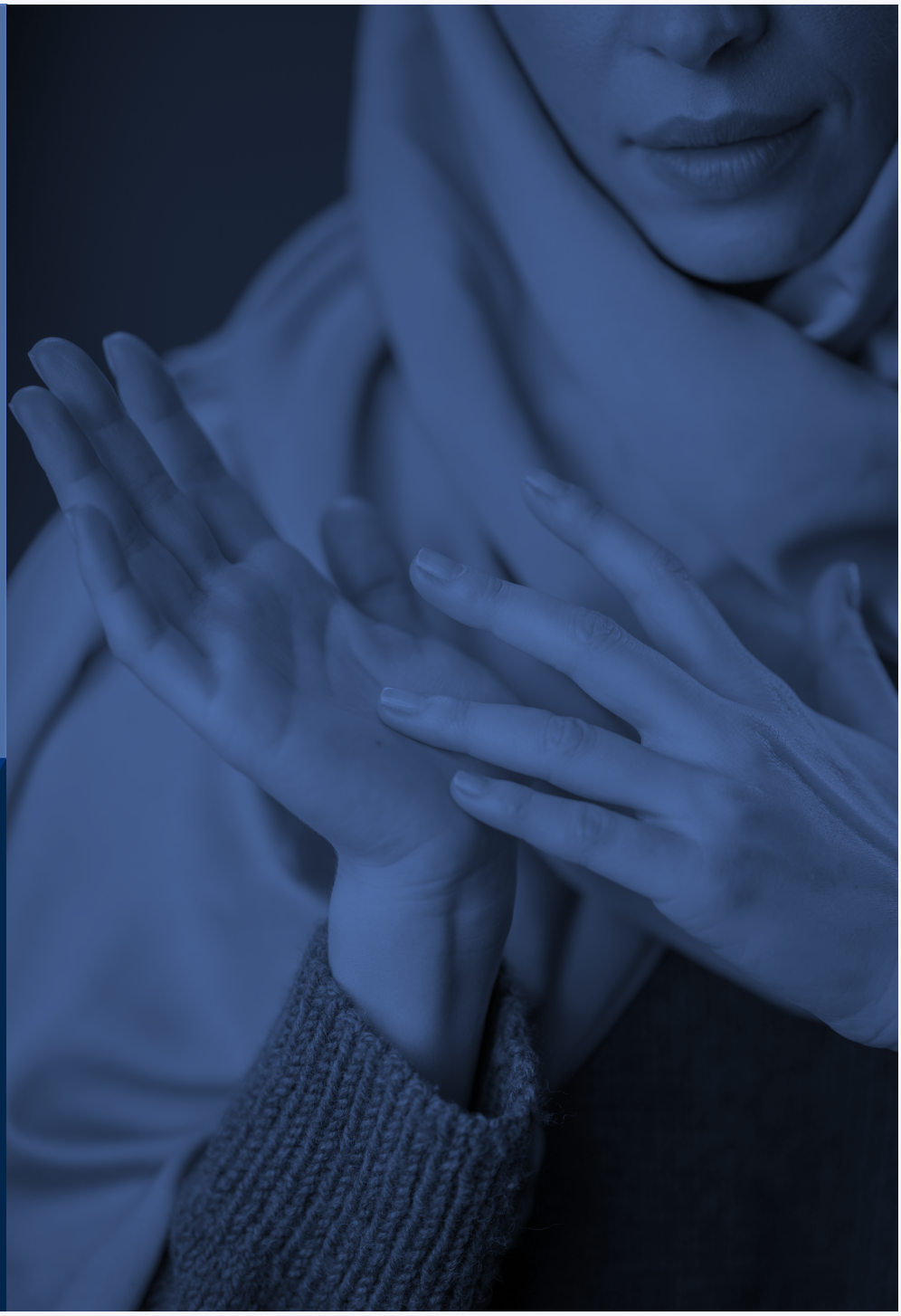

Substance Use, Addiction, and Recovery: Exploring Patterns and Perspectives Among American Muslims

Institute for Social Policy & Understanding

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Woman Age 40

“

I was filling a void—using something to fill an emotional and spiritual void. **That stems from a lot of trauma.**

Executive Summary

This report presents findings from a qualitative study exploring the lived experiences of American Muslims affected by substance use and addiction. Conducted by the Stanford Muslim Mental Health and Islamic Psychology Lab, in partnership with the Institute for Social Policy and Understanding, this study includes 14 in-depth interviews with individuals in recovery or with a familial history of addiction or substance use. Using a thematic analysis, five key themes emerged: 1) definitions and perceptions of addiction, 2) motivations for use, 3) the dual role of family as a support and a barrier, 4) access to and desire for culturally and spiritually informed resources, and 5) the role of the community as a hindrance in recovery and the need for communal support.

Participants commonly cited trauma, family history, early exposure, and emotional voids as triggers for substance use. While many found strength through faith and family, others experienced shame and isolation, often due to stigma within the community. Many participants lacked access to appropriate, culturally and religiously sensitive care and highlighted the urgent need for community education, mosque-based recovery support, and Muslim-centered addiction resources. The findings underscore the necessity to destigmatize addiction, enhance availability and access to culturally and religiously attuned resources, and foster inclusive support systems for individuals and their families struggling with substance use and addiction in Muslim communities.

Introduction

Substance use and addiction have had devastating effects in the United States, with rates of substance use, addiction, and drug-related deaths rising significantly over the past decade (Radel et al., 2018).[1] In fact, between 2018 and 2022, deaths by overdose among adolescents had more than doubled (Panchal, 2024).[2] According to the National Survey on Drug Use and Health, an estimated 35.8 million Americans reported using illicit drugs or misusing prescription pain relievers in the past month, and approximately 20.4 million Americans met the diagnostic criteria for substance use disorder (SUD) in 2019 (Kacha-Ochana et al., 2022).[3]

Substance use and addiction have profound effects on individuals and societies. Both are associated with increased national all-cause mortality, including overdose deaths, which reached over 81,000 between May 2019 and May 2020 (Kacha-Ochana et al., 2022). SUDs are associated with various social and health-related problems, including psychiatric disorders, hospitalizations, unemployment, incarcerations, and other legal issues (Kacha-Ochana et al., 2022).[4]

Clinical Definitions of Substance Use and Addiction

To understand the context of this report, the authors find it important to operationalize and contextualize what these key terms mean. The DSM-5 criteria for substance use disorders (SUDs) are comprehensive and include multiple distinct diagnostic categories depending on the specific substance involved, including alcohol, stimulants, and opioids ("Substance Use Disorders," 2013).[5] The general diagnostic criteria, according to the DSM-5 (2013), are as follows:

> A problematic pattern of use of an intoxicating substance not able to be classified within the alcohol; caffeine; cannabis; hallucinogen (phencyclidine and others); inhalant; opioid; sedative, hypnotic, or anxiolytic; stimulant; or tobacco categories and leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period:
>
> 1. The substance is often taken in larger amounts or over a longer period than was intended.
>
> 2. There is a persistent desire or unsuccessful efforts to cut down or control the use of the substance.
>
> 3. A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects.
>
> 4. Craving, or a strong desire or urge to use the substance.
>
> 5. Recurrent use of the substance resulting in a failure to fulfill major role obligations at work, school, or home.
>
> 6. Continued use of the substance despite having persistent or recurrent social or interpersonal problems caused or exacerbated continued use of the substance despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of its use.
>
> 7. Important social, occupational, or recreational activities are given up or reduced because of the use of the substance.
>
> 8. Recurrent use of the substance in situations in which it is physically hazardous.
>
> 9. Use of the substance is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.
>
> 10. Tolerance, as defined by either of the following:
>
> a. A need for markedly increased amounts of the substance to achieve intoxication or desired effect.
>
> b. A markedly diminished effect with continued use of the same amount of the substance.
>
> 11. Withdrawal, as manifested by either of the following:
>
> a. The characteristic withdrawal syndrome for other (or unknown) substance (refer to Criteria A and B of the criteria sets for other [or unknown] substance withdrawal).
>
> b. The substance (or a closely related substance) is taken to relieve or avoid withdrawal symptoms." ("Substance Use Disorders," 2013).[6]

The DSM-5 further classifies SUDs based on how many of the 11 criteria are met:

- A mild SUD meets two to three of the above criteria.
- A moderate SUD meets four to five of the above criteria.
- A severe SUD meets six or more of the above criteria.

Demographics of Substance Use and Addiction

Vasilenko et al. (2017) discussed that the National Epidemiologic Survey of Alcohol and Related Conditions-III, a representative survey of the American population, found that men generally have higher rates of SUDs compared to women. Men consistently had higher rates of alcohol use disorder and tobacco use disorder compared to women across most ages. Opioid use disorder (OUD), however, had a unique pattern: men had higher rates in young adulthood (ages 22–28), but women had higher rates at older ages (68–77) (Vasilenko et al., 2017).[7]

Chen and Jacobson (2012) also noted that racial disparities exist that vary by drug class and age. Black participants experience a "crossover effect" such that they report lower SUD rates than whites in youth but higher rates in midlife and older adulthood.[8] Comparatively, Latino participants generally have lower rates of SUD across the various drug categories. White individuals have higher rates of OUD in early adulthood, while Black and Latino participants have higher rates at older ages (Lippold et al., 2019; Vasilenko et al., 2017).[9] Interestingly, the 2018 National Survey on Drug Use and Health by the American Addiction Centers found that Asian Americans reported lower rates of substance use overall, with only 4.8% having a SUD compared to 7.4% of the total population and significantly lower rates of lifetime illicit drug use (27.6%) compared to white Americans (54.5%), African Americans (45.9%), and Hispanic Americans (37.7%) (American Addiction Centers, 2024).[10]

Substance Use and Addiction in Marginalized Populations

According to the National Institutes of Health, the race or ethnic group with the highest rates of substance use in the U.S. is Indigenous Americans, with 25% having a SUD in the last year (American Addiction Centers, 2024).[11] Beyond this statistic, rates of use among other racial or ethnic groups tend to be closer in range (Substance Abuse and Mental Health Services Administration, 2022), with youth of color actually having lower reported rates of substance use compared with white young adults (Vasilenko et al., 2017).[12] When comparing racial/ethnic minority experiences with substance use with that of white Americans, the challenge for marginalized communities is not in the rates of use but rather in the consequences of use. This is especially true for illicit substance use, where the detrimental effects of the discriminatory "War on Drugs" are still being felt (Taifa, 2021).[13] In fact, one study found that among nonviolent drug offenders, Black individuals were three times more likely to be sentenced compared to white individuals, and their sentences were nearly 100% longer than those of white individuals (Rosenberg et al., 2017).[14] Not only are criminal charges harsher for Black and Brown individuals, but overdoses are more lethal (Friedman et al., 2021), and access to appropriate addiction treatment is significantly more limited (Burlew et al., 2021).[15] These facts are of critical relevance for American Muslim communities, given that at least 59% of American Muslims are categorized as non-white, and nearly 30% identify as Black or Hispanic (Pew Research Center, 2017).[16] [1a]

Substance Use and Addiction among American Muslims

This context of racial and systemic inequities underscores the importance of examining substance use and addiction among American Muslims, a group that may face unique intersectional race, culture, and/or religion-related barriers to treatment and recovery. While research regarding substance use and addictions in American Muslim communities is limited, a study on the prevalence of addictions among American Muslims estimated that 10.85% have a history of substance use and 18.42% have a tobacco addiction (Ragheb et al., 2023).[17] These findings indicate that Muslim communities experience addictions at a lower rate compared to the general American public, an estimated 17% of whom experience substance use or addictions (Substance Abuse and Mental Health

[1a] This number is likely higher considering that U.S. Census data has categorized individuals with Middle East and North African (MENA) heritage as white, despite the fact that individuals of these ethnicities are not viewed by the general populace as white (Maghbouleh et al., 2022). While this has recently changed and MENA will be a racial category in the U.S. Census as of 2024 (Orvis, 2024), data collected prior to this year continues to face the challenge of misclassification. N. Maghbouleh, A. Schachter, and R. D. Flores, "Middle Eastern and North African Americans May Not Be Perceived, nor Perceive Themselves, to Be White," Proceedings of the National Academy of Sciences 119, no.7 (2022): e2117940119; K. Orvis, "OMB Publishes Revisions to Statistical Policy Directive No. 15: Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity," The United States White House, March 28, 2024.

Services Administration, 2023).[18]

Substance use is clearly prohibited according to Islamic jurisdiction[2b] (Mallik et al., 2021), which can result in high rates of stigma among Muslims, leading substance users to avoid seeking help for fear of being ostracized or lowering their social status within their community (Al-Ghafri et al., 2023).[19] Beyond the fear of stigma and discrimination, Muslims, like many other marginalized communities, have a lack of trust in medical establishments and institutionalized resources and service providers (Al-Ghafri et al., 2023), making it even more challenging to seek necessary care for substance use and addiction challenges. As a result of stigma, shame, and a lack of access to culturally relevant and faith-oriented recovery resources (Al-Ghafri et al., 2023), it is likely that the number of American Muslims struggling with addiction is significantly underreported.[20]

Further, it is crucial to understand the attitude of community members toward fellow members who struggle with addictions and the consequences of those views. It has been documented that imams and other religious leaders are the gatekeepers of their communities and often one of the first sources of support that community members turn to in times of challenge and distress (Humam et al., 2023).[21] That said, according to Mallik et al. (2021), in a qualitative study of imams' attitudes toward substance use and addictions, all of the participants agreed that substance use is prohibited in Islam and that there are negative spiritual and social consequences within and outside American Muslim communities. There was disagreement, however, when discussing the appropriate approach to engaging individuals with SUDs in American Muslim communities. One group of imams felt that it was their responsibility to focus on forgiveness and embracing and aiding individuals struggling with their addictions; another group of imams tended to take a more negative approach, focusing on the sinful nature of substance use and the consequences of substance use at the individual and social levels. Even more concerning was the imams' perception of who was considered "part of the community." Some imams viewed their community as only those who regularly attend the mosque and do not have substance use challenges, while others took a more inclusive approach, identifying the mosque as a refuge for those who need support and care (Mallik et al., 2021). This distinction is critical to understanding who imams view as their responsibility to care for as the leaders of their communities. Importantly, imams with inclusive attitudes highlighted that substance use, addiction, and related issues are likely underreported in Muslim communities at large, especially within mosques, noting the need for therapeutic approaches to assist all individuals affected by substance use (Mallik et al., 2021).[22] Not only are these issues underreported in Muslim communities, but the factors associated with these issues are also complex and interconnected.

Factors Associated with Substance Use and Addictions

The socioecological model is a framework often used to understand how individual behaviors such as substance use and addiction can be influenced by multiple, interconnected levels of influence: individual, familial, communal, social, and policy levels (Kilanowski, 2017).[23] Individual characteristics such as age, mental health status, and gender significantly influence substance use behaviors. For instance, a 2016 study involving 10,123 adolescents (ages 13–18) found that a history of mental health disorders significantly increased the risk of transitioning from not using drugs to first-time substance use. Adolescents with anxiety and behavioral disorders had the highest rates of substance use, with 17.3% and 20% abusing alcohol and drugs, respectively. These findings suggest a strong correlation between mental health issues and the propensity for substance use among adolescents (Conway et al., 2016).[24]

Family and communal dynamics play another critical role in the development of SUDs. In a cross-sectional study that investigated the influence of social networks on substance use among 344 emerging adults (ages 15–25) from disadvantaged urban neighborhoods in Birmingham, Alabama, results showed that higher substance use was significantly associated with peer and family encouragement of use and having close peer members who engaged in substance use. Conversely, peer discouragement was significantly linked to reduced substance use. These findings underscore the critical role of peer networking in both facilitating and mitigating substance use behaviors among young adults (Tucker et al., 2015).[25]

[2b] This statement interprets "substance use" as nonprescription and/or recreational use and/or using in a way that is not as intended by the prescribing medical professional.

Addiction is attributed to many factors, including various socio-environmental influences such as trauma and ostracism (McAuslan, 2020).[26] While America is a melting pot of diverse groups of minorities, many experience marginalization, racism, increasing identity trauma, and a lack of security within themselves (Carliner et al., 2016).[27] This is especially relevant for American Muslim communities, which comprise a diverse range of racial and ethnic groups and experience Islamophobia and faith-based discrimination (Pew Research Center, 2017).[28] In addition, many American Muslims often hold multiple intersecting marginalized identities, compounding the effects of marginalization and discrimination (Colgan et al., 2024).[29] Research has demonstrated that being a first-generation American may lead to feelings of disconnectedness and social isolation post-resettlement (Cifci, 2024).[30] Further, social disconnection and isolation, in general, are linked to increased substance use and addiction challenges (Hosseinbor et al., 2014), especially among recently resettled immigrants and refugees (Aleer et al., 2023).[31] Considering that approximately 60% of American Muslim adults identify as first-generation Americans (Pew Research Center, 2017), these are critical factors when considering the influences leading to substance use and addiction among American Muslims.[32] In fact, a study examining patterns between substance use and feelings of belonging among American Muslims found that individuals with a higher sense of belonging and socioeconomic status were less likely to engage in substance use compared to other participants (Hashem et al., 2024).[33] Additionally, Ragheb et al. (2023) found that approximately 46% of their sample that reported an alcohol or drug use disorder at any point in their life was not born in the U.S., while nearly 37% of those reporting tobacco use disorder at any point in their life was not born in America, indicating that SUD is a universal challenge regardless of country of origin or heritage.[34]

While socioeconomic factors and belonging can influence addiction, some studies suggest that gender and gender self-concept may be overlooked factors when considering substance use and addictions (Clinkinbeard & Barnum, 2017; McAuslan, 2020).[35] Specifically, Arab American Muslim men are more likely than women to report using alcoholic substances, marijuana, and tobacco (McAuslan, 2020). While higher religiosity was correlated with lower levels of marijuana and substance use, it was not a protective factor for men with regard to tobacco. Alternatively, Arab American women with higher levels of religiosity were less likely to use tobacco (McAuslan, 2020).[36] Additionally, traditionally dominant or masculine characteristics were more closely associated with alcohol consumption than feminine characteristics for both men and women (Clinkinbeard & Barnum, 2017). The study suggests that normative feminine characteristics such as sympathy, understanding, and compassion can serve as protective factors for social consequences of binge drinking for men, while traditionally masculine characteristics such as aggression, forcefulness, and dominance were commonly found as predictive behaviors for binge drinking. Traditionally masculine attitudes such as assertiveness and independence, however, protected female participants from social consequences of binge drinking (Clinkinbeard & Barnum, 2017). Although the findings presented in Clinkinbeard and Barnum's (2017) study focused on the general population and not Muslims specifically, the authors provide critical insight into the differences in experiences by gender that can be applied broadly given the dearth of gender-focused research on substance use and addiction among Muslims.[37]

Man Age 35

> I believe that it is a disease, [and] like a disease, **it does have a solution**.

Study Aims

Given the widespread stigma surrounding substance use and addiction, little is known about either within the context of American Muslim communities. Using a phenomenological framework and a case study approach (Crowe et al., 2011; Neubauer et al., 2019),[38] this study had five primary goals: 1) provide insight into the lived experience of American Muslims who struggle or have struggled with substance use and addiction; 2) explore the support and treatment resources that would be helpful for American Muslims struggling with substance abuse and their families; 3) identify key barriers to developing resources for American Muslims struggling with substance abuse and their families, 4) describe the social attitudes toward substance abuse in American Muslim communities, and 5) detail the mission, history, development, successes, and challenges of organizations on the front lines of service provision for substance use and addiction among American Muslims. To our knowledge, there have not been any qualitative studies that assess substance use and addiction from the perspective of American Muslims in substance use and addiction recovery, those with a family history of substance use and addiction, and service provider leadership. This study is the first of its kind in documenting barriers and desired treatment options for American Muslims, allowing for the improvement of existing resources and the development of additional resources that can benefit Muslims experiencing substance use challenges or addiction. By focusing on the Muslim population, we hope this study will decrease stigma within American Muslim communities and serve as a gateway to understanding the unique experiences and needs of American Muslims with SUDs and addictions.

Research Methodology

Established as a partnership between the Stanford Muslim Mental Health and Islamic Psychology (SMMHIP) Lab and the Institute for Social Policy and Understanding (ISPU), this project sought to gather both Muslim addiction-focused service provider leaderships' and community members' perspectives on substance use and addictions. Using a combination of convenience sampling and snowball sampling[3c] across the U.S., recruitment strategies utilized social media and community digital networks. To be included in the study, participants had to identify as Muslim, speak English, reside in the U.S., and be above the age of 18. Recruited individuals were also required to have a personal or familial history of substance use and addiction. The final sample consisted of 14 in-depth interviews (nine direct personal accounts and five familial history perspectives).

In-Depth Interviews

Following recruitment, the 14 in-depth interviews were held with participants in substance use and addiction recovery or participants with a family history of substance use and addiction. Prior to receiving consent, researchers screened individuals to ensure they were 18 years of age and eligible for the study. [4d] Participants took part in approximately one-hour-long semi-structured interviews on Zoom, discussing six topics of focus: the definition of substance use and addiction, history and motivation for using, family influence on addiction, resource engagements, resources needed, and the role of community. Participants provided verbal consent to the study during the screening and at the beginning of the interview. Zoom was used to record and transcribe the interviews. The analysis team cleaned, anonymized, and reviewed transcriptions for accuracy and destroyed transcriptions when the study was completed.

Thematic Analysis

This study used thematic analysis to analyze the interview data. A team of three researchers independently reviewed the transcripts and then engaged in an iterative process of identifying themes in the data across three categories of discussion: 1) the individual's lived experience with and history of substance use and addiction, 2) the resources engaged in the recovery process, and 3) the resources participants felt were missing or needed but not available for recovery. After identifying the three main topics, the research team reviewed each transcript to verify the themes in each of the three topic areas. Upon discussion, the research team reached an agreement regarding the presence and definition of each theme. The research team then reviewed the transcripts to quantify the number of participants who fit the identified themes and noted the participants who diverged. Following this, the research team conducted a final review of transcripts to identify illustrative quotes that best demonstrated the themes identified.

[3c] Convenience sampling is a non-probability method (i.e., an approach that does not rely on random selection) of recruitment of study participants (Galloway, 2005). This study used social media advertisement, social network distribution, and community organization support to recruit participants. Additionally, this study used a subtype of convenience sampling, snowball sampling, which engages individuals who have already participated in the study to refer other individuals who meet study criteria (Galloway, 2005). A. Galloway, "Non-Probability Sampling," in Encyclopedia of Social Measurement, edited by K. Kempf-Leonard (Elsevier, 2005), https://doi.org/10.1016/B0-12-369398-5/00382-0.

[4d] As race/ethnicity was not a required part of the inclusion criteria for this study, this data was not collected at screening. As such, collecting racial/ethnic data for all participants during the interview was challenging. While most participants were forthcoming with this information, some were not. Therefore, some participants are noted as not having that data via "N/D" in the demographics table at the end of this report.

Woman Age 23

“I’m doubting my religion. **I have no one to go to and talk to.**

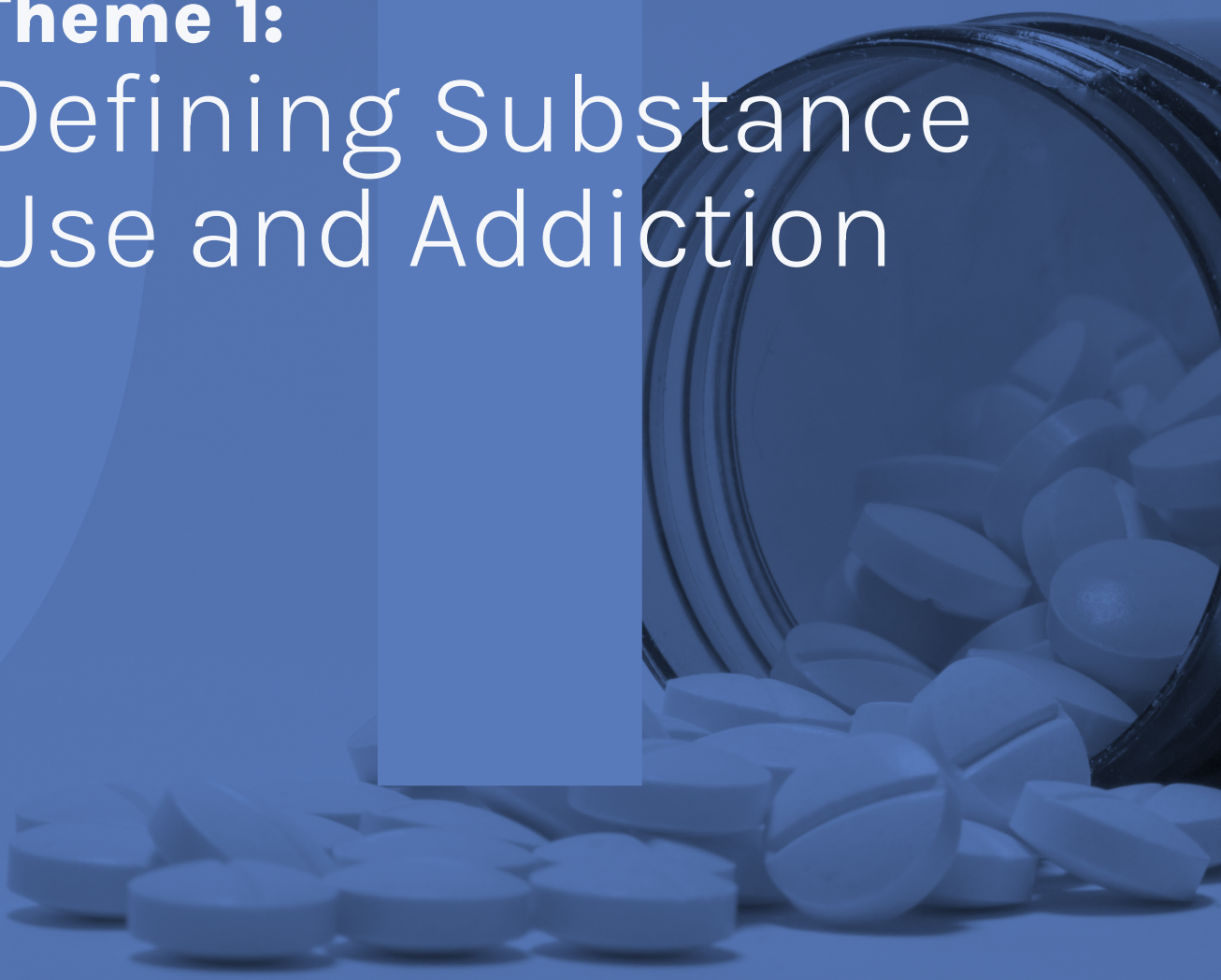
Results

The research team identified five major themes through their analysis of the in-depth interviews: the definition of substance use and addiction, the motivations for substance use, family serving as both a help and hindrance in recovery, the resources participants engaged and desired for recovery, and the role of their Muslim communities in their journeys. Of the 14 participants, five individuals reported having family members struggling with substance use and addiction, while nine participants were first-person accounts. Additionally, seven of the participants were women, and the average age of the sample was 36 years old. See Table 1 for a full description of the demographic characteristics of the in-depth interview sample.

01

Theme 1:

Defining Substance Use and Addiction



While many participants shared their opinions on the difference between substance use and addictions, not many explicitly defined what substance use meant for them. A few participants reflected on the characteristics of what would constitute substance use, including the use of substances recreationally to have some desired effect on mindset, mood, or emotions. Some participants reflected on the progression of substance use becoming an addiction when one becomes reliant or dependent on the substance and can no longer control it. Far more varied responses were received on the operationalization of addictions; however, there were some recurring themes around addiction being an illness that affects people on a daily basis and something they can no longer control or stop despite its negative consequences.

Of the 14 participants, five explicitly detailed what substance use meant for them. Two of the participants described substance use as something that is done for fun, as an Afghan American participant expressed, "I think it can start off with using substances recreationally" (Woman, age 40, personal recovery).

Three of the participants shared that substances are used to change the way one thinks, feels, and functions or simply to change one's mindset. A Palestinian/Jordanian American participant illustrated this point: "My personal definition would be relying on a substance to make you feel different" (Man, age 35, personal recovery).

Another participant, a mother of a 47-year-old son with a history of substance use, shared her definition as "using any [substances], stimulants, psychotropics, anything that changes the way you think, the way you function" (Woman, family member recovery).

Three of the 14 participants also identified that substance use can progress into addiction, as another mother of a 29-year-old son with a history of substance use in the sample, stated, "[Addiction is] when you're using substances, and they start to take control over everything" (Woman, family member recovery).

Every participant weighed in with their thoughts on how addiction can be operationalized from their perspective. Some participants provided more nuanced definitions, while other participants shared a simpler response on how addiction differs from substance use. Interestingly, one participant, an Afghan American, had two definitions of addiction—one from before she began her personal recovery and one from after. She initially thought that addiction was a moral failing that had no solution and that she was alone in this issue. Through her healing journey, she identified addiction as a progressive illness that requires ongoing spiritual and clinical treatment. She shared:

> For my first definition, I would say before learning more about what addiction is, I thought it was a moral issue, and I thought I was one of [the only people] in the world who had this issue that had no solution and that something was wrong with me and I was cursed by Allah. But now, of course, in recovery, I've learned it's far from that, and it's a progressive and terminal illness when not treated, and it requires lifelong treatment, in many ways spiritually and also clinically. . . . You can start off using substances recreationally, but if you are an addict, it will progress and move to daily searches, frequency will increase, and behaviors will become riskier.
>
> Woman, age 40, personal recovery

In this vein, many participants concurred on their understanding of addiction as both a disease and something that consumes the person's life. For example, three participants reflected on the nature of addictions being similar to that of an illness, with a Middle Eastern/North African (MENA) American participant saying, "I believe that it is a disease, [and] like a disease, it does have a solution" (Man, age 35, personal recovery).

Five of the 14 participants stated for substance use to become an addiction, the substance used is required to function, and as such, there is a daily consumption of the substance when one is addicted. One participant, a Mexican American, succinctly captured this, stating that addiction means "you need to use [the substance] to get through the day" (Woman, age 29, personal recovery).

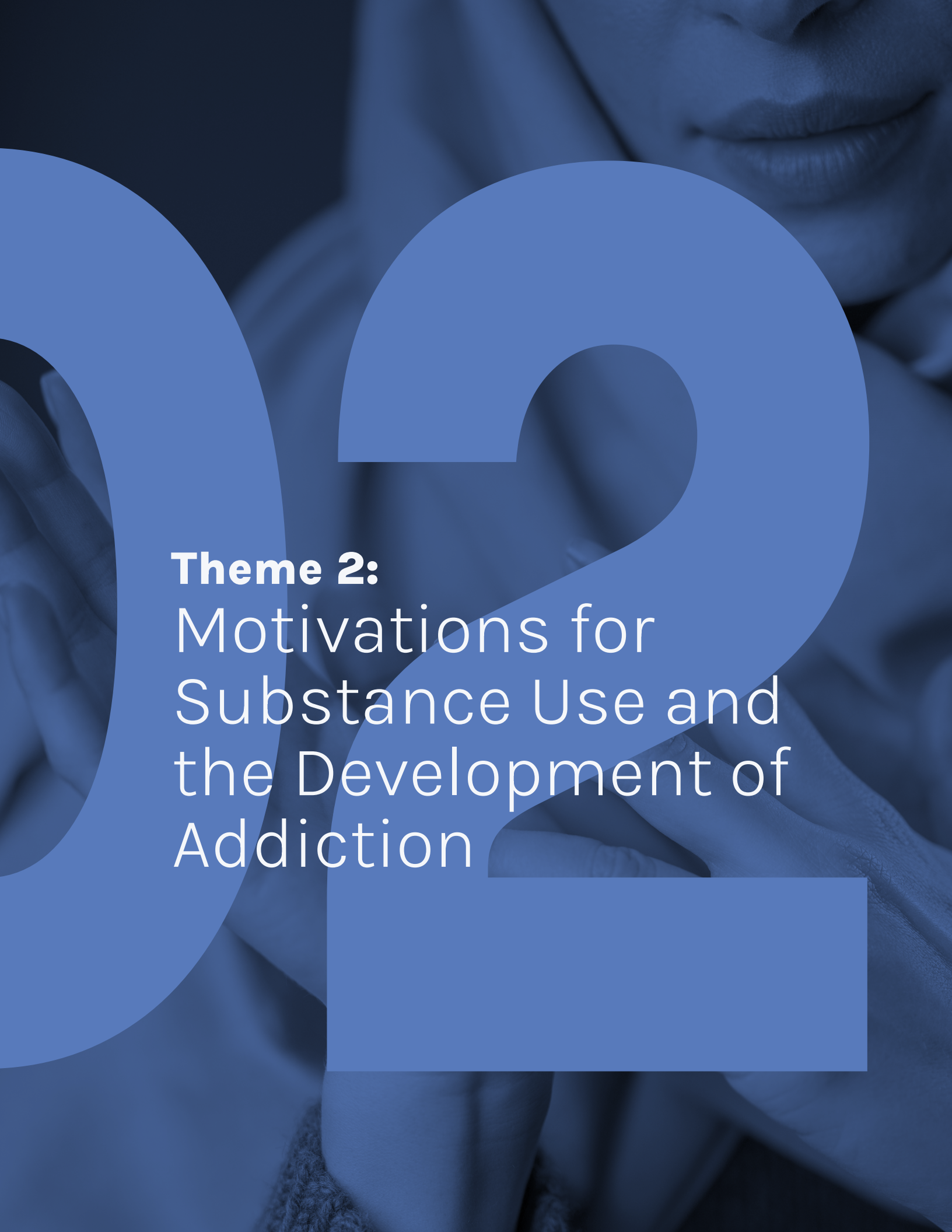
In that vein, seven participants identified the idea that addiction is reached when there is a loss of control or inability to stop using substances. One participant, a

MENA American, explained, “It becomes compulsive. You lose the power of control and the freedom of will around that behavior or substance” (Man, age 35, personal recovery).

Expanding on the discussion of what mental processing for people with addictions looks like, three participants noted that people may continue using substances despite an awareness of or experience with the negative consequences. Another participant, a mother of an 18-year-old child with a history of substance use, described, “They persist in using, despite really harmful consequences [like] losing friends, not being able to keep jobs, risking death, overdosing multiple times” (Woman, family member recovery).

A fellow participant, a Somali American, expanded on this point by using the metaphor of a blanket to describe addiction: “Everything that [addiction] covers [is] things that you’ve really been dealing with in your life, which can be mental health issues, traumatic experiences that you’ve dealt with in your life, and addiction is just that sort of blanket that really covers everything, covers all of that” (Man, age 24, personal recovery).

While there were no blatant disagreements or divergences in the definition of substance use and addiction, participants offered a range of perspectives on how addiction should be understood, with some providing more complex interpretations and others offering simpler distinctions between addiction and substance use. Several individuals emphasized the idea that addiction is a progressive illness that requires both spiritual and clinical treatment, highlighting the shift in understanding from viewing addiction as a moral failing to recognizing it as a chronic condition. Many participants agreed that addiction is a consuming disease, often marked by a loss of control and continued use despite negative consequences, with some describing it as a mental and emotional issue that covers up deeper struggles.



Theme 2:
Motivations for Substance Use and the Development of Addiction

Trauma and Family History

Trauma and family history emerged as two primary risk factors influencing participants to engage in substance use. Out of 14 participants, five explicitly mentioned trauma as a contributing factor to substance use. Their traumatic experiences included the loss of a father, the end of significant relationships, living with undiagnosed severe mental health disorders, physically and emotionally abusive parents, caregiving for an ill parent, and the suicide of a friend. One Yemeni American participant reflected on how the tragic suicide of a childhood friend deeply affected him and marked the beginning of his substance use:

> I was probably 14 at the time when we experienced in our community one of our friends we were growing up with, who was also born in the United States, the first time he jumped out [of] the window on the second floor thinking he was Superman or whatever, and then later on, he committed suicide. He shot himself, and that was like a shock to the community. We all took it bad[ly]. I would like to say that's when I started experimenting, drinking, smoking marijuana.
>
> Man, age 59, personal recovery

Another participant, an Afghan American, further elaborated on this idea of trauma as a trigger for the origins of substance use and addiction: "I was filling a void—using something to fill an emotional and spiritual void. That stems from a lot of trauma" (Woman, age 40, personal recovery).

In contrast, seven participants did not explicitly associate trauma with their substance use. Three of these participants, however, grew up in environments where drug use was normalized within their friend groups or experienced peer pressure from within close social networks. Another participant mentioned challenges like academic pressure from family, while three others identified post-9/11 social pressure to fit in or simply curiosity as the impetus for starting to use substances. While none of these participants directly identified these experiences as traumatic, given the definition of trauma outlined by Gradus and Galea (2023),[39] [5e] the experiences may be understood as trauma and linked to these participants' history of substance use.

A family history of substance use was identified as a significant factor influencing participants to engage in substance use. Out of 14 participants, six reported a family history of substance use. This included having parents or siblings who used substances or struggled with addiction, which created an environment where substance use was normalized. To illustrate this point, one participant, a Mexican American, shared: "My mom is currently still addicted. She smokes marijuana. She smokes it multiple times a day. I'm talking about after every five prayers that we do, she's outside, when she wakes up or she goes to bed. Then, my father was addicted too. He's been in recovery for years now. He was addicted to crack cocaine" (Woman, age 29, personal recovery).

Another participant, an Afghan American, added that the presence of addiction in her family allowed her to justify her own use: "My brother is an addict. My sister is an addict. My mom ended up having knee problems and getting prescribed pain medication, so our household was chaotic, and to me, they were the addicts. So I was justifying a lot and pointing fingers" (Woman, age 40, personal recovery).

Trauma and family history emerged as two primary risk factors influencing participants' engagement in substance use. Some participants explicitly linked their substance use to traumatic experiences such as loss, abuse, and mental health struggles; however, not all participants experienced trauma leading to substance use. Others cited social pressures, curiosity, or normalized drug use within their environments (which may still be understood as trauma). Additionally, a family history of substance use played a crucial role, as participants who grew up in households where substance use was prevalent often viewed it as normal or justified their own use in relation to their family members' addictions.

Early Exposure within Social Networks

Early exposure to substance use and social networks who engaged in substance use were also identified as primary risk factors for substance use. While

[5e] In this paper, trauma is defined as a deeply distressing experience that can have lasting emotional, psychological, and physical effects (Gradus & Galea, 2023). It is important to recognize that trauma is subjective; what may be defined as trauma for one person may not have the same impact on another (Gradus & Galea, 2023). Each reaction depends on an individual's unique perceptions, innate resilience, and past experiences. Secondly, the type of event does not need to be life-threatening to be traumatic (Gradus & Galea, 2023). For some people, growing up around drug use itself can be a traumatic experience, even if it does not involve causing direct harm, due to the instability and stress it can create in a household. J. L. Gradus and S. Galea, "Moving from Traumatic Events to Traumatic Experiences in the Study of Traumatic Psychopathology," American Journal of Epidemiology 192, no. 10 (2023): 1609–12, https://doi.org/10.1093/aje/kwad126.

some individuals did not report any family history of substance use, all of the participants except one mentioned that they had exposure to substance use during their early teenage years. This exposure often involved witnessing substance use among family, friends, or within their community. One participant, a MENA American, described how simply being around substance use influenced his later behavior:

> I believe that I have a family member who is also an addict who's undiagnosed. So, I knew about it before I ever tried the substance. I had seen it, and I had felt the effects of it being in close proximity, and I think part of that is you want to find meaning for what you're going through so I would read a lot about it. I was fascinated with movies about it. And so [understanding of substance use and addiction and use of substances] really did develop simultaneously, I think.
>
> Man, age 35, personal recovery

Of the 14 participants, 12 reported that friends or social circles played a key role in introducing substance use. Factors mentioned included peer influence, accessibility, and a desire to fit in. One participant, a Palestinian/Jordanian American, succinctly captured the trend: "I had a friend who was a little more adventurous and wild than me. One night when I was sleeping over at his house, he said, 'Hey, I got a little bit. You wanna try it?'" (Man, age 35, personal recovery).

As demonstrated by the previous quotes, nearly all participants reported encountering substance use during their early teenage years, whether through family, friends, or their broader communities, which contributed to their eventual experimentation. Peer influence, accessibility, and a desire to fit in were key drivers, highlighting the powerful role that social environments play in shaping substance use behaviors.

External Stressors

One prominent driver of substance use was the presence of external stressors.[6f] Over half of the participants (n=8) identified clear major life stressors as significant influences on their decision to begin using substances. One multiracial participant mentioned how the absence of social support at home and moving to a town where she was the only Muslim led her to substance use:

> I'm doubting my religion. I have no one to go to and talk to. My friends are like, "Do you want to feel good? Do you want to do what everyone's doing? Do you want to be part of our squad? Yes or no?" Of course, I do. Where else can I go? Nobody at home. Everyone at home is fighting. My sisters are on their own path. . . . [Using] feels like I can say whatever. I can do whatever. I literally feel invincible. There was no force in the entire world that could stop me. I became unstoppable. My personality came out, and I'm dancing on the table. Everyone's like, "You are so fun. You are so cool."
>
> Woman, age 23, personal recovery

Two other participants noted familial abuse as the external influential factor in their substance use, with one MENA American participant stating:

> I had a very difficult childhood in a very dysfunctional family [with] divorced parents; my father was very, very ill for a lot of my life, and it progressively got worse until he was bedridden. There was a lot of neglect. So there was a lot of emotional pain. It was this very deep pain that was from a lot of neglect and dysfunction in my upbringing that directed me in life to try and find some type of satisfaction, [which is how] I found drugs.
>
> Man, age 35, personal recovery

Another participant, speaking about her 18-year-old daughter's history of substance use, shared how the process of her own divorce from an abusive husband led to her daughter's use:

> I was in this long process of splitting up with her father. He could be emotionally abusive toward her, and so I think, as she started to use more and more substances, she became more vulnerable to just things happening to her because she would be out in the world, vulnerable and impaired.
>
> Woman, family member recovery

[6f] External stressors refer to life challenges that originate outside the individual, such as academic struggles, relationship conflicts, family problems, social stigma (e.g., being the only Muslim in a peer group), and global crises like the COVID-19 pandemic. These stressors can overwhelm an individual's coping mechanisms, leading them to seek relief or escape through substance use.

Overall, participants described factors such as lack of social support, familial dysfunction, and experiences of abuse as key contributors, with substance use providing an escape from emotional pain and social isolation. For some, difficult family dynamics, including parental divorce and neglect, heightened their vulnerability to substance use as a coping mechanism.

Search for Escape

Beyond external stressors, another key influence of substance use that emerged from the data was "the search for an escape." All of the participants mentioned that substance use started as a means of internal avoidance, allowing individuals to numb or disconnect from overwhelming feelings of emotional pain, boredom, emptiness, or a general lack of meaning in their lives. For some, substance use offered momentary relief from these feelings; for others, it became a routine way to avoid confronting their emotions. Their need to escape wasn't always conscious; many participants only later realized that their substance use was an attempt to fill emotional voids or manage psychological discomfort. Many summarized general substance use as a kind of coping mechanism: "People use it to cope [with] their problems, to escape. . . . It's like I can't deal with society . . . and there were times [when] I was working at my restaurant and there's liquor, and I am thinking about a drink, and I was telling myself I was not going to do it" (Man, age 59, personal recovery).

A mother described that her son's reasons for using substances came from a need to cope with and escape from the abuse he was experiencing and traumatized by: "He seemed to particularly pick on my son. He was physically abusive. He was emotionally and mentally abusive. . . . My ex-husband would beat him. Those kinds of things are very traumatic and had a bigger impact than the diagnosis of the ADHD. I'm sure he's suffered from some depression from it, a lot of anger. . . . He's stuck in those memories [and] it's difficult for him to move forward" (Woman, family member recovery).

In most of these anecdotes, there is a common thread of feeling stuck or not being able to endure this immense pain that is caused by their circumstances. In such situations, these individuals express turning to substances as a form of relief or escape.

The search for escape was a central influence on substance use, with all participants describing it as a way to avoid emotional pain, boredom, or a lack of meaning in their lives. Some used substances for temporary relief, while others unknowingly relied on them to self-medicate or fill voids driven by deeper emotional needs or comfort in their own skin.

Collectively, the search for escape, external stressors, early exposure to substance use in social networks, a family history of addiction, and experiences of trauma have been identified by participants as the significant motivating factors contributing to their development of substance use challenges and addiction. Many linked their substance use to traumatic experiences such as loss, abuse, and family dysfunction, while others cited social pressures, peer influence, and curiosity. A family history of substance use also played a role in normalizing substance use and justifying personal experimentation. Ultimately, substance use was often described as a means of coping with emotional pain, social isolation, or a deeper need for validation and belonging: "The weight of the world is on you. . . But yet all you could focus on is that you know that drug or that obsession" (Woman, age 29, personal recovery).

Theme 3:
Family as Both a Help and a Hindrance

Most of the participants believed that their families had good intentions for them and wanted to see them recover. However, the lack of resources, awareness, and knowledge on the part of the family limited their support and, in some instances, even made their attempts at support a detriment.

Family as a Help

Thirteen of the 14 participants aligned with the idea that their families were supportive during their struggles and in the recovery process. They expressed that although their families did not understand the experiences they had, their constant support and efforts helped them gain hope through their recovery. One participant, a Palestinian/Jordanian American, captured this sentiment: "But then, at the same time, they never really gave up on me. They always had faith and kept trying, which was huge because their hope and faith eventually helped give me hope and faith that I could get through it. She [my mom] would do a ton of research and recommend things; at one point, she thought I needed religion and hooked me up with different mosques and Muslim AA groups" (Man, age 35, personal recovery).

Another participant, a MENA American, reflected on his experience with his family and highlighted the nuanced experiences that family members of someone struggling with addiction go through, noting that despite misconceptions and biases, his family did the best they could to support him through this period in his life:

> Relative to other people, I got very lucky in the family department. They definitely had to go through their own learning, and they still have their own beliefs about addiction. But they were supportive when it mattered. In the beginning, there's a lot of anger. There was a lot of trying to control my use in different ways, and now I have the maturity to look back and say they were doing the best that they could. They were doing what they knew to do. [It is] very scary for family members and a very painful experience to have a family member who is an addict. But, you know, they helped me get treatment.
>
> Man, age 35, personal recovery

Even though families may not have fully understood their experiences, most participants described their families as a vital source of support during their struggles with addiction and recovery. Not only did family members provide emotional support, hope, and encouragement, but some also provided practical support, such as resources or connecting their loved ones to recovery communities. Despite challenges and misunderstandings, families played an important role in helping participants access treatment and support throughout their recovery journey.

Family as a Hindrance

For the five participants who explicitly identified their family as a hindrance to the recovery process, common challenges included an unwillingness on the part of the family to learn about addiction and substance use, feelings of judgment from family members, and family serving as enablers to continued use. One participant, a multiracial American, believed her family hindered her recovery and was a source of stress and judgment. She expressed that her family did not understand her experiences as a substance user, causing her hesitation in seeking resources and further creating stress for her. This hesitation also stemmed from feeling ostracized by her family. She shared: "She [my mother] is so judgmental. 'Why are you doing this? Why are you uncovering? Why are you guys like this?' I did not seek out help from them. I did not seek out help from them until my daughter was four or five months [old], and then I moved back to [my home state]" (Woman, age 23, personal recovery).

Although family was seen as a source of help for the majority of the participants, half of those participants who did see their family as sources of support also noted that other family members' substance use was a challenging aspect that required navigation. Specifically, for one participant, a Pakistani American, family members participated in social drinking, which created a welcoming atmosphere for drinking, leading him to relapse: "The funny thing was my brother at one point and my sister-in-law, they drank socially, and at a time when I had stopped drinking, we went out one time for his birthday, and they were kind of like not stopping me from drinking. So I started again after not drinking for three months at his birthday party. So that wasn't helpful, but that's my brother" (Man, age 39, personal recovery).

A sibling of someone with substance use challenges, a Palestinian American, shared how her brother's

ongoing addiction and the family's reliance solely on prayer, without seeking mental health support, shaped her brother's perspective on substance use and mental health: "He's probably been an addict for years. [They] have convinced themselves that prayer alone can solve this. Never looked into therapy, never looked into psychiatry [or] rehab, nothing like that, and I wish that Muslims were more open to mental health assistance" (Woman, family member recovery).

In addition to these explicit examples of recovery being hindered by family, there were three participants who noted that they intentionally hid their addiction challenges from their families. One participant, a Mexican American, shared: "I don't think [my family] have any idea about my addiction or substance use. I think they knew I was like using like on and off, but I don't think they know the severity of it. To this day, they don't. I've never been open to them about it. I've never been honest with them about it" (Woman, age 29, personal recovery).

A MENA American participant shared similar experiences, noting that he hid his substance use from his family intentionally: "My family was very religious. It was very haram [religiously impermissible]. There was really no space for that, even drinking in the house would make the house impure, and that would be the worst thing ever. So I hid it very, very, very intensely from them" (Man, age 35, personal recovery).

This participant went on to share that his family did eventually learn of his addiction and were ultimately supportive and assisted in his recovery journey.

While most participants identified their families as sources of support, those same participants offered some examples in which family was seen as a hindrance to their recovery. This challenging experience with family was often due to a lack of understanding of addiction, judgment, and/or enabling behaviors. Additionally, some participants concealed their addiction from their families, either out of fear of judgment or because of cultural or religious stigmas surrounding substance use.

Healthy Boundaries

Four of the participants highlighted the importance of healthy boundaries that, were they enforced by their families while they were using substances, would have held them accountable for their actions and provided them a reason to pursue recovery. One participant, an Afghan American, noted:

> The enabling was definitely more harmful than beneficial, and giving so many chances to keep coming back, that harmed me [more] than benefited me, and also them not saying, "Okay, this is what you need to do. These are the proper resources. This is how we can help you. This is what we are going to do to help you." They left me to my own devices to kind of create the plan, which I manipulated and did without properly committing to it.
>
> Woman, age 40, personal recovery

Another participant, a Palestinian/Jordanian American, mentioned: "I think what wasn't helpful was that they continued to enable me, as I always knew I could fall back on them if things got really bad, unlike other families where people might get kicked out or cut off completely, which never happened to me and allowed me to keep going longer" (Man, age 35, personal recovery).

Participants emphasized the importance of healthy boundaries set by their families during their struggles with substance use, which helped hold them accountable and motivated them to pursue recovery. Some shared how enabling behaviors by family, like repeatedly giving chances without setting clear boundaries or providing proper resources, ultimately hindered their recovery process. These participants recognized that healthier boundaries could have encouraged them to take more responsibility for their actions and seek the necessary help.

Theme 4:
Resources Engaged and Desired

Participants provided a wide array of responses on the resources that were available and accessible to them, in contrast with the resources they were seeking. On one end of the spectrum, only one participant, a Somali American, explicitly stated, "I had all the resources I needed" (Man, age 24, personal recovery). On the other hand, four participants shared that there was nothing readily available, captured by the following statement of one of the participants regarding her 68-year-old father: "I don't think there were any resources for my dad, except probably the medical doctor telling him to stop drinking" (Woman, family member recovery). Amid these extremes, many participants shared details about existing resources and the need for increased faith-based intervention, education, destigmatization, and spiritually sensitive support.

Service-Based Resources

Service-based resources played a critical role in supporting participants on their paths to recovery from substance use. Nine participants accessed resources, including rehabilitation treatment centers (both outpatient and inpatient), medication-assisted treatment, therapy, and structured support programs like 12-step groups. The effectiveness of these services varied among participants, with some finding particular approaches more beneficial than others. Collectively, these services provided essential tools for addressing both the physical and psychological aspects of substance use and recovery. The analysis of participant responses revealed that the most effective treatments were the service-based resources and personal support systems. These resources were consistently reported as effective due to their comprehensive and personalized approaches.

Seven participants reported engaging with rehab treatment centers as part of their recovery process. Rehab centers offered structured environments for drug detoxification, counseling, and relapse prevention. For some, inpatient treatment provided the necessary separation from triggering environments. As one participant, a Palestinian/Jordanian American related:

> My cousin works in recovery as well, and he recommended this place outside of [city in Texas]. It's [an] all-male rehab center, pretty hardcore. You're doing chores, you're doing groups all day, you're doing 12-step stuff. You're working through the 12 steps. I went there for 60 days, and then after that, I went to a sober living. I was in a sober living for a year and a half. You know the [rehab], the main one that I did, is why I'm still sober.
>
> Man, age 35, personal recovery

Medication was another tool that two of the participants used to support their recovery. One participant, a Pakistani American, cites how medications served as both an aid to his ongoing mental health conditions as well as withdrawal symptoms: "I think the meds definitely helped. ADHD meds and depression meds. Like it helped me get off. The hardest part of giving up alcohol was just like the feeling of just the chemical stuff that's going on in your brain" (Man, age 39, personal recovery).

Therapy was widely utilized, with the nine participants who shared first-person accounts citing therapy as a primary resource during their recovery. One participant, a MENA American, highlighted the value of being introduced to diverse therapeutic options: "I met really great therapists, really great people, and they really try to, at least the ones that I went to, try to expose you to a bunch of different things, whether that is AA or different types of therapy, you know, gardening therapy, coloring therapy, talk therapy, one-on-one therapy, group therapy, and all of those different things" (Man, age 35, personal recovery).

Six of the 14 participants engaged in 12-step programs such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA). The participant cited above emphasized the transformative impact of Alcoholics Anonymous on his recovery journey:

> AA is the one thing that is most responsible for my sobriety because it actually gave me an alternative. It gave me a different way of living that was far more effective than all the therapy, which was focused on analyzing "Why are you the way that you are?" I now understand why I am the way that I am, probably better than a lot of people, but that still doesn't really inform how I can be different. AA kind of was the foundation that taught me I need to take care of myself.
>
> Man, age 35, personal recovery

Service-based resources—such as rehabilitation centers, therapy, medication-assisted treatment, and support groups—were vital to participants' recovery, with each offering personalized approaches to address both physical and psychological aspects of substance use. While the effectiveness of these services varied, many participants found that a combination of rehab treatment, therapy, and support programs like 12-step groups played a critical role in sustaining their sobriety.

Faith and Spirituality

Faith and spirituality played a complex and dual role in the participants' experiences with substance use, acting both as a powerful source of support for some and as a source of shame and guilt for others. Eight participants identified faith and spirituality as a key factor in their recovery. One participant, a Mexican American, expressed how deeply religion helped her recover: "I know it's funny because everyone says [it], but, honestly, religion really saved me and helped me out" (Woman, age 29, personal recovery).

Another participant, an Afghan American, reflected on how revisiting Islamic teachings was essential in her healing process: "Unlearning everything I knew about Islam and relearning it from its truth and not from a cultural way, making a huge commitment and shift in my faith has helped me. But also getting the help that I needed and deserved, actually being willing to receive the help too" (Woman, age 40, personal recovery).

For others, integrating recovery tools with their religious identity was challenging but ultimately empowering. One participant, a Pakistani American, described navigating this balance: "As Muslims, sometimes we put ourselves in a box. It was something that I had to grapple with. But at the end of the day, I realized that there's nothing that they're [12-step programs are] saying here and nothing that they're doing that's incompatible with Islam" (Man, age 39, personal recovery).

For five participants, however, faith was, at times, a source of deep shame and guilt. Some internalized the belief that their struggles and substance use were a sign of divine punishment. This perception often intensified feelings of isolation and unworthiness. A Mexican American participant stated: "I really didn't see Allah in a very good light. . . . He's already written me among the damned. What am I going to do? And I don't know if this is just culture or something we say, but as Muslims, we're like, 'just go pray, and everything will be [al]right, all you need to do is pray'" (Woman, age 29, personal recovery).

Another participant, an Afghan American, similarly felt cursed and beyond help: "I thought I was [the only] one in the whole world that had an issue that had no solution and that something was wrong with me and I was cursed by Allah" (Woman, age 40, personal recovery).

Faith and spirituality served a complex role in participants' recovery experiences, serving as both a powerful source of support for some and a source of guilt and shame for others. While many found strength in their religious practices and teachings, some struggled with the belief that their substance use was a sign of divine punishment, which intensified feelings of isolation.

Lack of Appropriate Recovery Options

One of the most significant and widespread barriers to effective treatment was the lack of awareness about available recovery programs. All nine of the participants who directly struggled with substance use reported that they either didn't know certain services existed or discovered them too late. This gap in information meant that many struggled alone or believed that quitting substances required extreme measures such as going "cold turkey." One participant, a Lebanese American, emphasized: "I never knew that there was any help out there. I didn't know. I just thought that if you had quit, you would just quit cold turkey. I didn't know that there was drug treatment where you go through [a] medically assisted detox" (Man, age 39, personal recovery).

This lack of outreach made it difficult for participants to access potentially life-saving resources. Many were unaware of professional support options and relied on unsafe methods to manage their substance use.

Short-term rehabilitation programs were reported as ineffective by several participants. Although participants felt that rehabilitation programs helped with initial detoxification, the short-term nature of these programs often failed to provide long-term strategies for maintaining sobriety or addressing their deep-rooted psychological dependencies. One Afghan American participant explained: "30 days, I don't think is enough for anyone to really address what they need to. It gives you enough [time] to detox and become somewhat stable, but that was just my brain chemistry, so [I] needed a lot more than that 30 days" (Woman, age 40, personal recovery).

A participant shared that there were few resources available for her 68-year-old father: "I think he should have had rehab centers or therapy. Therapy would have helped. Rehab would have helped him be in peace. I think until and unless they decide on their own that they are going to make the choice, the decision should come from the addict" (Woman, family member recovery).

Finally, these resources were often ineffective because they failed to offer real-world coping strategies, essential life skills, or practical techniques for preventing relapse. While therapy was useful, nearly a third of participants felt unprepared for real-world challenges. One participant, an Afghan American, explained the gap in support: "I was like, okay, well, you know I'm grateful. I'm happy to have been here [in rehab] and then getting outpatient [care], but looking back, I really had hoped that there would have been a little bit more education on what I was dealing with and more tools that were given" (Woman, age 40, personal recovery).

Another participant, a Palestinian/Jordanian American, agreed with this sentiment, stating that the ineffective treatments were the ones that didn't guide him on how to go through life once treatment was over: "A lot of them were just like therapy once you're in this bubble of treatment. It was cool, I was dealing with trauma, but what happens when I get out into the real world?" (Man, age 35, personal recovery).

A major barrier to effective treatment was the lack of awareness about available recovery programs, leaving many participants to struggle alone or rely on unsafe methods like quitting cold turkey. Short-term rehabilitation programs were also seen as inadequate, as they provided initial detox but failed to offer long-term strategies for maintaining sobriety. Additionally, many participants felt unprepared for real-world challenges after treatment, highlighting the need for more practical life skills, coping strategies, and relapse prevention support.

Faith-Based Service Providers and Resources

Muslim care providers and support systems played a significant role in participants' recovery experiences. For some, access to faith-based mental health care was crucial in addressing both their psychological struggles and their spiritual needs. Participants without access to Muslim or faith-based care often felt misunderstood or unsupported, leading to frustration and a sense of isolation in their recovery journey. Three participants expressed positive experiences with Muslim therapists. This dual approach helped participants navigate both their mental health struggles and their religious beliefs without feeling conflicted. One participant, a Mexican American, praised her therapist for thoughtfully blending these two perspectives: "I love my therapist because she tries to look at this from an Islamic and a non-Islamic [perspective], and at some point, traditional psychology and Islam psychology" (Woman, age 29, personal recovery).

Another participant, a Palestinian American, shared similar sentiments, stating that mental health professionals within her community were a source of comfort for her in understanding her brother's condition and helping him, as they understood the culture and religious consequences. Her mother, however, did not trust the providers due to stigma and lack of general support. Their mother believed maintaining the family secret was a protective factor for her son, shielding him from communal backlash:

> My mom would get very upset—she doesn't want us to tell any of our aunts or other cousins. But then we met [name redacted], and she was a psych resident, and she's also Palestinian, and she understands our culture and our mom. She's Muslim as well. So she was someone that we've been able to talk to and helps us understand things. I don't think that [my brother] had anyone to talk to. I don't know if he did. I don't know if he talks to his friends or anything or just kind of shoved it under the rug. It's my assumption [that] he probably just pretends it's not there.
>
> Woman, family member recovery

A specific barrier to service access was the feeling of being misunderstood by non-Muslim mental health professionals. There was a notable lack of cultural competency, especially around Islamic values and identity, leaving some participants feeling unsupported in therapy and rehabilitation settings. One Afghan American participant reflected: "When I went to rehab, I remember being the only hijabi, not feeling like I belonged there at all, and there wasn't proper clinical support. . . . I just culturally didn't feel safe in those environments" (Woman, age 40, personal recovery).

Another participant, a multiracial American, further described how non-Muslim therapists failed to understand her internal religious struggles:

> I was sitting there, having spiritual warfare. I want to be a good Muslim woman, but I do not want to give up the Dunya lifestyle. [The therapist is] looking at me, and they are like, "Do what makes you happy, darling." They are like, "Well, maybe you do not have to pray five times a day. Maybe because your Lord is so forgiving and graceful, you do not have to do those things." So I [was] done. There was nobody. I had nobody.
>
> Woman, age 23, personal recovery

Despite this lack of cultural and spiritual sensitivity, participants shared that there were far more readily available resources in the church context with access to pastors and faith leaders. One participant, a Palestinian/Jordanian American, noted the existence and effectiveness of recovery programs in churches, particularly in spreading awareness. He suggested that mosques should offer recovery programs or resources: "I would say through the mosque, the imams [can] spread awareness that there are resources" (Male, age 35, personal recovery).

Continuing in this vein, seven participants mentioned the importance of increased faith-based opportunities for recovering members of the community, allowing them access to mosques and, more specifically, support groups within the mosques. One participant, an Afghan American, mentioned: "I wish we had a faith-based intervention [or a] team. This is a big wish, but some sort of intervention from the faith community that helped me understand what was going on, what was going to happen, [and that] there was hope" (Woman, age 40, personal recovery).

Furthermore, both this participant and a mother in the study also mentioned how important it is to create a safe environment for people struggling with addictions and for their families in faith spaces. They noted that it would be important to have mosque leadership, including both faith leaders and organization leadership (i.e., mosque board of directors), be trained in substance use and addiction, with a particular focus on the Muslim community. The mother of an 18-year-old daughter struggling with substance abuse suggested: "I think that [mosques] should host recovery groups on their campuses" (Woman, family member recovery).

Specifically, two participants emphasized the need for faith-based education interventions to assist the community and those struggling to understand substance use and addictions. They stated that they sought out these resources and would have found them to be helpful had they been more widely accessible within their communities, but that such programs still carry a stigma. One mother of a 29-year-old struggling with substance abuse shared: "I knew the religious component. So many people would be like, 'Oh, I talked to the pastor at church,' and I could never do that. I can never go talk to the guy at the masjid or anybody. So that was never an option for us. So I think that that's an important thread of conversation I wanted to have" (Woman, family member recovery).

Additionally, another participant speaking on her 68-year-old father's experience, stated that he doesn't feel comfortable using resources provided by mosques because the culture is very different, and they don't believe the mosques comprehend the complexity of addictions. She noted: "It's actually substantive that

they actually understand the extent of issues. There should be a connection between what is out there with respect to [substance use] and the Masjid."

She expressed skepticism regarding any support from the mosque due to their experience with stigma. She details how although her father was the one struggling with addiction, she also felt that she was living a dual life in her role as a Muslim community member and someone involved in substance use. Although she was participating in the study from the perspective of a family member of someone with a history of addiction, she detailed this dichotomy not through the experiences of her father but through her own substance use: "In my early twenties, I started drinking. The choices that I made were not aligning with my faith. But I did read namas [prayer] the next day because that's what I'm supposed to be doing. That [was the] conflict or have[ing] two different opposite opinions in your head."

When asked if she would be willing to see a Muslim addiction specialist, however, she stated: "I would see them as any other doctor. So it's just the filtering through the masjid community [that] was hard" (Woman, family member recovery). She indicated that it is not the faith of the addiction specialist that she would find challenging, but rather the stigma of seeking care through the community.

Muslim care providers played a crucial role in participants' recovery by addressing both psychological and spiritual needs. Those without access to faith-based care often felt misunderstood, highlighting a gap in culturally competent mental health services. Many participants expressed a strong desire for increased faith-based interventions, mosque-led recovery programs, and substance use education within Muslim communities to reduce stigma and improve support.

Theme 5:
The Role of the Muslim Community

Muslim Community as a Hindrance

Participants were asked if their Muslim community generally was more of a help or a hindrance in the process of recovery. All 14 participants agreed that it was a source of stress and hindrance to their recovery, as many of them feared the stigma they could face if they sought help. Several participants stated that they wished for faith-based intervention within the community and education regarding the condition and available resources. Some highlighted resources similar to mentorship opportunities that they believed would assist families in navigating the illness of addiction, including this Afghan American participant:

> I wish we had like an intervention, a faith-based intervention team of like this circle of sisters, that, you know, who were in recovery that could come and just tell me, "It's going to be okay, you're going to be okay." [They] let you know, "Let's get you to a safe place first and then we can work from there." So that would be like a big wish, but like some sort of intervention from the faith community that helped me understand, okay, what was going on was going to be [okay], that there was hope, because it was really confusing for me to try to figure out how to help myself from something that I didn't even know really what was going on.
>
> Woman, age 40, personal recovery

All 14 participants highlighted the significance of stigma, discrimination, and a lack of understanding of substance use and addiction within their communities. Participants highlighted that their fear of social consequences and ostracization due to their substance use made them reconsider seeking help from their Muslim community. One participant, a Pakistani American, captured this sentiment: "I don't know if it's 'let down,' but I . . . do feel like judged in a way. I think there's a lot of shame and stigma that does make it hard to get help. You don't want to talk about this with anyone, like if anyone finds out, . . . you could be [an] outcast" (Man, age 39, personal recovery).

Additionally, another participant, a Palestinian/Jordanian American, shared his fear that the community's reaction would have restrained him from seeking help, even if the community had resources to assist him: "No, I didn't think that there was resources, and if there was any resources, I would never have ever asked anybody in Muslim community because I was too embarrassed" (Man, age 35, personal recovery).

Additionally, the following participant, a mother of a 47-year-old son struggling with substance abuse, stated that after confiding in a trusted community member about her son's struggles, her request for assistance was rejected and met with judgment, with the community member informing her that her son's condition was not a priority of the community. This event was memorable for the participant and a constant reminder that substance users were not welcomed: "Our communities can be very judgmental and unaccepting and critical. Wherever I reached out for help, I didn't get anything. I didn't get any support. In fact, one member of the community I was associated with, when I went to them and asked for some support, some help, I was told, 'The bottom line is, nobody cares about your son.' And I've never forgotten that" (Woman, family member recovery).

This participant's experience underscores the deep-seated stigma and exclusion faced by substance users and their families within Muslim communities. The rejection and judgment she encountered when seeking support highlight the broader systemic failure to recognize addiction as a communal concern, reinforcing feelings of isolation and unworthiness.

For convert community members, there was an additional sense of stigma and judgment beyond the generalized stigma against substance use and addiction. One participant explained that she was reminded by the community that her family was not an ideal Muslim family, as she is a convert and her 18-year-old daughter, who was struggling with addiction, was not:

> I would feel like I'm so far away, like my family situation is so far away from what you are describing as an ideal family and way to raise your children, that I just, my feeling was like, well, that's nice, you know, [but] I cannot relate. I cannot relate to what you are describing. So maybe that's something that was lacking for me—some kind of nod or acknowledgment of the fact that, you know, there are families who are different.
>
> Woman, family member recovery

All study participants agreed that their Muslim community acted as a hindrance to their recovery due to the stigma, shame, and fear of judgment associated with addiction, making them hesitant to seek help. Many expressed a desire for faith-based interventions and resources, such as mentorship and support systems, to help individuals and families navigate addiction. Experiences of rejection and judgment from the community, including the lack of understanding and prioritization of addiction, further contributed to feelings of isolation and hindered recovery, with converts facing additional stigmatization due to their perceived differences from the non-convert majority.

Lack of Muslim Community-Focused, Addictions-Related Education and Resources

Participants noted that due to the lack of education and resources related to substance use and addiction within the community, many families attempted to navigate addictions silently out of fear of facing social consequences. This further isolated both families and individuals struggling with addictions, making them more vulnerable. Consequently, all 14 participants agreed that there was an increased need for psychoeducation, coupled with empathy, in Muslim communities.

The participants also spoke of the necessity for increased educational opportunities and resources to facilitate a cultural shift that could decrease stigma in Muslim communities. Alongside the earlier desire for training among faith leaders, one participant, a multiracial American, shared, "I wish there were books, podcasts, pamphlets, and events where I could network with other people" (Woman, age 23, personal recovery).

Furthermore, two participants spoke about how they experienced confusion and frustration in the face of self-directed research for existing resources and would have benefited more from readily available information, as evidenced by the following from an Afghan American participant:

> Because it was really confusing for me to try to figure out how to help myself from something that I didn't even really know what was going on, identifying that I had a problem, and I was an addict. Now, I can help someone else who's in that type of experience, and [I hoped for] someone that explained that there are medications to help me because [otherwise] it was all medications are bad at this point . . . because it could lead to misuse.
>
> Woman, age 40, personal recovery

The lack of community-focused education and resources on addiction forced many families to navigate substance use issues in isolation, fearing social consequences. This isolation increased vulnerability for both individuals and their loved ones. All study participants emphasized the need for psychoeducation paired with empathy to reduce stigma within Muslim communities. Participants also highlighted the necessity of accessible educational materials—such as books, podcasts, pamphlets, and events—to facilitate a cultural shift.

The Need for a Community of Support

Support from people close to the participants—such as friends, mentors, and peers in recovery—was another critical factor in successful recovery. Seven participants reported that this personal support was instrumental in fostering motivation when quitting substance use. One participant, a Somali American, emphasized how being surrounded by supportive individuals in recovery created a sense of belonging: "It was very welcoming. I felt really at home. I really felt at home because, even though I wasn't with my family, you start to realize that, 'Hey, you know, this is the only way that I can get better—by being with people who want to get better'" (Man, age 24, personal recovery).

Four people spoke about the importance of a cultural shift to address the stigma, shame, and fear of judgment that is faced by Muslims struggling with addiction and trying to seek or maintain a connection with their faith-based community. One of these participants, a MENA American, mentioned the need for a cultural shift that could begin with the provision of resources and access to nonjudgmental individuals in Muslim communities: "You know, what I would

love to see [are resources] from [the community], and it's so hard because I remember my fear of going to a Muslim when I was in active use and telling them my problem was so great because of the judgment around that stuff. It was almost easier for me to go to a non-Muslim" (Man, age 35, personal recovery).

This participant further detailed the benefit of having opportunities for community members not struggling with addictions to learn about addiction, identifying a need for a significant cultural shift in educating non-addicts about what addiction truly is so that Muslims struggling with addiction can feel comfortable in Muslim spaces and not feel judged or viewed negatively.

Another one of the participants, who is currently working on bringing cultural change to their community, added the following insights about the detriments of stigma in certain intersectional communities more than others. They noted that stigma surrounding addiction is particularly pronounced in Muslim communities, especially in comparison with non-Muslim communities. In comparison, according to the following participant, a Pakistani American, addiction is more openly discussed in Indian and non-Muslim groups, where it is less stigmatized. While the participant noted there is a lot of work still to do, he suggested mosques "have [substance use and addiction] resource[s] that [are] not under wraps [hidden or inaccessible], something that's just out there that people know is available to use" (Man, age 39, personal recovery).

One participant, a mother to a 47-year-old son struggling with substance abuse, described how a family can only be as effective in supporting their loved one who is recovering from addiction as the support they themselves are given: "The family cannot be held a hundred percent responsible all the time for everything. Because if the family is not getting support, the family doesn't know how to give the support that's needed."

She goes on to describe how family counseling, marital counseling, and providing support to family members can be pivotal to the recovery journey as both the individual and their family collectively suffer through the challenges of addiction and the recovery process:

> Family counseling, marital counseling, counseling for the one who is addicted, but [also] counseling for the family members, the siblings, whoever is in the household because it's not just a "them problem." It's a "we problem." When anyone within that family structure is not able to support the one who needs the support, everybody suffers. It's just really, really important that the people who are dealing with any family member who is addicted have to have support, too. They have to be held up and supported. They have to be helped to see that there's somebody there for them, too.
>
> Woman, family member recovery

While some participants briefly mentioned how having more of an openness to dialogue in the cultural and faith-based community would have been helpful, some described the details of what that community support may have looked like. For example, three participants wished to create a physical or virtual community space for check-ins, conversations, spiritual mentorship, and services like transportation or errand support. One participant, a Lebanese American, shared how he had advocated for there to be financial support available in the early phases of recovery: "I didn't have access to a car for two years. I walked everywhere. I had a suspended license. On the Families Against Narcotics Board, I developed a scholarship where anyone in early recovery gets paid" (Man, age 39, personal recovery).

Another participant, a multiracial American, shared her vision around potential networking events, describing:

> Events where I could network with other people. It could be something like meeting at a coffee shop with people who have lived experience with mental health and substance abuse. We could sit across from one another and say, "How are you doing?" and genuinely connect. Then, I could text that person late at night and ask, "Hey, what are some things you do? Tricks and tips that actually work?" Even Zoom meetings could be helpful—just meeting with other Muslims who have really changed their lives [and we have] more people talking about being Muslim, what that looks like in the household growing up, and the connection between addiction, being Muslim, and the impact it has on your faith.
>
> Woman, age 23, personal recovery

Four people discussed the need to be able to talk to community members, imams, teachers, advisors, and other resourceful leaders in the community more openly about these concerns to create more awareness, programs, and spaces for healing and comfort. One participant, a Palestinian/Jordanian American, captured this sentiment: "Yeah, a support group within the mosques, within the communities. Being comfortable enough to bring up these problems with the imam, with the school teachers, not pretending it does not exist. So I guess being comfortable enough to bring those topics up" (Man, age 35, personal recovery).

Participants emphasized the need for Muslim communities that are supportive, caring, empathetic, and educated to generate a cultural shift to reduce the stigma and fear of judgment surrounding addiction. They noted the need for advocating for non-judgmental resources and education for community members not struggling with addiction to foster inclusivity. Many expressed the necessity of a strong support system, particularly within families, highlighting the importance of family counseling and collective healing in the recovery process. Additionally, participants envisioned tangible community support structures such as physical or virtual check-in spaces, educational tools, networking events, and open conversations with religious and community leaders to create awareness and facilitate healing.

Discussion

Substance use and addiction are pervasive issues not only in the general American society but also within American Muslim communities, often in ways that remain underexplored. Our study revealed key themes that provide essential insights into how substance use and addiction exist in this population. The themes identified in this study highlight the complex factors contributing to this challenging disorder. Substance use, addiction, and the stigma surrounding both are often associated with social isolation and a reluctance to seek help. Fear of being ostracized by family, community, and religious leaders prevented many from accessing the support that they needed.

Another major theme this study uncovered was the lack of culturally competent care that integrates both spiritual and psychological aspects. Many participants struggled to reconcile their addiction with their faith. This faith-based disconnection often led to feelings of alienation, making recovery more difficult. Family dynamics were shown to have a dual impact on recovery; for some, it was positive, and for others more negative. Families often lacked the necessary knowledge to support recovery, emphasizing the need for greater education. Faith was both a source of strength and conflict for participants. Some found solace in religious practices, while others struggled with feelings of guilt and shame. Some of the participants even saw their own addiction as a personal failure in their relationship with God. The lack of accessible and effective resources within Muslim communities also emerged as a major theme from our data. The majority of our participants lacked support networks, educational programs, and recovery networks within mosques. This made many individuals either suffer in silence or seek help from non-preferred sources.

The findings of the study have broader implications for mental health care, particularly for diverse, marginalized communities. Addressing substance use and addiction in culturally sensitive ways can enhance overall mental health care by promoting holistic healing that treats both the psychological as well as the spiritual aspects of mental health. Strategies discussed are not only relevant for Muslims but can be applied to a variety of communities facing mental challenges. As we work to reduce stigma and enhance the cultural competence of mental health services, we can help foster a welcoming environment and ultimately contribute to healthier more resilient communities.

Recovery is not just about individual treatment; it requires a communal response. By working together, faith leaders, healthcare professionals, and community members can create a supportive environment that empowers rather than hinders Muslim mental health. Our study showed the impact that family members, religious leaders, institutions, and the community at large have on overall recovery. Many participants of our study emphasized how key individuals close to them—friends, siblings, and even peers—were what finally motivated them to stop their cycle of addiction. Hearing these stories is a call to action for all in the community to step up, to challenge the stigma, and be the change needed.

Man Age 39

“As Muslims, sometimes we put ourselves **in a box**. It was something that I had to grapple with.

Recommendations

Community Members

To combat addiction-related stigma within American Muslim communities, educational efforts and resources should focus on two key areas: understanding addiction as a medical condition and learning from the experiences of substance users. This approach may help build empathy and reduce ostracization of affected individuals and their families. By providing community discussions, seminars, and lectures focusing on discussions such as mental health and substance use from a spiritual and scientific perspective, the community can begin meaningful discussions in understanding addictions within Islamic approaches.

It was revealed through this study that several participants utilized Alcoholics Anonymous groups or other 12-step programs to find community and mentorships from individuals who have experienced similar struggles. Including similar programs that utilize Islamic approaches and practices, such as Overcoming Addictions (Adisa, 2021),[40] in Muslim communities can assist families and individuals struggling to find solace within their community and create a sense of belonging.

Lastly, increasing faith-based social services and mental health resources and the funding necessary to effectively sustain them can help build trust in mental health services and minimize the stigma surrounding them.

Community and Religious Leaders

To effectively address substance use stigma and misinformation among American Muslim Community and Religious Leaders (CaRLs), evidence-based, culturally sensitive, and Islamically grounded strategies must be taught and adopted by these leaders. A central issue that was revealed through the interviews was the harmful stigma that surrounds addiction, often leading to social isolation and a reluctance to seek help. To actively combat this stigma, CaRLs should give relevant khutbas and organize community forums with subject matter experts, which can foster an environment of understanding by normalizing these discussions within the mosque setting.

Another critical step for CaRLs is to work with individuals with specialized training in addiction counseling and mental health awareness. Evidence suggests that culturally competent care allows for more effective mental health care (Hall et al., 2016).[41] By combining religious guidance with medical knowledge, leaders can offer holistic care that addresses both the spiritual and psychological aspects of addiction recovery.

Studies show that early intervention significantly reduces the risk of developing substance use disorders later in life (Lubman et al., 2007).[42] Preventative measures targeted at youth are essential in mitigating the onset of substance use. Imams and community leaders should implement mentorship programs and youth initiatives that allow for the building of healthy, supportive relationships. Following the examples provided in Islamic history, CaRLs should create programs that cultivate resilience, a sense of belonging, brotherhood/sisterhood, and, ultimately, an overall positive, safe, and nurturing environment.

In addition, CaRLs should actively advocate for resource allocation and policy changes both within the mosque and outside of it. Many of the people interviewed in this study mentioned the lack of resources provided by the mosque and how they wished their Muslim community had done more to support them. For example, setting up AA meetings, or Islamic adaptations such as Overcoming Addictions (Adisa, 2021) or Millati Islami (a religiously congruent 12-step program created by and for Muslims) (Imani, 1992; Millati Islami, n.d.) at the mosque can be immediately impactful.[43]

Unfortunately, CaRLs are often looked to provide more than they are capable or trained to; CaRLs are often tasked with being counselors, khateebs, educators, scholars, mediators, and much more. Expecting CaRLs to successfully and effectively address all of these issues, including mental health and substance-related challenges, is both unrealistic and unfair. There is no doubt that CaRLs play an essential role in supporting the community, but they cannot address every challenge alone. It is crucial that other community members take the initiative to learn, educate, and actively combat substance use and addiction and the associated stigma within Muslim communities. By working together, communities can support one another to create a stronger, healthier environment for all.

Clinicians

Clinicians have an integral role to play in the recovery journey of Muslims struggling with addictions. While Muslim clinicians might be able to connect better with the spiritual and cultural needs of Muslim community

members, it is important that all clinicians engage in specialized training. There are two levels of specialized training that would benefit Muslim clients interfacing with healthcare professionals: 1) a greater understanding of SUDs and addictions and 2) building spiritual and cultural responsiveness to understand how these issues affect Muslim communities in multifaceted ways.

Furthermore, Islam is a collectivist religion that prioritizes the family unit in the health, healing, and well-being of people with mental health concerns, including substance use and addiction. Many times, family members may feel helpless, powerless, and unable to support their loved ones' journey because of the lack of awareness, resources, and dialogue around addictions. As such, clinicians should incorporate, when possible and with permission, family members in the healing process and recovery plan. This may also include providing family members with psychoeducation and other similar resources. By doing so, clinicians ensure that clients have an active support system around them, which may increase adherence to the treatment modalities.

In conjunction with increasing family support, clinicians can create stronger networks of interdisciplinary healthcare providers through collaborations with allied health professionals. Every healthcare professional has their own area of expertise and their own skill set, which can collectively be leveraged to empower the patient to adhere to the recovery plan. The recovery team can be further broadened and diversified through the inclusion of spiritual or community leaders to support the patient more holistically.

Policymakers

Based on the findings of this report, there are two primary recommendations to policymakers and others in positions of political influence. First, individuals in these roles should seek out educational opportunities that address the unique needs of American Muslims in the context of substance use and addiction. Second, it should be a priority at the federal, state, and local levels to increase the accessibility of funding and the creation and the facilitation of access to funds for faith-based programs including Muslims, specifically for substance use treatment, education, and service provision.

Limitations of This Research

Given the stigma surrounding addictions and substance use within American Muslim communities, many individuals struggling with addiction or substance use may feel reluctant to share their experiences out of fear. This limited the recruitment capabilities for this and similar studies, making it challenging to fully understand the variety of lived experiences in relation to this topic. Additionally, while this study is a qualitative examination of lived experiences, the presence of this stigma makes it similarly challenging to gain a quantitative scope of substance use and addiction among American Muslims.

Additionally, the study excludes non-English speakers, which can further decrease inclusion given the diversity and high rates of immigrant and refugee populations among American Muslims. This may also exclude community members who are more comfortable discussing their experiences in their native language. While the study aimed to highlight the needed support for this community, it is evident that American Muslims have diverse intersectionalities in the form of ethnic groups, gender, immigration status, religious and cultural practices, faith conversion, etc., that the study could not individually address.

Finally, this study excludes participation from anyone under the age of 18. Given the rates of substance use and addiction among young adults mentioned previously, their perspective may provide additional perspective and nuance.

Next Steps

While this report provides valuable insight into the lived experiences of Muslim individuals with a history of substance use and addiction from their own perspectives as well as from the point of view of family members and the work of prominent substance use and addiction organizations serving American Muslim communities, there remains a significant gap in our understanding of this challenge and their associated needs. More research is required to expand our understanding of the experiences of substance use and addiction. Work must examine the various subpopulations of American Muslims, with a focus on more targeted sampling for qualitative work as well as quantitative work that allows for a broad generalized overview of these issues within American Muslim communities.

Additionally, while it is true that more work is needed

to support American Muslims in recovery, significantly more research and interventions must be conducted with American Muslims with active substance use and addiction challenges. In that vein, research specifically aimed at improving our understanding of behavioral addictions—particularly gaming, social media, and pornography addictions—is also necessary.

American Muslim communities are collectivist communities, meaning oftentimes the role of family is critical in the lived experiences of individuals, and individuals are seen as being part of a larger collective (Amer & Bagasra, 2013).[44] While this current work focuses on the lived experiences of both family members of individuals in recovery from substance use and addiction and the individuals themselves, it is critically important, given the collectivist nature of American Muslim communities, to further expand the understanding of the experiences of family members of those with SUD/addiction challenges.

Finally, as a next step, community organizations and leadership must be developed and improved to address this need. In particular, the Stanford Muslim Mental Health and Islamic Psychology (SMMHIP) Lab takes on this challenge through the development of a Muslim Addictions Manual created to serve as a rigorous clinical and research-based primary tool for Muslim communities on this topic. Further, this manual provides the foundation for Maristan—a community partner of the SMMHIP Lab—to offer a certificate training program for Muslim community and religious leaders to effectively engage with, serve, and support community members struggling with addiction and their families. Additionally, it is important that a rigorous, in-depth evaluation of existing Muslim-specific substance use and addiction services is conducted. To maximize the effectiveness and reach of these organizations and the critical services that they provide, SWOT [97] analyses should be performed. By identifying organizational strengths such as culturally tailored programming, community trust, and partnerships with mosques and mental health professionals, organizations can build on existing assets while recognizing weaknesses, including limited funding, inadequate training, or insufficient outreach, to allow for targeted improvements. SWOT analyses help uncover external opportunities that organizations might engage in to expand and enhance services, such as increased public awareness, emerging funding sources, and a growing network of professionals trained to serve Muslims struggling with addiction, enabling organizations to expand their reach. Simultaneously, assessing threats—including stigma, lack of culturally competent mainstream services, and structural barriers like Islamophobia—allows organizations to develop proactive strategies such as stigma-reduction initiatives, advocacy for equitable treatment access, and collaboration with mainstream providers. Integrating SWOT analyses into long-term planning ensures these services remain adaptable, impactful, and responsive to the evolving needs of Muslim communities. Further, developing and implementing recurring rigorous metrics for evaluation of program success will ensure organizations and the services they provide continue to be as effective as possible.

Addressing addiction-related mental health needs and associated communal stigma requires a community-wide effort that includes education, culturally responsive care, and policy support. Religious and community leaders, clinicians, and researchers must collaborate to normalize discussions on substance use, expand access to mental health resources, and develop evidence-based, culturally relevant interventions. Faith-based education programs, family involvement, and religiously sensitive clinical initiatives can foster support and prevention, while policymakers should prioritize funding for sustainable services. A holistic approach that integrates lived experiences, interdisciplinary collaboration, and ongoing research will strengthen efforts to combat stigma and improve recovery outcomes.

[97] Strengths, Weaknesses, Opportunities, and Threats

Appendix

Table 1: Demographic Characteristics of In-Depth Interview Participants

	Gender	Age	Ethnicity	Perspective	Self-Reported Substances Used
# 1	Female	29	Mexican American	Self	Alcohol, Marijuana, Opioids
# 2	Female	40	Afghan American	Self	Alcohol, Nicotine, Marijuana, Opioids
# 3	Male	35	MENA American	Self	Marijuana, Alcohol, Cocaine, Opioids, Mushrooms, Ecstasy, Ketamine, Over-the-Counter Medications
# 4	Male	39	Pakistani American	Self	Marijuana, Alcohol, Adderall, Painkillers
# 5	Male	35	Palestinian/ Jordanian American	Self	Marijuana, Alcohol, Opioids, Other Pills
# 6	Female	23	Multiracial	Self	Alcohol, Marijuana, Nicotine
# 7	Male	24	Somali American	Self	Marijuana, Opioids, Fentanyl
# 8	Male	59	Yemeni American	Self	Alcohol, Marijuana, LSD, Crack, Cocaine, Vicodin, Opioids
# 9	Male	39	Lebanese American	Self	Marijuana, Alcohol, Adderall, Ecstasy, LSD, Mushrooms, Cocaine, Crack, Vicodin, Xanax, Opioids
# 10	Female Interviewee	29 (Son)	N/D	Mother discussing son's experience with SU/A	Marijuana, Methamphetamines, Opioids
# 11	Female Interviewee	68 (Father)	N/D	Daughter discussing father's experience with SU/A	Alcohol
# 12	Female Interviewee	N/D	Arab American (Palestinian)	Sister discussing brother's experience with SU/A	Marijuana, Adderall, Opioids, Other Pills
# 13	Female Interviewee	18 (Daughter)	N/D	Mother discussing daughter's experience with SU/A	Opioids, Methamphetamines, Marijuana, Nicotine, Benzodiazepines, Psychedelics
# 14	Female Interviewee	47 (Son)	N/D	Mother discussing son's experience with SU/A	Marijuana, Methamphetamines, Opioids

* N/D Not Disclosed SU/A Substance Use and Addiction

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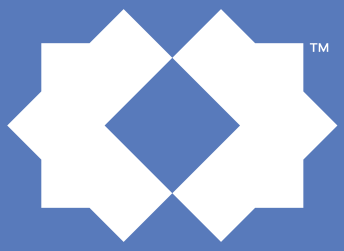

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