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The Impact of Drug Abuse Severity and Economic Burden on Family Well-Being in Khyber Pakhtunkhwa, Pakistan

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Abstract

Drug abuse is still a public health and social issue which is injurious not only to the individual but also to the stability of family life. This study investigated the relationship between the severity of drug abuse and the associated economic burden associated with the use of substances with respect to family well-being in Khyber Pakhtunkhwa, Pakistan. A cross-sectional quantitative study was adopted by using a structured questionnaire that was filled out by 150 adult respondents from households affected by drug use. Drug abuse severity and economic burden were considered independent variables, and family well-being deterioration as the dependent variable. The data were analyzed via SPSS using descriptive statistics, scale reliability, bivariate associations with the chi-square test, Pearson correlation, independent samples t-test, and multiple linear regression. The chi-square tests revealed significant relationships between the level of severity and the level of family well-being and the level of economic burden as well as the level of family well-being ($p < .001$). Correlation analysis showed positive associations between the severity of drug abuse and deterioration of family well-being ($r = 0.573$, $P < .001$) and economic burden and deterioration of family well-being ($r = 0.725$, $P < .001$). Multiple linear regression revealed that after adjusting for age, gender, and household income, drug abuse severity ($B = 0.194$, $p = .046$) and economic burden ($B = 0.627$, $p < .001$) were significant predictors of family well-being deterioration that explained 52.3% variance of the outcome. There was no statistically significant gender difference for mean family well-being deterioration ($p=.417$). The results suggest that some of the families with more serious drug abuse problems also report being more financially stressed and having poorer family well-being, suggesting the need for a family-centered approach to prevention and support.

Keywords: Drug Abuse, Economic burden, Family Well- Being

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1. Introduction

Drug abuse is widely recognized as a multidimensional problem that affects health, social relationships, and economic stability. International evidence links drug use to mortality, long-term illness, disability, and reduced participation in education and work. World Health Organization reporting notes that in 2019 around half a million deaths were linked to drug use, with a large share associated with opioid overdose. Global monitoring also suggests continuing growth in drug use and drug-related harms. The United Nations Office on Drugs and Crime reported that an estimated 296 million people used drugs at least once in 2021 and that 39.5 million people were living with drug use disorders (UNODC, 2023). These figures show a large population that going through the issues of addiction and its consequences.

While much attention is directed toward the individual who uses substances, family members often experience hidden and sustained harm. Drug use within a household is linked to conflict, reduced trust, reduced parenting capacity, and stress-related mental health problems among spouses, parents, and children. Family Systems Theory provides a useful lens for this problem because it views the family as an interconnected unit in which changes in one member shape the functioning of all members (Bowen, 1978). From a community perspective, Social Disorganisation Theory links substance use and related deviance with social and economic conditions such as poverty, weak social controls, and limited access to services (Shaw & McKay, 1942). Together, these perspectives suggest that drug abuse is not only an individual-level condition but also a family-level and community-level issue.

In Pakistan, the family unit often includes extended family members and shared economic responsibilities, which increases the reach of drug-related harm across the household. Official reporting has estimated high levels of drug use nationally. A UNODC technical summary report estimated 6.7 million people in Pakistan used drugs during the previous year and 4.25 million people were classified as drug-dependent. Even where services exist, stigma and fear of reputational damage restrict help-seeking, which prolongs the period of family stress. Families in Khyber Pakhtunkhwa face additional challenges linked to mobility, employment insecurity, and limited access to specialist treatment in some districts. As a result, family well-being often deteriorates through emotional strain, financial loss, and disrupted family roles.

The present study investigates how drug abuse undermines family well-being in Pakistan, with a focus on households in Khyber Pakhtunkhwa. Family well-being refers to the degree of stability in the emotional life, quality of relationship, safety, and day-to-day functioning of the household. Two independent variables are evaluated. The first is the severity of drug abuse, which was measured using perceptions of frequency, dependency symptoms and behavioural disruption associated with drug use. The second is economic burden, which is determined by self-report of financial stress from purchasing drugs, treatment costs, lost income, and debt. A third domain of support orientation is investigated as an indicator of family beliefs regarding professional treatment and willingness to support recovery.

2: Review of Literature

Drug abuse has consequences on the family in the form of behavioural disruption, financial loss, emotional anguish and alteration of family roles. Recent literature has treated these impacts more as linked domains, rather than isolated outcomes, given the degree to which

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severity of use affects the magnitude of economic costs, the degree of household conflict and stress. As shown in Pakistan and other similar environments, extended family members tend to provide informal care during active use and therapy and impose a burden on emotional health, social interactions, and family resources (Azad et al., 2024).

2.1 Drug Abuse Severity and Family Disruption

Drug abuse severity is a pattern of frequent use, presence of dependence symptoms and behavioural problems associated with substance use. Recent Pakistani evidence showed the link between drug use and relapse risk and poorer family functioning, suggesting that strained family relationships are both a reflection and a cause of the course of addiction. According to Jan et al. (2023), the family functioning is connected with the results of relapses, and psychological resources can play an important role in recovery. Similarly, Saleem and Masood (2024) found that relapse tendency is related to family functioning and drug abstinence self-efficacy, implying that families influence recovery through both the climate (i.e., relational climate) of the family as well as support for behaviour change.

Beyond relapse, the presence of severity can often be seen in conjunction with aggression, secrecy, and impaired daily functioning which are reported by families as points of conflict and loss of trust. Qualitative research in Pakistan is used to describe household managing of repeated crisis related to intoxication, withdrawal and social consequences such as policing and community judgement. Mubashir et al. (2025) related caregivers experiencing relentless concern, household strain and limited social involvement when assisting relatives with substance use disorder. At the population level, patterns of drug use in Pakistan also suggest sustained pressure on the family. Sarfaraz et al. (2025) conducted an analysis of a long-term clinical laboratory data and documented the changes in drug abuse trends in Pakistan which is a continuing context in which family harms continue to be relevant.

Severity also has an interaction with social and psychological factors that affect recovery. Mahsud et al. (2025) looked at rehabilitation scenarios in Islamabad and highlighted the role family dynamics and social support plays in determining the resilience of people in treatment. This evidence is consistent with Family Systems Theory as it locates family interaction patterns at the centre of substance use problems development and perpetuation (Bowen, 1978). It too fits with the Social Disorganisation Theory that relates exposure to deviance and lack of collective support to community context and low levels of protective structures (Shaw and McKay, 1942).

2.2 Economic Burden on Families

Economic burden includes direct costs such as expenditure on substances and treatment and indirect costs such as lost income, reduced productivity and debt. Recent research from Pakistan indicates that members of families often report on financial stress as part of the caring role. Azad et al. (2024) concluded that there are emotional and social burden on caregivers in addition to financial stress in Pakistan with less access to external support. Mubashir et al. (2025), for instance, reported that caregivers say they have lost their earnings, unstable home budgeting and tensions over money within the family.

Financial stress also has consequences in terms of help-seeking. In cases where the family resources are stretched, families tend to put off treatment or resort to temporary measures that fail to resolve the underlying dependence. Even where treatment is begun, the household financial instability would continue during rehabilitation in the form of travel costs, several re-admissions and reduced work participation. There is also the multi-domain

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caregiver burden such as financial strain that was reported in studies and defines the sustainability of informal care (Azad et al., 2024; Mubashir et al., 2025).

In Pakistan, there is also an intersection of economic burden with gender roles and care-giving labour. Women are often responsible for household budgeting, but also for care work, meaning that women are at the core of the issue for the economic consequences of addiction. There is some quantitative evidence from Pakistan that suggests the mental health impacts on careers too. Kumar et al. (2021) reported the depression among the primary caregivers of the drug abuse patients suggesting that economic stress and caregiving responsibility co-occur with the psychological symptoms. This connection is also supported by related Pakistani evidence on the topic of caregiver depression (Ali et al., 2022).

2.3 Emotional and Psychological Effects on Family Members

Emotional distress is a central pathway through which substance use harms families. Stress, fear, shame, and uncertainty about safety concerns often become chronic when drug use is persistent or severe. In qualitative accounts, caregivers describe sleep disruption, persistent worry, and reduced social interaction linked to stigma and the need to manage the behaviour of the substance-using member (Azad et al., 2024). These outcomes support findings from Pakistani caregiver studies that describe isolation and limited access to counselling support.

Children and adolescents are also affected through disrupted parenting, inconsistent routines, and exposure to conflict. A recent meta-analytic review of parental drug use disorders found associations with youth substance use and total psychological problems, indicating that parental drug disorders are linked to risks that extend beyond immediate household stress (Anderson et al., 2023). Such evidence supports the intergenerational framing used in prevention research, in which family instability contributes to emotional and behavioural problems in children (Brook et al., 2001). Within Pakistan, families also report heightened fears about children's safety and social development when drug use occurs in the household (Azad et al., 2024).

Substance use also intersects with intimate partner conflict and household safety.

Although the pathways differ by substance type and context, literature links exposure to intimate partner violence with adverse substance use outcomes and treatment challenges among women. Ogden et al. (2021) reviewed evidence on intimate partner violence as a predictor of later substance use outcomes and argued that treatment settings should incorporate screening and referral for violence-related risks. In family settings, violence and fear also harm the wider household, including children and older family members.

2.4 Family Well-Being and Social Relationships

Family well-being includes relationship quality, trust, household functioning, safety, and social connectedness. Studies in Pakistan show that stigma intensifies the burden experienced by families and shapes family communication. Sageer et al. (2024) examined caregivers of individuals with substance use disorder in Pakistan and reported associations between stigma, caregiver burden, and expressed emotions, indicating that social judgement and family emotional climate are connected. Qualitative evidence also describes families withdrawing from social networks, which reduces emotional support and increases reliance on internal family coping (Azad et al., 2024).

Family functioning is also linked to recovery outcomes and relapse risk. When family communication is characterised by conflict and blame, families often respond with hostility or avoidance rather than structured support for recovery, which increases stress for both the user and the household. Findings from Pakistani studies on family functioning and relapse

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emphasize that supportive family environments are relevant for sustaining abstinence and rebuilding daily routines (Jan et al., 2023; Saleem & Masood, 2024).

2.5 Support Systems, Stigma, and Help-Seeking

Some of the support systems are health services, rehabilitation programs, counselling and informal support provided by extended family and community networks. Barriers in Pakistan have been noted to be associated with stigma, costs, and service availability, and most caregivers note the absence of formal support (Azad et al., 2024). Families often realise the importance of professional treatment but support is still limited by affordability and the coverage of services. According to international literature, the results of treatment and recovery stemming out of the services provided are better when they address family stressors, safety risks, and social determinants in combination with clinical management. For instance, Ogden et al. (2021) highlighted the importance of incorporating violence screening and referral into treatment programming with women.

Psychoeducation, organized communications support, and connection to social welfare programs are family-oriented strategies that involve families in a loss of jobs and indebtedness. Evidence from Pakistan indicates that caregiver self-compassion moderates the link between stigma and expressed emotions, suggesting that supportive counselling and peer support groups are relevant for reducing conflict and strengthening coping (Sageer et al., 2024).

2.6 Theoretical Framework

This study draws on Family Systems Theory and Social Disorganisation Theory. Family Systems Theory views the family as an interdependent unit, so addiction is expected to produce ripple effects across communication, roles, and emotional regulation (Bowen, 1978). Social Disorganisation Theory emphasizes that neighborhood and community context shapes exposure to deviance, access to support, and patterns of informal social control (Shaw & McKay, 1942). In Pakistan, both frameworks are relevant because families are embedded in extended kinship structures and community networks where stigma, poverty, and limited service access influence both drug use patterns and family responses.

Conceptualization and Conceptual Framework

Drug abuse severity is conceptualized as the intensity of drug use and dependence-related disruption experienced by the household. Economic burden is conceptualized as financial stress linked to drug use and related costs. Family well-being is conceptualized as the stability of family relationships, emotional climate, safety, and household functioning.

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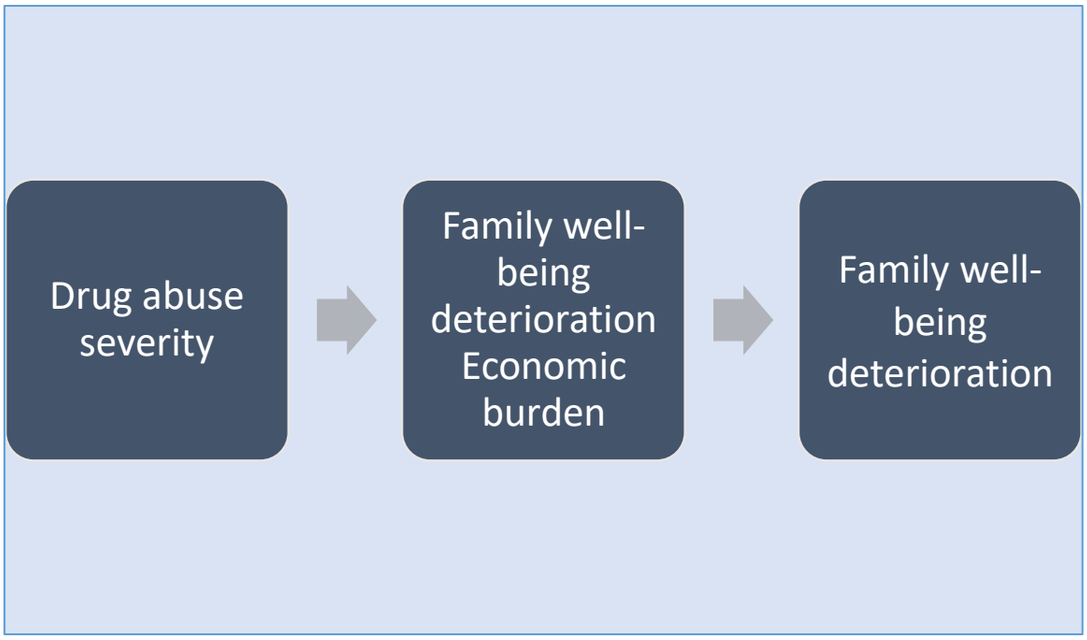

Figure 1. Conceptual Framework of the Study (Source: Author's Illustration)

3: Methodology

The study applied a quantitative, cross-sectional survey design. Primary data were collected through a structured questionnaire administered to adult respondents from households affected by drug use. The target population comprised households in urban and semi-urban areas of Khyber Pakhtunkhwa, Pakistan, in which at least one family member was known or perceived to use drugs in a problematic manner. The unit of response was the household, represented by one adult respondent aged 18 years or above who reported knowledge of the family situation and the substance use problem. A purposive sampling strategy was used to reach households affected by drug use through community contacts and informal referral within the study area. The achieved sample consisted of 150 respondents, meeting the minimum sample size requirement for quantitative testing in the project guidelines. A structured questionnaire was used to capture socio-demographic characteristics and key constructs related to drug abuse and family well-being via Google Forms. The instrument included demographic items and sets of Likert-scale statements. Items were designed to reflect the conceptual definitions in the study and to cover behavioural indicators of drug abuse, financial impacts, emotional distress, and family functioning outcomes. The questionnaire format supports standardization across respondents and supports statistical comparison across groups. All scale items used a five-point response format ranging from 1 strongly disagree to 5 strongly agree. Scale scores were calculated as mean values across items within each construct, so higher values represent higher levels of the measured construct. Drug abuse severity was measured through 12 items capturing frequency and intensity of drug use, dependence-related behaviour, concealment, and related behavioural disruption. Examples include statements on daily use, failure to stop use, and impaired decision-making. Economic burden was measured through 13 items capturing household financial stress linked to drug purchases, treatment costs, loss of income, borrowing, and reduced savings. Emotional distress was measured through 5 items reflecting stress, anxiety, and emotional strain among family members. Family well-being deterioration was measured through 13 items reflecting conflict, weakened trust, reduced cohesion, disrupted routines,

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perceived safety risks, and social isolation within the family. Support orientation was measured through 3 items reflecting belief in the need for professional treatment, belief that treatment improves family well-being, and readiness of the family to support recovery. Data were entered and cleaned prior to analysis via SPSS. Descriptive statistics were computed to summarize respondent characteristics and to describe scale distributions using means and standard deviations. Internal consistency of multi-item scales was assessed using Cronbach's alpha. Bivariate analysis assessed associations between categorical groupings of key variables. Chi-square tests of independence were applied to examine relationships between grouped levels of drug abuse severity and family well-being deterioration, and between grouped levels of economic burden and family well-being deterioration. Effect size for chi-square tests was reported using Cramer's V. Group difference testing was conducted using an independent samples t-test to examine differences in mean family well-being deterioration by respondent gender. Pearson correlation analysis assessed linear associations between continuous scale scores. Multiple linear regression was used to estimate the combined and independent contributions of drug abuse severity and economic burden to family well-being deterioration while adjusting for basic socio-demographic factors. The statistical significance threshold was set at $p < .05$.

4: Results

4.1 Data Screening and Preparation

Data were screened for completeness and coded for analysis. Likert responses were coded from 1 strongly disagree to 5 strongly agree. Composite scores were calculated as mean values across items within each construct, so higher scores represent higher drug abuse severity, higher economic burden, higher emotional distress, and greater deterioration in family well-being.

4.2 Respondent Demographics

Table 1 summarizes the demographic profile of the 150 respondents. The sample included both male and female respondents, with a small number identifying outside these categories.

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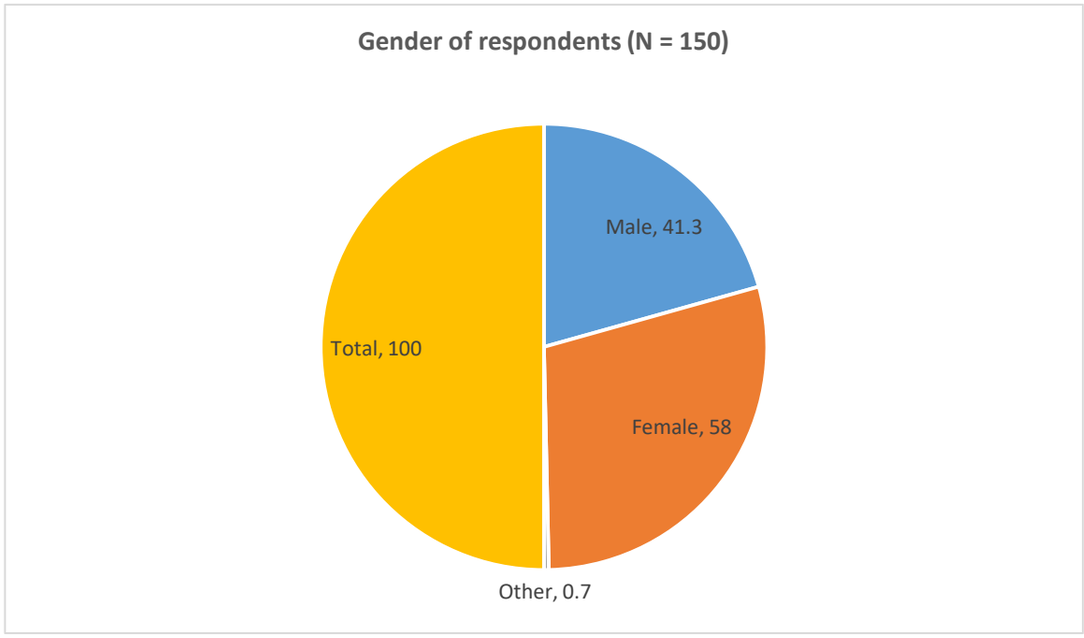

Figure 2. This figure shows the gender composition of the sample. Female respondents formed the majority (58.0%), followed by male respondents (41.3%), while 0.7% selected other. Source: Primary survey data.

Most respondents reported single or married status. Education levels ranged from primary education to postgraduate education, with a substantial share reporting graduation or higher. Students formed the largest occupational group, followed by teachers and a broad range of other occupations.

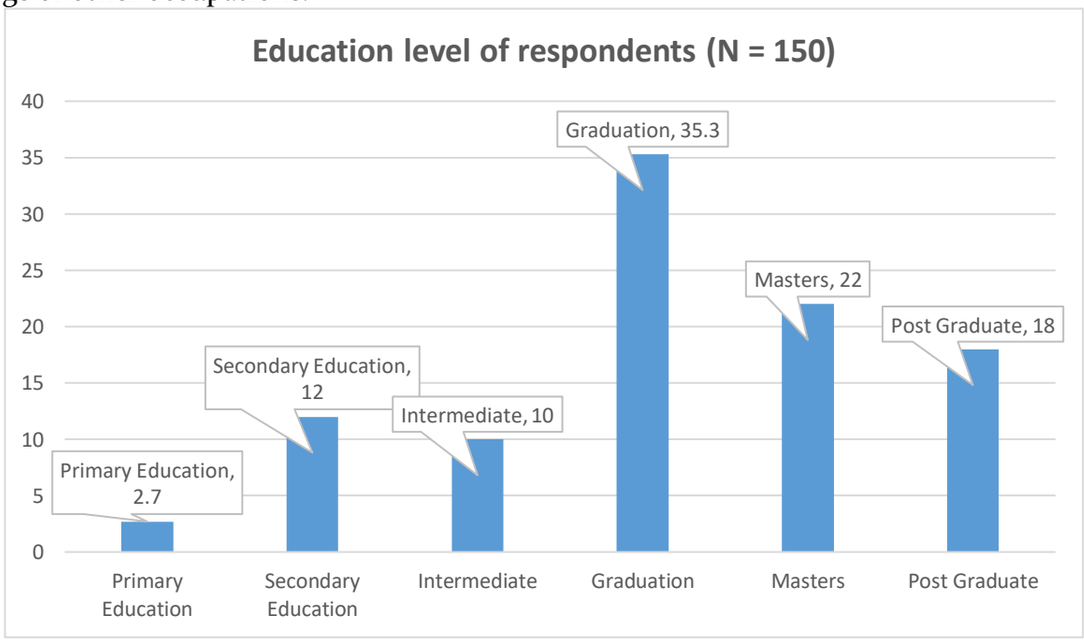

Figure 3. This figure presents respondents' highest education level. Most participants reported graduation (35.3%), followed by masters (22.0%) and postgraduate education (18.0%), indicating a largely educated sample. Source: Primary survey data.

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Household income was distributed across four brackets, with the middle-income bracket forming the largest share. Respondents most often reported that the drug-using person was a relative or another household member, followed by spouse and sibling relationships.

Table 1: Demographic Profile of Respondents

Variable	Category	n	%
Gender	Male	62	41.3
Gender	Female	87	58.0
Gender	Other	1	0.7
Marital status	Single	71	47.3
Marital status	Married	67	44.7
Marital status	Divorced	12	8.0
Education level	Primary Education	4	2.7
Education level	Secondary Education	18	12.0
Education level	Intermediate	15	10.0
Education level	Graduation	53	35.3
Education level	Masters	33	22.0
Education level	Post Graduate	27	18.0
Occupation	Student	49	32.7
Occupation	Teacher	34	22.7
Occupation	Business	8	5.3
Occupation	Housewife	8	5.3
Occupation	Unemployed	8	5.3
Occupation	Other occupations	43	28.7
Occupation	Missing	0	0.0
Monthly household income	<30,000	42	28.0
Monthly household income	30,000–60,000	48	32.0
Monthly household income	60,000–100,000	32	21.3
Monthly household income	>100,000	28	18.7
Relationship with drug-using member	Spouse	29	19.3
Relationship with drug-using member	Child	21	14.0
Relationship with drug-using member	Sibling	28	18.7
Relationship with drug-using member	Parent	25	16.7
Relationship with drug-using member	Relative	47	31.3

Table 2: Continuous Demographic Characteristics

Variable	Mean	SD	Min	Max
Age (years)	26.81	11.65	15	61
Total family members	6.96	4.04	1	30

4.3 Scale Reliability and Descriptive Statistics

Reliability analysis was applied to assess internal consistency of the multi-item scales. Table 3 reports Cronbach's alpha values, which indicate acceptable internal consistency for all scales, with strong reliability for the primary constructs of drug abuse severity, economic burden, and family well-being deterioration. Table 4 reports descriptive statistics for the composite scale scores. Mean values for drug abuse severity and economic burden were above the midpoint of the scale, indicating that respondents frequently endorsed items reflecting harmful use patterns and financial strain. Mean emotional distress and family

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well-being deterioration scores were also above the midpoint, indicating elevated stress and reduced household stability.

Table 3: Scale Reliability

Scale	Number of items	Cronbach's alpha
Drug abuse severity	12	0.915
Economic burden	13	0.903
Emotional distress	5	0.860
Family well-being deterioration	13	0.906
Support orientation	3	0.727

Table 4: Descriptive Statistics for Study Variables

Scale	N	Mean	SD	Min	Max
Drug Severity	150	3.06	0.78	1.00	5.00
Economic Burden	150	3.11	0.79	1.00	5.00
Emotional Distress	150	3.28	0.96	1.00	5.00
Family Wellbeing Deterioration	150	3.32	0.84	1.00	5.00
Support Orientation	150	3.26	0.99	1.00	5.00

4.4 Bivariate Analysis Using Chi-square Tests

Chi-square analysis was used to test association between grouped levels of key constructs. This approach is appropriate where variables are expressed as categorical levels such as low, moderate, and high, and the goal is to test whether the distribution of one variable differs across levels of another variable. Table 5 shows statistically significant associations between drug abuse severity level and family well-being deterioration level and between economic burden level and family well-being deterioration level. Effect sizes based on Cramer's V indicate moderate association for severity and strong association for economic burden. Support orientation level also showed a statistically significant association with family well-being deterioration level.

Table 5: Chi-square Tests of Association

Association	χ^2	df	N	p	Cramer's V
Severity level × family well-being level	35.106	4	150	< .001	0.342
Economic burden level × family well-being level	61.333	4	150	< .001	0.452
Support orientation level × family well-being level	37.047	4	150	< .001	0.351

4.5 Group Difference Testing Using t-test

An independent samples t-test was used to test whether mean family well-being deterioration differed by respondent gender. This test is appropriate when comparing mean values across two independent groups. Table 6 indicates similar mean family well-being deterioration scores for male and female respondents, with no statistically significant difference.

Table 6: Family Well-Being Deterioration by Gender

Gender	N	Mean	SD
Male	62	3.340	0.907
Female	87	3.292	0.790

Table 7: Independent Samples t-test Summary

Test	t	df	p	Cohen's d
Independent samples t-test (Welch)	0.815	142.03	0.417	0.133

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4.6 Correlation Analysis

Pearson correlation analysis assessed the direction and strength of linear association between continuous composite scores. Table 8 indicates statistically significant positive correlations between drug abuse severity, economic burden, emotional distress, support orientation, and family well-being deterioration. The strongest bivariate relationship with family well-being deterioration was observed for economic burden, followed by support orientation and emotional distress.

Table 8: Pearson Correlation Matrix

	Drug abuse severity	Economic burden	Emotional distress	Family well-being deterioration	Support orientation
Drug abuse severity	1.000	0.716***	0.561***	0.573***	0.547***
Economic burden	0.716***	1.000	0.719***	0.725***	0.692***
Emotional distress	0.561***	0.719***	1.000	0.651***	0.557***
Family well-being deterioration	0.573***	0.725***	0.651***	1.000	0.653***
Support orientation	0.547***	0.692***	0.557***	0.653***	1.000

Note. * p < .05. ** p < .01. *** p < .001.

4.7 Regression Analysis

Multiple linear regression was used to estimate the independent contribution of drug abuse severity and economic burden to family well-being deterioration while adjusting for age, gender, and household income. Regression is suitable where the dependent variable is continuous and the goal is to assess the combined effect of multiple predictors. The model explained 52.3% of the variation in family well-being deterioration. Economic burden showed the strongest association with family well-being deterioration, while drug abuse severity remained a statistically significant predictor after adjustment. Age, gender, and household income were not statistically significant predictors in this model.

Table 9: Multiple Linear Regression Predicting Family Well-Being Deterioration

Predictor	B	SE	Beta	t	p	95% CI lower	95% CI upper
Constant	-0.117	0.266	nan	-0.439	0.661	-0.643	0.409
Drug abuse severity	0.194	0.096	0.180	2.017	0.046	0.004	0.384
Economic burden	0.627	0.093	0.589	6.772	< .001	0.443	0.810
Age	0.000	0.004	0.003	0.038	0.970	-0.007	0.008
Gender (Male=1)	0.056	0.104	0.033	0.533	0.595	-0.150	0.261
Income level	-0.006	0.037	-0.010	-0.150	0.881	-0.079	0.068

Model summary. $R^2 = 0.523$. $F(5, 138) = 30.26$. $p < .001$.

4.8 Hypothesis Testing Summary

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Table 10 summarises the hypothesis tests. The results provide support for a statistically significant relationship between drug abuse severity and deterioration in family well-being. Economic burden also showed a statistically significant relationship with family well-being deterioration and emerged as the stronger predictor in the regression model. Support orientation was positively associated with family well-being deterioration, indicating stronger endorsement of treatment need and family readiness in households reporting higher levels of harm.

Table 10: Summary of Hypotheses and Findings

Hypothesis	Hypothesised relationship	Statistical test	Key result	Decision
H1	Drug abuse severity is positively associated with family well-being deterioration.	Pearson correlation and multiple regression	$r = 0.573$, $p < .001$; Regression $B = 0.194$, $p = 0.046$	Supported
H2	Economic burden is positively associated with family well-being deterioration.	Pearson correlation and multiple regression	$r = 0.725$, $p < .001$; Regression $B = 0.627$, $p < .001$	Supported
H3	Support orientation is positively associated with family well-being deterioration.	Pearson correlation and chi-square	$r = 0.653$, $p < .001$; $\chi^2 = 37.05$, $p < .001$	Supported

These results reject the null hypothesis for the primary test and support statistically significant relationships between drug abuse severity and family well-being deterioration. Economic burden showed the largest effect in both bivariate and multivariable analysis, indicating that financial strain is closely tied to household instability. Support orientation also increased with family well-being deterioration, indicating greater recognition of treatment need and willingness to support recovery in households reporting higher levels of harm.

Conclusion

This study focused on the correlation between drug abuse and the well being of the family in households of Khyber Pakhtunkhwa, Pakistan. Survey data from 150 adult respondents provided evidence that the severity of drug abuse and the economic burden associated with substance use are related to the poor well-being of families. Descriptive results showed that the respondents often agreed with items related to harmful use patterns, financial stress, emotional distress, and family-functioning disturbance.

Inferential results were consistent with this pattern. Chi-square analysis revealed that the households that were grouped at higher levels of drug abuse severity and higher levels of economic burden were more likely to be in the higher deterioration category of family well-being. Correlation analysis indicated positive relationships between severity, burden, emotional distress and deterioration of family well-being. Multiple regression analysis revealed that, controlling for age, gender, and income, economic burden (B=0.627, p=.001) and drug abuse severity (B=0.194, p=.046) were significant determinants of family well-being deterioration, and the model accounted for 52.3% of the variance in the outcome.

The analysis also revealed a close connection between emotional distress and family well-being deterioration that indicates psychological strain and family conflict accompany

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material loss. Support orientation was found to be positively associated with deterioration in family well-being, which may indicate that the more severe the family is harmed, the greater the agreement is expressed about the need for professional treatment and willing to support recovery. Overall, the results provide justification for treating addiction as a social problem for families that requires integrated services that address the importance of treatment access, financial strain on families, and psychosocial support for families. Through determination of severity, economic burden, emotional distress, and family well-being in one framework, the study needs evidential basis in order to introduce family-based prevention, strengthening of referral pathways to treatment and social welfare planning in Khyber Pakhtunkhwa, and settings with similar characteristics.

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