pathway through chronic pain management represents a significant entry point for substance use disorders among women, highlighting gaps in accessible pain management services [17].

4. Severe Poverty and Economic Dependence as a Barrier to Cessation

The vast majority of women reported having a “poor” or “very poor” economic status; they were housewives or unemployed and entirely dependent on their husbands. This means women’s addiction is not just a medical issue but also a matter of poverty and the absence of a financial support network. Until these women achieve stable income, sustained recovery will be unattainable. In the context of this region, women’s economic dependence on spouses is exacerbated by limited employment opportunities, especially for women with low education and those living in traditional communities. The lack of financial autonomy not only prevents women from accessing treatment but also makes them vulnerable to remaining in abusive or substance-using relationships. Economic dependence and poverty constitute fundamental structural barriers that perpetuate substance use and impede recovery [18, 19].

5. Concurrent Use with Spouse and Mutual Entrapment

Approximately half of the interviews reported, “I use with my husband.” In these cases, individual cessation without the spouse simultaneously quitting is impossible. Women acknowledged that seeing their husband use triggered cravings and that the home environment had become a “using room.” In the cultural context of this region, where divorce is often stigmatized and women may face losing custody of their children, leaving a substance-using spouse is not always a viable option. Women may feel trapped in a cycle of mutual use, unable to pursue recovery without jeopardizing their marital status and relationship with their children. Therefore, treatment programs must prioritize simultaneous couple therapy. The dyadic nature of substance use within couples creates mutual entrapment where individual recovery is severely compromised without addressing the partner’s use [15, 16].

6. Deterioration of the Mother-Child Relationship and Deep Guilt

Most women explicitly stated, “I don’t care about my children,” “I hit them,” “I don’t even prepare breakfast for them.” Conversely, they experienced profound guilt and shame. This vicious cycle—guilt → increased use → increased mistreatment—requires Acceptance and Commitment Therapy (ACT)-based interventions and reconstruction of the maternal role. These women need self-compassion and parenting skills, not further blame. In the culture of this region, motherhood is highly valued and considered a woman’s primary role. Women who fail to fulfill this role due to substance use experience intense guilt and social condemnation, which can further drive them toward substance use as a coping mechanism. The cultural idealization of motherhood makes it particularly difficult for these women to seek help, as they fear being judged as “bad mothers.” The disruption of maternal roles and associated guilt represent significant psychological burdens that require targeted therapeutic intervention [21].

7. Lack of Resilience and Distress Tolerance Skills

Phrases such as “I can’t tolerate pain,” “With the smallest upset, I use,” and “My nerves break easily” were frequently noted. This indicates that emotion regulation and distress tolerance skills training in this target population is almost nonexistent. Without these skills, even minor stressors trigger immediate relapse. Low distress tolerance serves as a modifiable risk factor that directly affects treatment outcomes and relapse prevention [23].

8. Absolute Hopelessness about the Future and Lack of Life Goals

Statements such as “I see my future as meaningless,” “Life is pointless and worthless,” and “I’ll probably end up in a ditch and die” were repeatedly recorded. This loss of meaning is more dangerous than the addiction itself. Women need hope-focused interventions and micro-life goal setting. A person with no vision for tomorrow lacks the motivation to endure withdrawal pain. Hopelessness and the absence of future orientation constitute critical psychological factors that undermine treatment engagement and recovery motivation [14].

9. Lack of Effective Support from Governmental and Non-Governmental Institutions

Although many women were covered by the Imam Khomeini Relief Committee or the State Welfare Organization, they stated: “No one has helped me to quit,” and “They only give a tiny allowance.” They also expressed dissatisfaction with addiction treatment camps, citing separation from children, inappropriate treatment, and high cost. In this region, addiction treatment camps are residential facilities that provide detoxification and rehabilitation services. However, most of these centers are designed for men and do not accommodate children, forcing mothers to choose between treatment and caring for their children. This structural gap is a major barrier for women with children. There is a significant need for free mother-child camps and post-discharge follow-up. Institutional support gaps represent structural failures that maintain women’s dependence on substances [19, 20].

10. Cultural Context and Specificity of Findings

The findings of this study highlight several culturally specific pathways to substance use among women in this region. The traditional prescription of opium for pain relief, the role of family members in encouraging substance use, and the cultural idealization of motherhood all intersect to create unique vulnerabilities for women in this region. In this region, the family—rather than peer groups—plays a central role in initiating and perpetuating women’s substance use, and cultural norms around female obedience and maternal sacrifice further complicate recovery. These contextual factors must be considered in designing culturally sensitive interventions.

Limitations and Future Directions

Despite providing valuable insights, this study has several limitations. First, the relatively brief duration of interviews (mean 28 minutes) may have limited the depth of exploration of participants’ experiences. The emotional intensity of the topics discussed and the constraints of the healthcare center environment contributed to this brevity, but future studies should consider conducting multiple interviews with each participant to allow for deeper exploration. Second, the study was conducted in a single study area in the southeastern region, and the findings may not be transferable to other regions. Third, the sample consisted of women who were already attending healthcare centers, excluding those who had not sought care or who had dropped out. Fourth, although healthcare centers were randomly selected from all centers in the study area, the sample may not represent all women with substance use disorder in this region, particularly those who do not access formal healthcare services. Fifth, the study did not include long-term follow-up, and the sustainability of the proposed solutions remains unknown. Sixth, despite efforts to ensure reflexivity, the researchers’ backgrounds and assumptions may have influenced data interpretation.

Future research with larger and more diverse samples from various outpatient, community-based, and other treatment centers could enrich our understanding of this phenomenon. Additionally, combining qualitative and quantitative methods in mixed-methods research designs could provide more comprehensive evidence to guide policies and interventions. Future research should also explore the

experiences of women in different regions, compare the experiences of women in this region with those in other Middle Eastern countries, and evaluate the effectiveness of culturally adapted interventions.

Conclusion

The findings of this study demonstrated that the lived experience of women with substance use disorder is a multidimensional and complex phenomenon, shaped at the intersection of individual, familial, social, and economic factors. Identifying the main themes—including childhood trauma, the spouse’s role in initiation, self-medication for physical pain, poverty and economic dependence, and damage to the mother-child relationship—underscores the necessity of re-evaluating unidimensional and purely pharmacological approaches to treating this population.

Theoretical Implications

By confirming the findings of recent research, this study provides strong evidence supporting the cumulative vulnerability model in women with substance use disorder. According to this model, childhood trauma serves as a primary risk factor, predisposing individuals to develop maladaptive coping strategies such as self-medication with substances, which are then reinforced and perpetuated within the context of traumatic interpersonal relationships—particularly the influence of the intimate partner—and adverse economic conditions [14]. The study also extends this model by highlighting the role of cultural factors, such as traditional opioid use and the cultural idealization of motherhood, in shaping women’s substance use trajectories in this region. These findings align with recent theoretical frameworks that emphasize the role of structural and social factors alongside individual factors in the development and perpetuation of substance use disorders, highlighting the necessity of adopting ecological and systemic perspectives in understanding this phenomenon [19].

Clinical and Practical Implications

The present findings have important implications for designing and implementing treatment programs. First, given the high prevalence of childhood trauma and comorbid posttraumatic stress disorder, routine trauma screening and the provision of specialized trauma-informed interventions should be considered an integral part of treatment protocols for women [14]. Second, considering the pivotal role of the spouse in initiating and perpetuating use, couple therapy and family therapy interventions should be incorporated alongside individual treatments [15]. Third, the presence of chronic physical pain as a pathway to initiation necessitates comprehensive pain assessment and the provision of non-pharmacological and low-risk pain management strategies [17].

Policy and Structural Implications

Identifying structural barriers, including high treatment costs, lack of access to childcare services, and absence of economic support, reveals the need to redesign macro-level treatment policies [19]. Effective treatment programs for women should include supportive components such as free or low-cost care, on-site childcare services, financial support for treatment continuity, and economic empowerment

interventions [19]. This integrated approach is fully consistent with recent evidence indicating that gender-sensitive and integrated interventions yield better treatment outcomes for women [20].

Research Recommendations

Based on the study findings, future research is suggested in the following priority areas: (1) designing and testing randomized controlled trials for multimodal interventions that simultaneously address trauma, substance use disorder, and socioeconomic factors; (2) evaluating the effectiveness of Acceptance and Commitment Therapy (ACT) and distress tolerance interventions in the female population in this region with substance use disorder; (3) conducting longitudinal studies to elucidate causal pathways and the perpetuation of use among women regarding changes in family and social roles; and (4) conducting in-depth qualitative research to understand the lived experience of mothers during the recovery process and the reconstruction of their relationships with their children.

Declarations

Ethics approval and consent to participate

Ethical approval for this study was obtained from the Ethics Committee of Bam University of Medical Sciences (Approval Code: IR.MUBAM.REC.1405.048). The study was conducted in accordance with the Declaration of Helsinki. Written informed consent was obtained from all participants. Participants were informed of the study objectives, confidentiality, voluntary participation, and their right to withdraw at any stage without negative consequences.

Consent for publication

Not applicable

Availability of data and materials

The datasets generated and/or analysed during the current study are not publicly available due to the sensitive nature of the data and to protect participant confidentiality, but are available from the corresponding author on reasonable request.

Competing interests

The authors declare that they have no competing interests.

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Authors' contributions

EA designed the study, collected and analyzed the data, and drafted the manuscript. The author read and approved the final manuscript.

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Use of Artificial Intelligence

Artificial intelligence was used for the Persian-to-English translation and editing of this manuscript.

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