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Social Support and Quality of Life: The mediating role of Self Compassion and Personal Growth in Individuals Recovered with Substance Use Disorders

by

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A thesis submitted in partial fulfillment for the degree of Master of Sciences

in the

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Department of Psychology

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With profound love and gratitude, I dedicate this thesis to my beloved parents. Papa, your unwavering support, endless sacrifices, and unconditional love have been my greatest source of strength and motivation. Mama, your prayers, guidance, and encouragement have shaped my journey. And to my brothers, this achievement would not have been possible without you. This work is a small tribute to their relentless efforts and the invaluable lessons they have instilled in me.

CERTIFICATE OF APPROVAL

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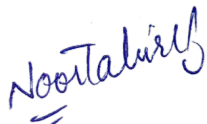

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Abstract

The present study examined the relationships between social support, quality of life, self-compassion, and personal growth in individuals recovered with Substance Use Disorders (SUDs). Additionally, the study investigated the mediating roles of self-compassion and personal growth in the association between social support and quality of life. More specifically the study aimed at comparing the differences at the level of gender, education and type of substance used in individuals recovered with SUDs. The study was conducted into two phases; firstly, the standardized scales were translated into Urdu and in the second phase the translated version of the scales were administered for data collection. A cross-sectional correlational research design was employed, and a sample of 302 individuals recovered with SUDs was recruited from the rehabilitation centers of Islamabad and Rawalpindi by using purposive sampling technique. Standardized Urdu translated measures; Social Support Scale [1], WHO Quality of Life Scale WHOQoL-BREF; [2], Self-Compassion Scale [3], and Personal Growth Initiative Scale-II [4] were administered individually. Various statistical analyses were conducted; Intercorrelation between study variables, Mann Whitney-U test, Kruskal Wallis H test and Mediation analysis. Results revealed a significant positive association between social support and quality of life ($r = .175^{**}$, $p < .01$). Social support was positively associated with self-compassion ($r = .397^{**}$, $p < .01$) but showed a weak negative relationship with personal growth ($r = -.189^{**}$, $p < .01$). Self-compassion was positively related to personal growth ($r = .066$, $p < .01$) and quality of life ($r = .484^{**}$, $p < .01$). Personal growth had a significant positive relationship with quality of life ($r = .385^{**}$, $p < .01$). Mediation analysis confirmed that both self-compassion ($B = 0.46$, $SE = 0.05$, $p < .001$) and personal growth ($B = 0.41$, $SE = 0.05$, $p < .001$) significantly mediated the relationship between social support and quality of life. Gender differences were observed, with females reporting higher social support, self-compassion, personal growth, and quality of life. Educational background and type of substance used also influenced these variables. These findings underscore the critical role of social support in enhancing the quality of life among recovered individuals while highlighting the mediating influence of

self-compassion and personal growth. The study provides implications for designing intervention programs for rehabilitation centers that foster self-compassion and personal growth to enhance recovery outcomes and reduce relapse rate. Additionally, strengthening social reintegration programs can help recovered individuals in rebuild relationships, secure employment and maintain long term recovery.

Key words: Social Support, Quality of Life, Self-Compassion, Personal Growth, Substance Use Disorders.

Contents

Author's Declaration iv

Plagiarism Undertaking v

Acknowledgements vi

Abstract vii

List of Symbols xiii

Abbrevations xiv

1 Introduction 1
- 1.1 Social Support . . . 3
- 1.2 Quality of Life . . . 5
- 1.3 Social Support and Quality of Life . . . 6
- 1.4 Self-Compassion . . . 7
- 1.5 Personal Growth . . . 11
- 1.6 Self-Compassion and Personal Growth as Mediators . . . 15
- 1.7 Developing Self-Compassion and Personal Growth Through Recovery Programs . . . 18
- 1.8 Rationale of the Study . . . 19
- 1.9 Theoretical Framework . . . 21
- 1.10 Conceptual Framework . . . 22
- 1.11 Objectives . . . 24
- 1.12 Hypotheses . . . 24

2 Literature Review 27

3 Research Methodology 34
- 3.1 Research Design . . . 34
- 3.2 Sample . . . 35
  - 3.2.1 Inclusion criteria . . . 36
  - 3.2.2 Exclusion criteria . . . 36
- 3.3 Procedure . . . 37

3.3.1 Phase-I . . . 38
3.3.2 Phase-II . . . 38
3.4 Instruments . . . 39
3.4.1 Information Sheet . . . 39
3.4.2 World Health Organization-Quality of Life BREF Scale . . . 40
3.4.3 Self-Compassion Scale . . . 41
3.4.4 Personal Growth Initiative-II . . . 41
3.5 Phase-I . . . 43
3.5.1 Translation . . . 43
3.5.1.1 Forward Translation . . . 43
3.5.2 Synthesis I . . . 43
3.5.2.1 Back-Translation . . . 44
3.5.3 Synthesis II . . . 45
3.5.3.1 Expert Panel . . . 46
3.6 Phase-II . . . 47
3.7 Data Analyses . . . 49
3.7.1 Pilot Study . . . 50

4 Results 53

5 Discussion 65

6 Conclusion 70
6.1 Limitations . . . 71
6.2 Strengths and Future Implications . . . 72

Bibliography 74

Annexes 85

List of Figures

1.1 Conceptual framework of the present study. 25

List of Tables

3.1 Cronbach's Alpha Reliability, Mean, Skewness, Range (actual and potential) and Standard deviation of Social Support, Quality of Life, Self-Compassion, and Personal Growth (N=10). 52
3.2 Descriptive statistics and correlation of Social Support Scale, WHO-Quality of Life BREF scale, Self-Compassion Scale and Personal Growth Initiative-II Scale (N =10). 52

4.1 Demographic characteristics of Participants (N=302) 54
4.2 Mean, Median, Mode, Skewness and Kurtosis of Age (N=302). . . . 57
4.3 Kolmogorov-Smirnov and Shapiro-Wilk values along with the values of significance of Demographic characteristics 58
4.4 Kolmogorov-Smirnov and Shapiro-Wilk values along with the values of Social Support scale, WHO-Quality of Life BREF scale. Self-Compassion Scale and Personal Growth Initiative-II scale. 58
4.5 Cronbach's Alpha Reliability of Social Support Scale, WHO-Quality of Life Scale, Self-Compassion Scale, and Personal Growth Initiative-II Scale (N=302) 59
4.6 Descriptive statistics and correlation of Social Support scale, WHO-Quality of Life BREF Scale, Self-Compassion Scale and Personal Growth Initiative-II Scale (N=302). 59
4.7 Mediator Analysis: Social Support (SSS) and Quality of life (WHO-QoL), with Mediators Self-Compassion (SCS) and Personal Growth (PGI-II) 61
4.8 Mann-Whitney-U test results comparing males and females on Social Support Scale, WHO-Quality of Life BREF Scale, Self-Compassion Scale and Personal Growth Initiative-II Scale (N=302). 62
4.9 Kruskal Wallis H test results comparing Substance used on Social Support Scale, WHO-Quality of Life BREF Scale, Self-Compassion Scale and Personal Growth Initiative-II Scale (N=302) 63
4.10 Kruskal Wallis H test results comparing Education level on Social Support Scale, WHO-Quality of Life BREF Scale, Self-Compassion Scale and Personal Growth Initiative-II Scale (N=302) 64

List of Symbols

f	Frequency
%	Percentage
α	Cronbach's Alpha
r	Corelation
$**$	Highly Significant
$*$	Significant
M	Mean
SD	Standard Deviation
p	Value of Significance

Abbrevations

SC	Self Compession
PG	Personal Growth
SUDs	Substance Use Disorders
SCP	Self Compassion Theory
SCS	Self COmpassion Scale
PGI-II	Personal Growth Initiative - II
WHO - QoL	World Health Organization - Quality of Life
QoL	Quality of Life

Chapter 1

Introduction

Substance Use Disorder refers to a complex, chronic condition characterized by the compulsive use of substances, such as drugs or alcohol, despite harmful consequences to one's health, personal life, and societal functioning [5]. In Diagnostic and Statistical Manual of Mental Disorders (DSM-5), SUD includes tolerance, withdrawal symptoms, and an inability to control substance use [6]. SUD has multiple levels of severity mild, moderate, and severe based on the number of diagnostic criteria met. Understanding these distinctions is vital as they inform treatment and intervention strategies ([7], p. 5). Recent studies highlight the neurobiological, psychological, and environmental components contributing to SUDs, underscoring their multidimensional nature and the need for comprehensive care models [8]. SUDs impose a significant burden not only on individuals but also on families and broader societal systems. The individual effects of SUDs are profound, often resulting in impaired physical and mental health, including an increased risk for conditions such as liver disease, cardiovascular disorders, anxiety, depression, and cognitive impairment [9]. Psychological well-being is particularly affected, as individuals with SUDs frequently experience guilt, shame, and a loss of self-worth, which perpetuates the cycle of addiction [10]. SUDs also affect personal relationships, employment stability, and financial security, creating a ripple effect on family members who may face emotional distress, social isolation, and financial strain [11].

At a societal level, the economic impact of SUDs is immense, with costs attributed to healthcare, law enforcement, lost productivity, and social services. In the United States alone, substance use costs exceed billions annually, with healthcare expenses encompassing emergency treatments, rehabilitation services, and long-term care for substance-related health conditions [12]. Additionally, substance-related offenses strain the criminal justice system, leading to overcrowded prisons and extensive legal expenditures. The workforce is also affected, as individuals with SUDs often face challenges maintaining consistent employment, resulting in productivity losses that impede economic growth. Collectively, these factors demonstrate the widespread ramifications of SUDs, highlighting the urgent need for policies and interventions to address its impact on both a micro and macro level.

Recovery from SUDs is a multi-stage process that extends beyond mere abstinence from substances; it involves the restoration of physical health, psychological well-being, and social integration. Recovery is often described as a dynamic and individualized journey, requiring medical, psychological, and social interventions tailored to each person's unique needs and experiences [13]. The early stages of recovery generally focus on detoxification and managing withdrawal symptoms, which includes physical pain, anxiety, and cravings. Medical support is crucial during this phase, as withdrawal can be life-threatening for certain substances, including opioids and alcohol [14].

After initial detoxification, individuals typically engage in structured treatment programs designed to orient the underlying causes of addiction which may include inpatient or outpatient rehabilitation, counseling, and support groups. Cognitive-behavioral therapy (CBT) and motivational enhancement therapy (MET) are commonly used to help individuals in developing coping strategies, addressing negative thought patterns, and building motivation for sustained recovery [15]. The recovery process also emphasizes building a strong support network, as social connections play a vital role in fostering resilience and preventing relapse. Family therapy and peer support groups like Alcoholics Anonymous (AA) provide valuable social support, creating a sense of community and accountability [16]. Despite the structured framework provided in treatment, individuals in recovery face numerous

challenges that can hinder their progress. Psychological and physical cravings, triggered by environmental cues, stress, or trauma, remain significant obstacles even after the initial stages of recovery [4]. Managing these cravings requires ongoing support and strategies, often involving continued therapy and lifestyle adjustments. Moreover, individuals with SUDs frequently encounter social stigma, which can lead to discrimination and reduce opportunities for social and occupational reintegration. This stigma creates additional stress, exacerbating feelings of isolation and potentially increasing the risk of relapse [17]. Employment re-entry is another formidable challenge, as many individuals with a history of SUDs struggle to secure stable employment. Employers may be hesitant to hire individuals with past substance use issues, and the stigma surrounding addiction can reduce job opportunities. Obtaining employment is not only crucial for financial stability but also contributes to a sense of purpose and self-worth, both essential for long-term recovery [18]. Additionally, the ongoing risk of mental health issues such as anxiety, depression, and post-traumatic stress disorder (PTSD) complicates recovery. Comorbid mental health conditions are prevalent among individuals with SUDs, requiring dual-diagnosis treatments that address both addiction and psychological disorders [8].

Housing instability further exacerbates the recovery process, especially for individuals from socioeconomically disadvantaged backgrounds. Stable housing provides the security and stability necessary for recovery, yet many individuals in recovery face homelessness or lack adequate housing support. Homelessness is often both a cause and consequence of SUD, creating a cycle of vulnerability that impedes access to recovery resources [11]. Transitional housing programs and sober living homes are vital in offering a structured environment that supports sobriety and reintegration into society.

1.1 Social Support

Social support is a fundamental component in the process of recovery from substance use disorders (SUDs). It is defined as the perception or experience of being

cared for, having assistance from others, and being part of a supportive social network [19]. Social support can come from family, friends, healthcare professionals, and peer support groups. For individuals in recovery, social support serves as a buffer against the stress and challenges associated with overcoming addiction, providing both emotional and practical assistance [20]. Studies consistently highlight that social support enhances resilience, aids in relapse prevention, and fosters a positive outlook, all of which are critical for sustaining long-term recovery [15]. Furthermore, support from empathetic and understanding individuals helps alleviate feelings of isolation and stigma, which are common experiences among those with a history of substance use [21].

Social support fulfils various roles in the recovery journey, such as providing emotional support, which includes encouragement, reassurance, and empathy, helping individuals cope with stress and emotional pain associated with recovery. Instrumental support, on the other hand, offers tangible assistance, such as financial help, housing, or employment opportunities, all of which contribute to stability during recovery [22]. Informational support provides guidance and resources, such as knowledge about coping mechanisms, recovery programs, and life skills training, which empower individuals to make informed decisions for their recovery process [23]. Peer support, often through groups such as Alcoholics Anonymous or Narcotics Anonymous, is particularly influential, as it creates a sense of community where individuals can share experiences and strategies with others who have similar backgrounds [24].

A significant factor in recovery is the prevention of relapse, and social support is recognized as a crucial element in maintaining sobriety. Relapse is often triggered by stress, environmental cues, and negative emotions, but a supportive network can help mitigate these risks [25]. According to recent research, individuals with strong social support are more likely to experience positive outcomes in their recovery journey, with lower rates of relapse compared to those with limited or no social support [26]. The mechanisms behind this protective effect include the ability of social networks to provide consistent reinforcement, accountability, and immediate assistance during high-risk situations [27]. Additionally, social support

fosters a sense of hope and motivation, which is essential for sustaining recovery in the face of challenges. By offering practical solutions and emotional strength, social support becomes an indispensable part of a holistic approach to preventing relapse and promoting long-term recovery.

1.2 Quality of Life

Quality of life (QoL) is a multidimensional construct that includes an individual's physical health, psychological well-being, social relationships, and environment. In the context of recovery, QoL serves as an indicator of the overall success and sustainability of the recovery process, extending beyond mere abstinence from substance use [2]. For individuals with a history of substance use, QoL is often significantly diminished, as addiction can lead to deteriorated physical health, mental health issues, disrupted family and social relationships, and economic instability [28]. Substance use impacts almost every aspect of life, creating problems that compromise an individual's ability to live a fulfilling life. Moreover, the stigma associated with addiction often further reduces QoL by reinforcing feelings of shame, isolation, and social exclusion [29].

Recovery from SUD involves not only cessation of substance use but also efforts to restore and enhance QoL. The concept of QoL in recovery encompasses the individual's sense of purpose, self-esteem, and life satisfaction for improved health and social functioning [30]. Recent studies emphasize that individuals in recovery experience significant improvements in QoL, particularly when they receive continuous social support that helps rebuild their physical, psychological, and social dimensions [31]. Recovery-oriented approaches that prioritize QoL aim to address the broader needs of individuals, promoting social reintegration and personal growth as integral parts of the healing process [21].

The impact of substance use on QoL is well-documented, with research indicating that SUD leads to profound impairments in various areas of life. Physical health often suffers significantly due to the toxic effects of substances, leading to chronic

conditions such as liver disease, cardiovascular issues, and weakened immune systems [14]. Mental health is also compromised, as substance use is closely linked to increased risks of depression, anxiety, and other psychiatric disorders [32]. These health issues, combined with impaired cognitive functioning, reduce an individual's ability to manage daily responsibilities, maintain employment, and engage in meaningful social interactions [30]. Social relationships, a key component of QoL, are frequently disrupted by substance use. Individuals with SUD often experience conflicts, broken relationships, and social isolation due to the behavioral consequences of addiction, such as aggression, deception, and neglect [33]. Economic hardships further exacerbate QoL, as financial instability and legal issues are common among individuals with SUD, often leading to a cycle of poverty and homelessness [34]. Collectively, these factors illustrate the extensive impact of substance use on QoL, highlighting the need for recovery programs to focus on holistic improvements rather than solely on abstinence.

1.3 Social Support and Quality of Life

Social support plays a transformative role in enhancing QoL for individuals recovering from SUDs. Through consistent encouragement, tangible assistance, and emotional reinforcement, social support networks help individuals overcome the challenges that impair their QoL. Support from family members, friends, and peers can contribute to advancement in self-esteem, a critical component of QoL, by validating individuals' efforts to change and reinforcing their sense of self-worth [35]. Social support also promotes stability in living conditions, employment, and mental health management, all of which contribute to a positive QoL trajectory in recovery [36].

For individuals in recovery, peer support groups offer a unique form of social support that significantly boosts QoL. These groups create a non-judgmental space where individuals share experiences, receive guidance, and build friendships with others on a similar path [27]. The presence of a peer group that understands the struggles associated with addiction fosters a sense of belonging, which is essential

for QoL [37]. Additionally, peer support helps reduce the stigma frequently associated with SUD, allowing individuals to regain their dignity and social acceptance, further enhancing their QoL [14].

Social support not only improves QoL directly but also fosters personal growth, which further contributes to a higher QoL in recovery. Personal development in recovery is characterized by self-awareness, resilience, and a redefined sense of purpose. Social support facilitates this growth by providing opportunities for learning, self-reflection, and developing life skills that promote independence and self-efficacy [21]. This personal growth, in turn, enhances QoL by equipping individuals with the psychological tools needed to navigate life after addiction [24].

Studies indicate that individuals who experience personal growth in recovery report higher life satisfaction, increased social engagement, and a stronger sense of meaning, all core elements of QoL [32].

By integrating social support into recovery programs, healthcare providers can create environments that not only encourage abstinence but also promote comprehensive well-being. Such programs aim to build a foundation for individuals to achieve sustained recovery, improved QoL, and personal growth. The reciprocal relationship between social support, QoL, and personal growth illustrates the importance of a holistic approach in SUD recovery, where the individual's overall well-being is prioritized alongside efforts to prevent relapse.

1.4 Self-Compassion

Self-compassion is a psychological construct defined as being kind and understanding toward oneself in times of personal difficulty or failure. It involves three core components: self-kindness, common humanity, and mindfulness, each contributing uniquely to a compassionate approach toward the self [38]. Self-kindness emphasizes treating oneself with warmth and empathy rather than harsh self-criticism. Individuals practicing self-kindness are more likely to accept their flaws and shortcomings, recognizing that imperfection is part of the human experience. This

nurturing attitude fosters emotional resilience, enabling individuals to approach personal challenges with enhanced tranquility and understanding [39].

The second component, common humanity, underscores the connection between individual suffering and the shared experiences of others. Recognizing that hardship is part of the collective human experience helps reduce feelings of isolation, which are particularly common among individuals recovering from substance use disorder (SUD). By embracing common humanity, individuals understand that they are not alone in their struggles, which can mitigate feelings of shame and alienation often experienced during recovery [40]. The final component, mindfulness, involves maintaining a balanced awareness of one's thoughts and emotions without becoming overly absorbed. This non-judgmental awareness allows individuals to experience their feelings without exaggeration or suppression, enabling a balanced response to distress and promoting psychological stability [41]. These three components of self-compassion work synergistically to foster a positive self-view, enhancing resilience and emotional well-being. For individuals recovering from SUDs, self-compassion provides a foundation for personal growth by countering the pervasive self-criticism and shame that can impede recovery. Research indicates that self-compassion enables individuals to face their struggles without fear of judgment, creating a supportive internal environment that encourages sustainable recovery [23]. Emotional regulation is a crucial skill for individuals in recovery from SUDs, as unmanaged emotions often contribute to relapse. Self-compassion has been shown to play a key role in enhancing emotional regulation, providing individuals with tools to manage negative emotions constructively [42]. By cultivating a compassionate attitude toward oneself, individuals are better equipped to address emotions like shame, guilt, and frustration common feelings during recovery without succumbing to self-destructive coping mechanisms. Studies demonstrate that self-compassion helps to reduce the intensity of negative emotional responses, allowing individuals to process emotions in a more balanced and adaptive way [43]. Research highlights that individuals who practice self-compassion experience less emotional volatility and are more likely to participate in adaptive coping strategies. A study by [44] found that self-compassionate individuals exhibited lower levels of emotional reactivity and were better able to handle

stress without turning to substance use. Self-compassion enables individuals to distance themselves from harsh self-judgment, which can often exacerbate negative emotions. Instead, they learn to approach their feelings with curiosity and kindness, creating a supportive internal dialogue that facilitates healthier responses to stress [45]. This capability is especially beneficial for individuals in recovery, as it reduces the risk of emotional triggers that can lead to relapse. Shame is a pervasive emotion among individuals with a history of SUDs, often stemming from societal stigma and self-blame. It is a powerful and debilitating emotion that can hinder recovery by reinforcing feelings of worthlessness and inadequacy [40]. Self-compassion has emerged as an effective tool in reducing shame by encouraging a kinder, more forgiving view of oneself. When individuals practice self-compassion, they are less likely to internalize shame and more inclined to view their mistakes as part of the human experience rather than as personal failures. This shift in perspective reduces the self-blame and condemnation often associated with shame [46].

A recent study by [47] demonstrated that self-compassion significantly reduced feelings of shame among individuals in recovery by promoting self-acceptance and a non-judgmental stance toward past behaviors. By fostering a compassionate self-attitude, individuals can reframe their past mistakes as learning experiences rather than sources of shame. This transformation is essential for sustainable recovery, as it prevents individuals from becoming overwhelmed by negative self-perceptions, which can trigger relapse [48]. Moreover, by reducing shame, self-compassion also fosters social connectedness, allowing individuals to feel more comfortable seeking support and sharing their experiences with others without fear of judgment. Self-compassion not only aids in emotional regulation and shame reduction but also enhances resilience, a critical factor for long-term recovery success. Resilience refers to the ability to adapt positively to adversity, and it is essential for individuals recovering from SUDs who face ongoing challenges in maintaining sobriety. Studies suggest that self-compassion strengthens resilience by promoting adaptive coping mechanisms and reducing emotional vulnerability [38]. Resilient individuals are more likely to view setbacks as temporary obstacles rather than insurmountable failures, an attitude fostered by self-compassion's emphasis on self-kindness

and common humanity [45].

The practice of self-compassion equips individuals with a positive internal framework that reinforces their ability to persist through difficulties. For instance, individuals who engage in self-compassionate practices are more likely to bounce back from relapses by reframing these experiences as part of the recovery journey rather than as failures. This perspective not only enhances resilience but also improves self-efficacy the belief in one's capacity to achieve recovery goals [48]. With increased resilience, individuals are better prepared to navigate the ups and downs of recovery, maintaining a commitment to sobriety even when faced with challenging situations. Social stigma is a significant barrier to recovery, as individuals with a history of SUDs often face discrimination and negative judgments from society. This stigma can lead to self-stigmatization, where individuals internalize societal prejudices, resulting in further shame and decreased self-worth [49]. Self-compassion serves as a protective factor against the effects of social stigma by encouraging individuals to view themselves through a lens of kindness and understanding. By fostering a compassionate attitude, individuals have an improved ability to resist the negative impact of societal judgments, allowing them to maintain a positive self-image despite external stigma [47]. In recent studies, self-compassion has been shown to reduce the internalization of stigma by promoting self-acceptance and resilience. A study by [50] found that individuals with high levels of self-compassion were less likely to be affected by social stigma, demonstrating a stronger sense of self-worth and a lower tendency to engage in self-criticism. By reducing the impact of stigma, self-compassion enables individuals to focus on their recovery without being weighed down by societal judgments, which can otherwise act as a significant barrier to progress [51]. Given the numerous benefits of self-compassion in recovery, there is a growing interest in incorporating self-compassion training into recovery programs. Self-compassion interventions, such as mindfulness-based self-compassion (MSC) programs, have been shown to improve emotional well-being and enhance recovery outcomes by teaching individuals how to respond to their suffering with compassion rather than self-criticism [42]. These programs typically involve exercises that encourage self-kindness, mindfulness practices, and activities that foster a sense of shared

humanity. Research indicates that participants in self-compassion programs report lower levels of shame, greater emotional resilience, and improved quality of life [38]. In addition to improving individual recovery outcomes, self-compassion training has the potential to positively influence recovery communities by promoting a culture of empathy and support. When individuals in recovery adopt self-compassionate attitudes, they are more likely to extend compassion to others, fostering a supportive environment that benefits the entire community [52]. This collective empathy can enhance the effectiveness of recovery programs by creating an inclusive atmosphere where individuals feel valued and accepted, further reinforcing their commitment to recovery.

1.5 Personal Growth

Personal growth, as a psychological construct, is defined as the positive developmental process through which individuals achieve enhanced self-understanding, resilience, and a renewed sense of purpose, particularly after overcoming significant adversity [53]. Personal growth reflects the transformative journey individuals undergo as they rebuild their lives, reconnect with their values, and cultivate new strengths. As people move through recovery, they often undergo a reevaluation of their identity, developing a stronger sense of self-worth, responsibility, and purpose. Interpersonal relationships are redefined with an emphasis on trust, empathy, and genuine connection, replacing patterns of manipulation or isolation that may have existed during substance use.

Additionally, life priorities shift away from immediate gratification or escape and toward long-term goals, personal fulfillment, and meaningful contributions to family and society. This holistic transformation marks true growth in recovery, extending far beyond the physical cessation of substance use. Recovery can catalyze this growth, as individuals learn to adapt to new coping strategies, rebuild self-esteem, and embrace a more meaningful life [13]. Studies suggest that personal growth in recovery manifests through increased self-awareness, emotional resilience, and goal-setting abilities. The recovery journey often compels individuals to confront

and reassess aspects of their identity and past behaviors, prompting a reevaluation of their core values and beliefs. This self-reflective process encourages individuals to cultivate self-compassion and empathy, which are integral to personal growth [31]. Additionally, personal growth in recovery involves the development of new coping mechanisms and a proactive approach to managing stress and adversity, further contributing to emotional stability and resilience [54]. Ultimately, personal growth in recovery is characterized by a shift from a survival-oriented mindset to one focused on thriving, allowing individuals to create and pursue a life that aligns with their intrinsic values and aspirations.

Positive relationships and support systems are essential in facilitating personal growth for individuals in recovery. Recovery can be an isolating experience due to the social stigma associated with substance use, yet having a supportive network of family, friends, and peers helps individuals overcome feelings of shame and loneliness, creating a foundation for growth [26]. Supportive relationships foster a sense of belonging and acceptance which is essential for individuals as they work to reestablish their identities beyond addiction. Through these connections, individuals receive validation for their efforts, encouragement to persist, and guidance in navigating the challenges of recovery, all of which are instrumental in fostering personal growth [33]. Family support is particularly impactful in the recovery process. Family members who approach recovery with empathy and understanding contribute to the individual's sense of stability, reducing the stressors that frequently coexist with reintegration into society [55]. For instance, family therapy is often recommended in recovery programs to address relational conflicts and establish effective communication, thereby strengthening family bonds and creating a positive, nurturing environment that supports personal growth [47].

Families who actively engage in the recovery process help individuals feel valued and understood, which fosters self-confidence and a desire to rebuild their lives positively [25].

In addition to family, peer support groups serve as a unique form of social support that significantly contributes to personal growth in recovery. Peer support groups, such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA), provide a

non-judgmental space where individuals can share their experiences, challenges, and achievements with others who have faced similar struggles. These groups offer a sense of community that mitigates feelings of isolation, promoting personal growth by encouraging individuals to view their recovery journey as a shared experience rather than a solitary endeavor [35]. Within these groups, individuals are often encouraged to step into mentoring positions, helping others throughout their recovery process. This process of guiding and supporting peers not only reinforces personal accountability but also fosters a sense of purpose and self-worth, integral aspects of personal growth [28].

Therapeutic relationships with mental health professionals also contribute to personal growth in recovery by offering guidance, accountability, and skill-building. Therapists provide individuals with tools for emotional regulation, coping strategies, and a safe environment to explore their thoughts and emotions. Through counseling and therapeutic interventions, individuals develop insights into their patterns, emotional triggers, and underlying issues contributing to substance use. These insights are foundational for personal growth, as they enable individuals to gain control over their lives and make conscious choices that support their well-being and long-term recovery [51]. Additionally, therapy helps individuals reframe past experiences, reducing shame and guilt associated with substance use and encouraging a more compassionate self-view that fosters resilience and motivation for continued growth [48]. Community-based support programs, including recovery-focused organizations and local support networks, offer additional opportunities for personal growth. These programs provide resources, such as job training, educational support, and recreational activities, that support skill development and reintegration into society. Engaging in community activities allows individuals to rebuild social connections, regain self-confidence, and contribute positively to their communities, reinforcing their sense of purpose [36]. Community support also helps individuals establish routines and stability, essential for maintaining sobriety and fostering long-term personal growth [49]. Recent studies highlight that community involvement during recovery is associated with higher levels of life satisfaction and self-efficacy, indicators of personal growth [24]. Programs that promote community service and volunteerism empower individuals to

use their experiences constructively, transforming personal adversity into social contribution. This shift in focus from self-recovery to community impact not only strengthens personal growth but also fosters a renewed sense of identity, as individuals begin to view themselves as valuable contributors to society [26]. In this way, community-based support programs create a mutually reinforcing continuous development, as individuals who experience personal growth through community engagement are often motivated to assist others in similar situations.

Self-reflection and goal-setting are key components of personal growth in recovery. Recovery provides a unique opportunity for individuals to reassess their values, beliefs, and life goals, allowing them to realign their lives with their aspirations and intrinsic motivations. Self-reflection enables individuals to gain insight into the root causes of their substance use, the impact of their actions, and the changes needed to lead a more fulfilling life. This process fosters personal accountability, as individuals recognize their capacity to make conscious choices that support their well-being and growth [29]. By engaging in regular self-reflection, individuals can track their progress, identify areas for improvement, and maintain a proactive approach to personal development.

Goal-setting, often facilitated through counseling or peer support, further contributes to personal growth by providing individuals with a clear direction for their recovery journey. Setting realistic and meaningful goals, whether related to health, career, relationships, or personal interests, gives individuals a sense of purpose and motivation. Achieving these goals, even incrementally, enhances self-efficacy and self-esteem, reinforcing the belief that recovery is not only achievable but can also be a path to a fulfilling and purposeful life [51]. Goal-setting also fosters resilience, as individuals learn to adapt their goals to evolving circumstances, developing flexibility and perseverance in the face of challenges [37].

Individuals who experience personal growth report greater life satisfaction, improved mental health, and lower relapse rates, indicating that personal growth is a protective factor in sustaining recovery [52]. Through self-awareness, resilience, and purpose, individuals are better equipped to manage stress, cope with setbacks, and pursue positive life changes that assist their sobriety [39]. Personal growth

also fosters a sense of autonomy and independence, as individuals recognize their ability to shape their lives and achieve their goals, reducing their vulnerability to external pressures and triggers. In the context of SUD recovery, personal growth is not only a desired outcome but also a vital component of relapse prevention. By fostering a mindset focused on self-improvement and continuous learning, personal growth encourages individuals to seek new challenges, develop new skills, and build a life that aligns with their values and aspirations. This proactive approach to recovery reduces the appeal of substance use as a coping mechanism, as individuals gain confidence in their ability to handle life's challenges constructively [54]. Ultimately, personal growth in recovery represents a profound transformation, where individuals move beyond the limitations imposed by addiction and embrace a future defined by resilience, self-fulfillment, and hope.

1.6 Self-Compassion and Personal Growth as Mediators

In recovery from substance use disorders (SUDs), social support plays a crucial and well-documented role in enhancing an individual's quality of life (QoL). It serves as a protective factor against relapse and provides emotional, psychological, and sometimes even practical resources that help individuals navigate the challenges of recovery. Support from family, friends, peers, and structured groups such as 12-step programs fosters a sense of belonging, reduces feelings of isolation, and helps rebuild trust and self-esteem—elements often eroded during active substance use. Moreover, positive social connections can reinforce healthy behaviors, encourage accountability, and offer hope and motivation for sustained recovery. By creating a stable, empathetic environment, social support contributes not only to sobriety but to improved emotional well-being, life satisfaction, and reintegration into society—key aspects of overall QoL. However, recent research highlights that the impact of social support on QoL is often mediated by factors like self-compassion and personal growth. These mediators help translate social support into psychological and emotional resilience, enabling individuals to experience greater benefits from

supportive relationships. Self-compassion, defined as treating oneself with kindness and understanding during times of struggle, allows individuals in recovery to view themselves without judgment, reducing shame and promoting self-acceptance [43]. Personal growth, on the other hand, refers to the development of positive psychological traits and self-concept as individuals overcome adversity, building resilience and self-worth in the process [45]. Together, self-compassion and personal growth create an internal foundation that strengthens the impact of social support, enhancing QoL. The interaction between social support, self-compassion, and personal growth is essential for sustained recovery. Social support provides a sense of belonging, emotional validation, and practical assistance critical for initial recovery. However, the internalization of this support is often facilitated through self-compassion and personal growth. Self-compassion, for example, enables individuals to accept support without self-judgment, while personal growth encourages them to use this support as a basis for developing independence and self-efficacy [55]. These mediating factors contribute to a higher QoL by enhancing individuals' coping mechanisms, emotional resilience, and sense of fulfillment, transforming the benefits of social support into long-term personal outcomes [22]. Self-compassion plays a significant role in translating social support into improved QoL for individuals in recovery. Social support provides external affirmation and reduces isolation for mental health and emotional well-being. Self-compassion, however, enables individuals to internalize this external support, transforming it into a sustainable, self-driven source of strength. Research indicates that individuals with high levels of self-compassion have a greater capacity to manage negative emotions, reduce self-stigmatization, and maintain a balanced outlook on their recovery journey [28]. By fostering self-kindness, individuals learn to accept setbacks as part of the recovery process rather than as personal failures, which prevents the onset of shame and guilt that often accompany relapse [46].

Additionally, self-compassion enhances emotional regulation, allowing individuals to respond to stressors and emotional triggers with calmness and resilience. This emotional stability is critical for QoL, as it enables individuals to engage in meaningful relationships, pursue personal goals, and maintain sobriety without being overwhelmed by self-doubt or negative self-perception. According to a study by

[35], individuals who practice self-compassion experience greater overall life satisfaction and an increased likelihood to report positive emotions in daily life. This improved emotional state, in turn, increases the effectiveness of social support, as individuals feel worthy of the care they receive, further reinforcing their commitment to recovery and well-being [41].

Personal growth is another essential mediator that strengthens the relationship between social support and QoL. Recovery from SUDs often requires individuals to redefine their identity, develop new coping mechanisms, and cultivate a renewed sense of purpose. Social support facilitates this transformation by providing the validation and encouragement needed to pursue personal development. However, personal growth enables individuals to internalize the benefits of social support, transforming it into self-efficacy, resilience, and self-awareness [52]. These qualities are vital for long-term recovery, as they empower individuals to navigate life independently, fostering a sense of control and fulfillment that enhances QoL.

Through personal growth, individuals gain insight into their strengths, values, and aspirations, which fosters a proactive approach to recovery. For example, [20] found that individuals who reported high levels of personal growth in recovery also demonstrated increased resilience and a stronger sense of autonomy.

This growth-oriented mindset reduces reliance on external validation, as individuals learn to derive motivation from their internal goals rather than external sources. As a result, they are more likely to sustain their recovery efforts and maintain a high QoL, as they experience fulfillment and meaning beyond sobriety [56]. By encouraging individuals to embrace change and pursue self-actualization, personal growth works as a powerful mediator that maximizes the impact of social support, creating a robust foundation for long-term well-being. Empirical studies provide robust evidence on the mediating roles of self-compassion and personal growth in recovery, highlighting their impact on QoL. For instance, [48] conducted a study on individuals in recovery from SUDs, finding that self-compassion significantly reduced feelings of shame and guilt, which contributed to improved mental health and QoL. This study demonstrated that self-compassion helped participants internalize the help they received from friends and family, transforming it into a

positive self-view that enhanced their overall well-being. Similarly, [44] found that personal growth mediated the relationship between social support and life satisfaction in recovery, as individuals who reported higher levels of personal growth were better able to cope with stress and setbacks without relapsing. Another study by [37] explored the combined effects of self-compassion and personal growth, finding that these mediators amplified the impact of social support on QoL. Participants who scored high in self-compassion and personal growth demonstrated greater resilience, adaptability, and life satisfaction than those with lower scores. This finding supports the notion that self-compassion and personal growth operate synergistically, enabling individuals to fully leverage the benefits of social support, thereby enhancing QoL. Together, these studies underscore the importance of fostering self-compassion and personal growth in recovery programs, as they play a crucial role in translating social support into sustainable, positive outcomes.

1.7 Developing Self-Compassion and Personal Growth Through Recovery Programs

Through mediating roles, many recovery programs now focus on cultivating self-compassion and personal growth as part of a holistic approach to treatment. Mindfulness-based interventions, for example, are widely used to promote self-compassion, encouraging individuals to approach their thoughts and emotions with acceptance rather than judgment [42]. These interventions help individuals manage cravings, reduce emotional distress, and build a compassionate relationship with themselves, all of which contribute to long-term QoL improvements. By teaching individuals to view their recovery journey as an opportunity for growth rather than a source of shame, mindfulness practices foster a resilient, self-compassionate mindset that enhances the benefits of social support [57]. Personal growth is also promoted in recovery programs through goal-setting, counseling, and peer mentorship. These activities encourage individuals to set meaningful personal goals, explore their values, and develop a positive self-concept that aligns with their recovery aspirations. According to [35], individuals in recovery who

engage in structured goal-setting report higher levels of life satisfaction, resilience, and self-efficacy, suggesting that personal growth activities directly contribute to improved QoL.

Peer mentorship further reinforces personal growth by allowing individuals to share their experiences and support others, fostering a sense of purpose and community. As individuals take on mentorship roles, they develop greater confidence and self-worth, which enhance the positive effects of social support on QoL [40].

1.8 Rationale of the Study

Substance Use Disorders (SUDs) remain a pervasive public health issue in Pakistan, with profound implications for individuals' physical, psychological, and social well-being. Existing interventions, such as detoxification and rehabilitation services, are critical in addressing acute substance dependence. However, the post-treatment phase, marked by long-term recovery and quality-of-life concerns, remains a significant challenge. Individuals discharged from primary treatment often encounter difficulties in maintaining sobriety, reintegrating into society, and enhancing their quality of life. These challenges underscore the importance of understanding psychological and social factors that influence sustained recovery, including self-compassion and personal growth. Social support is a critical factor influencing recovery outcomes in individuals with SUDs.

Emotional, instrumental, and informational support from family, friends, and community networks significantly buffers the stress associated with recovery and enhances resilience. Research has demonstrated that robust social support networks reduce relapse risk, improve recovery trajectories, and foster a sense of belonging and shared responsibility. In Pakistan's collectivist cultural context, social support assumes even greater importance.

Family dynamics, including strong spousal and familial support, have been linked to better recovery outcomes, while dysfunctional family environments are associated with higher relapse rates. Thus, the interplay between social support, quality

of life, self-compassion, and personal growth warrants comprehensive exploration to inform tailored interventions in the Pakistani setting. Self-compassion, characterized by treating oneself with kindness during challenging times, and personal growth, involving the ongoing effort to enhance individual skills and qualities, play pivotal roles in the recovery journey. These constructs provide internal psychological resources to cope with stress and relapse triggers, fostering resilience and long-term sobriety. Despite their significance, the relationships between self-compassion, personal growth, and quality of life among individuals with SUDs in Pakistan have not been extensively studied. This gap in the literature highlights the need to examine these associations, particularly among individuals transitioning from intensive treatment to follow-up care.

The interconnection between self-compassion, personal growth, social support, and quality of life is critical for understanding sustained recovery in individuals with SUDs. Self-compassion mitigates the self-critical attitudes that often accompany addiction and relapse, fostering resilience. On the other hand, Personal growth provides individuals the motivation and tools to rebuild meaningful lives post-treatment. Together with social support, these constructs create a holistic framework that addresses internal psychological mechanisms and external relational dynamics essential for successful reintegration into society and long-term sobriety.

This research emphasizes the complementary roles of these variables in fostering recovery. Self-compassion and personal growth focus on internal resilience and adaptability, while social support provides the external framework for emotional and relational stability. The synergy between these constructs offers a comprehensive understanding of the factors contributing to the quality of life among individuals recovering from SUDs in Pakistan. This understanding in a cultural context that values community and familial ties, significantly impacts recovery outcomes. To address these research needs effectively, it is essential to employ culturally and linguistically appropriate assessment tools. Many existing scales for measuring self-compassion, personal growth, and quality of life have been developed in Western contexts which do not fully capture the cultural nuances of the Pakistani

population. Translating these tools into Urdu ensures their relevance and validity while enabling their immediate application in clinical and research settings. Cultural adaptation of these measures enhances their reliability, providing more accurate assessments and facilitating the development of targeted interventions.

By focusing on the translation and cultural adaptation of these assessment tools, this research seeks to bridge the gap between Western-developed constructs and their application in the Pakistani context. This approach not only improves the accuracy of data collection but also supports the design of interventions that address the unique cultural and linguistic needs of individuals recovering from SUDs. Ultimately, these efforts are expected to enhance recovery outcomes, reduce relapse rates, and contribute to a more nuanced understanding of the psychological and social determinants of quality of life in this population.

1.9 Theoretical Framework

The theoretical framework for this study is built upon Social Support Theory and Self-Compassion Theory [3], which collectively provide a foundation for understanding the interrelationships among self-compassion, personal growth, social support, and quality of life in individuals recovering from SUDs. Social Support Theory emphasizes the role of emotional, informational, and practical assistance as critical protective factors that play a role in emotional stability and recovery. Social support, provided by family, friends, and community networks, enhances resilience, reduces stress, and facilitates recovery [58]. It serves as a buffer against relapse and provides individuals with the encouragement and resources necessary to navigate the challenges of post-treatment reintegration into society. On the other hand, Self-Compassion Theory highlights the importance of self-kindness, mindfulness, and the recognition of shared humanity in fostering emotional resilience and personal growth. Self-compassion enables individuals to confront difficulties without excessive self-criticism or feelings of isolation, promoting adaptive coping strategies and psychological well-being [59]. This inward focus on treating oneself with understanding and care is particularly beneficial for individuals recovering

from SUDs, as it helps mitigate the feelings of guilt, shame, and inadequacy that often accompany addiction and relapse.

Integrating these two theories provides a holistic perspective on the recovery process. Social support serves as an external resource that enhances emotional and practical stability, while self-compassion acts as an internal psychological mechanism that facilitates personal growth and emotional resilience. The interplay between these constructs suggests that self-compassion and personal growth mediate the relationship between social support and quality of life. Specifically, individuals with higher levels of self-compassion are better equipped to effectively utilize social support, which in turn fosters personal growth and enhances their overall well-being.

This integration is particularly relevant in the Pakistani context, where cultural values such as collectivism and familial ties significantly influence recovery outcomes. The theoretical framework not only underscores the importance of social support in recovery but also highlights the need to nurture self-compassion and personal growth to achieve sustained recovery and improved quality of life.

1.10 Conceptual Framework

The conceptual framework for this study is constructed to examine the complex and interrelated dynamics among social support, self-compassion, personal growth, and quality of life (QoL) in individuals recovering from Substance Use Disorders (SUDs). At the core of this framework is the understanding that recovery is a multifaceted and deeply personal journey, influenced not only by individual psychological factors but also by the broader social environment.

Social support is positioned as the independent variable, encompassing the emotional, informational, and instrumental assistance received from family members, friends, peers, and community-based networks. This support system plays a pivotal role in promoting stability and resilience during the recovery process. Emotional support may include expressions of empathy and care, while informational

support refers to guidance and advice that aid in problem-solving, and instrumental support includes tangible help such as housing, transportation, or financial aid. Together, these forms of support can reduce stress, enhance coping strategies, and create a sense of connectedness, all of which are essential in maintaining sobriety and rebuilding one's life.

Within the framework, self-compassion and personal growth are conceptualized as mediating variables that help explain how and why social support influences overall QoL. Self-compassion—defined by self-kindness, mindfulness, and a recognition of common humanity—can foster emotional healing by allowing individuals to treat themselves with patience and forgiveness rather than shame or self-criticism, which are often heightened during recovery. Personal growth reflects the internal transformation individuals undergo during recovery, including improved self-awareness, a redefinition of life goals, and a renewed sense of purpose.

Quality of life is the dependent variable, representing the overall well-being and satisfaction with life domains such as physical health, psychological state, social relationships, and environmental conditions. The framework proposes that higher levels of social support contribute to increased self-compassion and personal growth, which in turn enhance quality of life. This model allows for a nuanced exploration of the pathways through which recovery-supportive mechanisms operate and offers a foundation for developing targeted interventions that address not only substance use but also the holistic well-being of individuals in recovery.

Self-compassion and personal growth are two mediators in this study. Self-compassion functions as a mediating variable, enabling individuals to process and internalize the benefits of social support effectively. It encompasses the ability to treat oneself with kindness, maintain mindfulness, and recognize shared humanity, reducing self-criticism and fostering emotional stability. Similarly, personal growth acts as a second mediator, reflecting the active efforts individuals make to rebuild their lives, enhance their skills, and set meaningful goals. Personal growth is a critical indicator of psychological transformation and life restructuring during recovery, serving as a bridge between social support and improved quality of life. The outcome of this framework is quality of life, the dependent variable, which reflects the

holistic well-being of individuals in recovery. Quality of life encompasses physical, emotional, and social dimensions, highlighting the extent to which individuals maintain sobriety, achieve life satisfaction, and successfully reintegrate into society. This framework underscores the interplay between external social resources and internal psychological mechanisms, illustrating how self-compassion and personal growth mediate the relationship between social support and quality of life. By focusing on these interconnected constructs, the framework provides a comprehensive understanding of the factors that help shape sustained recovery in the sociocultural context of Pakistan.

1.11 Objectives

Keeping in view the literature review on social support, quality of life, self-compassion and personal growth in individuals recovered with SUDs, the present research focused on the following objectives:

To investigate the relationship between Social Support, Quality of Life, Self-Compassion, and Personal Growth in individuals recovered with SUDs. Investigate the mediating role of Self-Compassion and Personal Growth in the association between social support and quality of life in individuals recovered from SUD.. To examine differences in Social Support, Quality of Life, Self-Compassion, and Personal Growth across demographic characteristics (ie., gender, level of education and type of substance used) in individuals recovered with SUDs.

1.12 Hypotheses

The following hypotheses were formulated on the basis of the above-mentioned objectives:

1. There would be a significant positive association between Social Support and Quality of Life in individuals recovered with SUDs.

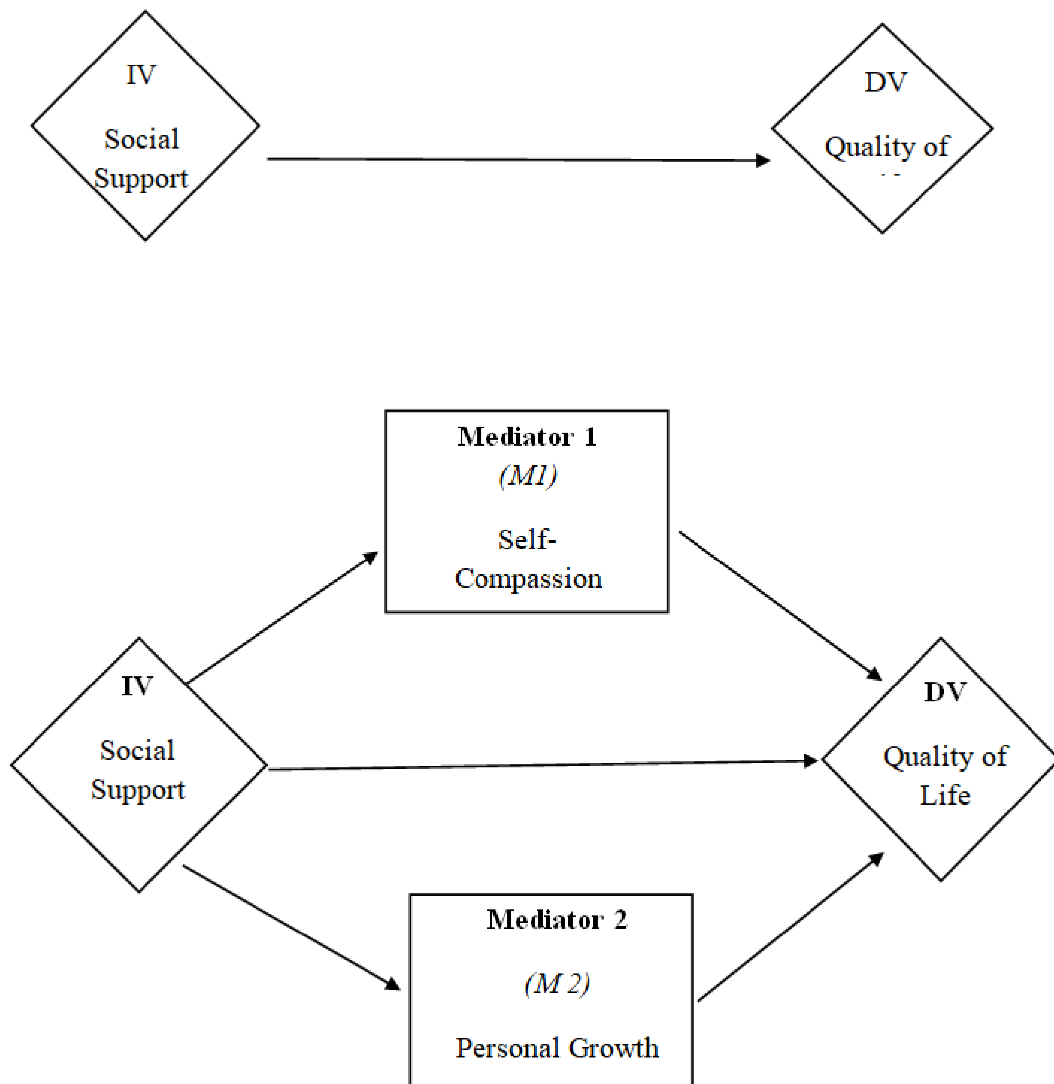

FIGURE 1.1: Conceptual framework of the present study.

2. There will be a significant positive relationship between Social Support and Self-Compassion in individuals recovered with SUDs.

3. There will be a significant positive relationship between Social Support and Personal Growth in individuals recovered with SUDs. There will be a significant positive relationship between Self-Compassion and Personal Growth in individuals recovered with SUDs. There will be a significant positive relationship between Self-Compassion and Quality of Life in individuals recovered with SUDs.

4. There will be a significant positive relationship between Personal Growth and Quality of Life in individuals recovered with SUDs.

5. Self-Compassion and Personal Growth will mediate the relationship between Social Support and Quality of Life in individuals recovered with SUDs.

6. Females in recovery from SUDs will report higher levels of Social Support, Quality of Life, Self-Compassion, and Personal Growth compared to males in recovery.

7. Individuals with higher levels of education will report greater Social Support, Quality of Life, Self-Compassion, and Personal Growth compared to those with lower levels of education.

8. Individuals who have recovered from SUDs will show significant differences in Social Support, Quality of Life, Self-Compassion, and Personal Growth based on the type of substance used.

Chapter 2

Literature Review

Social support is a critical determinant of quality of life (QoL) in individuals recovering from substance use disorders (SUDs), with recent research emphasizing the mediating roles of self-compassion and personal growth in this relationship [60, 61]. Grounded in frameworks like Stress and Coping Theory, social support fosters resilience by buffering stress and enhancing emotional well-being [62]. Self-compassion, characterized by self-kindness and mindfulness, further promotes adaptive coping and emotional resilience, contributing significantly to QoL improvements [63]. [64], conducted a longitudinal study with 325 participants and found that self-compassion fully mediated the relationship between social support and QoL, with personal growth reinforcing recovery by reducing relapse risk [64]. However, existing studies often rely on convenience sampling, neglect cultural variables, and focus predominantly on adult populations, limiting generalizability. Future research should explore cross-cultural dynamics, diverse age groups, and the integration of qualitative insights to develop holistic recovery frameworks tailored to varied contexts [64, 60, 63]. A study conducted in 2022 investigated the mediating roles of self-compassion and personal growth in the relationship between social support and quality of life (QoL) among individuals recovering from substance use disorders (SUDs). In a cross-sectional study with 450 participants, validated tools such as the Self-Compassion Scale (SCS) and the Quality of Life Inventory (QOLI) were used to measure the variables. The results demonstrated that

self-compassion partially mediated the positive impact of social support on QoL, while personal growth independently predicted improved outcomes, highlighting the multidimensional nature of recovery. Despite these significant findings, the study faced limitations, including reliance on self-reported data and the inability to establish causality due to its cross-sectional design. The authors emphasized the need for longitudinal research to confirm these pathways and explore diverse population dynamics [65].

A study of 2023 conducted a mixed-methods study to examine the relationship between social support, self-compassion, and quality of life (QoL) in individuals recovering from substance use disorders (SUDs). The study analyzed survey responses from 300 participants and complemented these with in-depth interviews from 25 individuals, providing quantitative and qualitative insights.

Results indicated that self-compassion partially mediated the positive impact of social support on QoL, the qualitative data emphasized personal growth as a dynamic and evolving recovery process rooted in lived experiences. Despite its strengths, including the comprehensive mixed-methods design, the study's preprint status, limited sample size for qualitative data, and underrepresentation of cultural diversity highlight the need for further validation and broader generalizability.

The findings contribute to understanding the multidimensional nature of recovery but call for future research employing longitudinal designs and diverse populations [66]. Carter and his colleagues in 2021 investigated how self-compassion and personal growth mediate the relationship between social support and quality of life (QoL) in individuals recovering from substance use disorders (SUDs). Their mixed-methods study of 400 participants combined quantitative tools, such as the Self-Compassion Scale and WHO Quality of Life-BREF, with qualitative insights to capture the nuanced interplay of these factors. The findings revealed that self-compassion significantly mediated the positive effects of social support on QoL, while personal growth provided an independent pathway for improvement. Participants with strong social support reported transformative recovery experiences, such as reframing negative self-perceptions and developing resilience. However, the study's cross-sectional nature limited causal inference, and its homogenous

sample reduced generalizability. The authors called for longitudinal research to validate these findings and expand them to diverse populations [67].

Social support, self-compassion, and personal growth are critical factors influencing the quality of life (QoL) in individuals recovering from substance use disorders (SUDs). Social support provides emotional, instrumental, and informational resources, fostering adaptive functioning and reducing relapse risks, as shown by Thompson and Reyes (2021). Self-compassion, characterized by self-kindness and mindfulness, mediates the impact of social support on QoL, while personal growth enables individuals to derive meaning and resilience from recovery experiences [68]. A study conducted in 2019 demonstrated that individuals with robust social support networks often redefined their identity through self-compassion and personal growth, emphasizing their role in sustained recovery. However, limitations in existing studies, such as cross-sectional designs and reliance on self-reported data, highlight the need for longitudinal research to establish causality and explore diverse populations [62, 69]. Addressing these gaps can inform holistic recovery frameworks, integrating social and psychological dimensions to enhance interventions. In 2019 Smith and his colleagues examined the roles of self-compassion and personal growth as mediators between social support and quality of life (QoL) among individuals recovering from substance use disorders (SUDs). Using a mixed-methods approach with 350 participants, the study employed tools like the Self-Compassion Scale and WHOQoL-BREF to measure key variables. Findings revealed that self-compassion significantly mediated the positive effects of social support on QoL, while personal growth enhanced resilience and recovery outcomes. Qualitative insights highlighted identity transformation and self-acceptance as key aspects of recovery for individuals with robust social support networks. However, the study's reliance on cross-sectional data and self-reported measures limited its ability to infer causality, underscoring the need for longitudinal research to validate these findings across diverse populations [62]. A study conducted in 2020 explored how self-acceptance, self-compassion, and loving connections mediate the relationship between social support and quality of life (QoL) in individuals recovering from substance use disorders (SUDs). Using a mixed-methods design with 400 participants, the study employed validated tools such as the Self-Compassion Scale

and the Loving Connection Inventory to evaluate key psychological constructs. Findings revealed that self-compassion significantly mediated the impact of social support on QoL, with higher levels of self-acceptance and self-compassion fostering greater personal growth, emotional resilience, and improved interpersonal relationships. The qualitative analysis emphasized the transformative role of loving connections in fostering self-acceptance and relational well-being. However, the study's cross-sectional design limited causal inferences, and its focus on a single cultural context reduced generalizability. The authors recommended longitudinal and cross-cultural research to deepen understanding and validate these dynamics [70].

Anderson and his colleagues in 2023 conducted a longitudinal study with 500 participants to investigate how self-compassion and personal growth mediate the relationship between social support and quality of life (QoL) in individuals recovering from substance use disorders (SUDs). Using validated tools like the Self-Compassion Scale and Quality of Life Inventory, the study revealed that self-compassion partially mediated the positive effects of social support on QoL, on the other hand, personal growth independently contributed to resilience and life satisfaction. Strong social support networks were associated with increased self-compassion, fostering adaptive coping, and reduced emotional distress. However, the study was limited by a predominantly urban sample, raising concerns about the generalizability of findings to rural populations. The authors recommended more diverse and culturally inclusive studies and called for the examination of under-examined factors like digital social support [71]. A study in 2023 investigated how self-compassion and personal growth mediate the relationship between social support and quality of life (QoL) in individuals recovering from substance use disorders (SUDs). Using a mixed-methods approach with 450 participants, the study combined quantitative tools, such as the Self-Compassion Scale and WHOQoL-BREF, with qualitative interviews. Findings revealed that self-compassion partially mediated the effects of social support on QoL, while personal growth was a significant driver of resilience and long-term satisfaction in recovery. Qualitative data underscored the importance of sustained social connections in reducing self-stigma and fostering self-growth. However, the reliance on self-reported measures and a

focus on urban recovery settings limited the study's generalizability to rural populations. The authors recommended further exploration of digital social support and longitudinal studies to understand the temporal dynamics of these mediators [72].

A study examined in 2015 explored the relationship between social support, self-compassion, and quality of life (QoL) in individuals recovering from substance use disorders (SUDs). Utilizing a mixed-methods approach with 400 participants, this study found that self-compassion partially mediated the impact of social support on QoL, while personal growth was critical for sustaining long-term recovery. Qualitative data revealed that supportive relationships helped reduce shame and promote self-acceptance, which enables personal growth. Despite its strengths, the use of qualitative insights, the study's reliance on self-reported measures, and its cross-sectional design limited causal inferences. The authors emphasized the need for longitudinal research to validate these relationships and highlighted the importance of studying diverse populations to improve generalizability [61]. Social support significantly enhances the quality of life (QoL) in individuals recovering from substance use disorders (SUDs) by fostering motivation, resilience, and healthy coping strategies while reducing stress and isolation [73].

Furthermore, mediators such as self-compassion or personal growth, respectively, can be said to increase the benefits by decreasing self-criticism and supporting the reconstruction of an identity. However, gaps persist in understanding long-term outcomes, cultural variations, and the role of digital platforms. Future research should explore these areas to develop holistic, culturally sensitive interventions [74].

[58] reported that Social support, self-compassion, and personal growth play a pivotal role in enhancing the quality of life (QoL) for individuals recovering from Substance Use Disorders (SUDs). Research highlights that social support fosters emotional and practical assistance, facilitating identity reconstruction and reducing relapse risk. The Social Identity Model and Personal Construct Psychology provide robust frameworks for understanding these dynamics. Self-compassion mediates the relationship between social support and QoL by mitigating self-criticism

and enhancing resilience, while personal growth offers renewed purpose and intrinsic motivation for sustained recovery. However, gaps in the literature remain, including the need for culturally sensitive approaches, exploration of digital support communities, and longitudinal assessments of mediators like self-compassion and personal growth. Addressing these gaps can inform holistic recovery interventions, thereby improving long-term outcomes for individuals recovering from SUDs [75, 58, 76].

A study conducted in 2015 by Cavailola and his colleagues explored that Social support significantly enhances the quality of life (QoL) in individuals recovering from substance use disorders (SUDs), acting through mediators like self-compassion and personal growth. While social networks foster emotional resilience and abstinence, constructs like self-compassion reduce shame and encourage adaptive coping, and personal growth adds purpose and meaning to recovery. Despite evidence supporting these relationships, limitations such as sample homogeneity and reliance on self-reported data necessitate broader, diverse studies. Future research should focus on integrative models and targeted interventions to further elucidate these dynamics and optimize recovery outcomes [3, 53]. The interplay between social support, quality of life, self-compassion, and personal growth is crucial in understanding recovery from substance use disorders (SUDs). Social support, encompassing emotional and instrumental aid, significantly predicts quality of life, as evidenced by studies highlighting its role in mitigating stress and improving psychological health [77]. Self-compassion acts as a mediator, fostering emotional resilience and reducing relapse rates through adaptive coping mechanisms [78, 79]. Similarly, personal growth, grounded in the Post-Traumatic Growth framework, enhances resilience and agency, contributing to sustained recovery [80].

However, the literature faces limitations, including cross-sectional designs, small sample sizes, and a lack of longitudinal studies. Future research should adopt diverse methodologies and explore underrepresented populations to develop holistic recovery frameworks that integrate these constructs effectively.

The study conducted in 2020 explained that recovery from substance use disorders (SUDs) is influenced by social support, self-compassion, and personal growth,

which collectively enhance the quality of life and promote sustained recovery. Social support mitigates stress, boosts abstinence-specific self-efficacy, and improves psychological well-being, with massive networks correlating with reduced stress and better recovery behaviors [81, 77]. Self-compassion fosters emotional resilience and adaptive coping, mediating the relationship between perceived social support and psychological well-being [78, 79]. Personal growth conceptualized through the framework of post-traumatic growth, enhances resilience and a sense of purpose, further supporting recovery [82, 17]. Despite these insights, gaps persist in integrating these constructs into diverse populations and longitudinal studies. Addressing these limitations can inform more holistic recovery frameworks and personalized interventions. Social support seems to be the strongest predictor in improving the life quality and recovery results of patients recovering from substance use disorders (SUD) with self-compassion and personal development towards which they grow as being the most important variables. Support from other members of the community like family includes emotional, informational, and instrumental support and this lessens the stress and enhances psychology thus making recovery possible. Self-compassion is a construct that involves self-kindness, self-mindfulness, and a feeling of common humanity. This helps to decrease self-blame and develop emotion regulation which is required for good recovery [3, 83]. Also, supportive networks are reported to be important for self-discovery and life purpose which also fosters engagement with realistic goals after recovery. However, despite these findings, some deficits are inherited, particularly in areas related to culture and fundamental concepts like resilience and spirituality. Future studies should adopt longitudinal and multi-ethnic while incorporating intervention methods to enhance the understanding of these mediators within the SUD recovery context.

Chapter 3

Research Methodology

3.1 Research Design

This study employed a cross-sectional correlational research design to investigate the associations among social support, quality of life, self-compassion, and personal growth in individuals who have recovered from Substance Use Disorders (SUDs). The cross-sectional component of the design enabled researchers to gather data from participants at a single point in time, making it possible to capture a comprehensive snapshot of the relationships among these variables within the target population. This approach is efficient for examining psychological and social constructs without requiring long-term follow-up, which can be particularly challenging in populations with complex health histories.

The correlational aspect of the design was instrumental in analyzing both the direction (positive or negative) and strength (weak, moderate, or strong) of the relationships between the variables. Rather than attempting to establish causal links, this method was used to reveal patterns of association that could inform future longitudinal or experimental research. By identifying meaningful correlations, the study aimed to shed light on how external factors, such as perceived social support, and internal psychological traits, like self-compassion, may work together to influence an individual's quality of life and capacity for personal growth following recovery from SUDs.

This design was well-aligned with the objectives of the study, as it enabled the exploration of multidimensional psychological and social dynamics within a culturally and contextually relevant framework. Given the complex nature of recovery, especially in diverse sociocultural settings, a cross-sectional correlational approach provided a useful foundation for understanding how supportive environments and intrinsic resilience mechanisms contribute to sustainable recovery and enhanced well-being. The findings from this design can offer valuable implications for developing interventions and support systems tailored to the needs of individuals in recovery.

3.2 Sample

A purposive sampling technique was used to select participants due to their accessibility and relevance to the study objectives. The sample consisted of 302 individuals recovered with Substance Use Disorders, recruited from rehabilitation centers in Rawalpindi and Islamabad, Pakistan. These centers were chosen to ensure access to a diverse population of individuals who had successfully undergone treatment for substance use and were in various stages of recovery. The sample included both males and females, aged 15 to 35 years, individuals over the age of 35 are at a higher risk of developing comorbid conditions, which may confound the study variables and outcomes [84]. The sample size was determined using G^* Power analysis. The input parameters for calculating the sample size were as follows: one-tailed test, effect size ($|\ p\ |$) = 0.2, α error probability = 0.05, and power $(1-\beta) = 0.95$. The resulting output parameters were: non-centrality parameter $(\delta) = 3.30$, critical $t = 1.65$, degrees of freedom $(df) = 260$, and total sample size = 302.

In accordance with the objectives and requirements of the study, the selection of samples was carried out based on specific inclusion and exclusion criteria. These criteria were carefully defined to ensure the relevance, reliability, and consistency of the data collected. The inclusion criteria outlined the essential characteristics that participants or samples needed to possess in order to be considered eligible

for the study. Conversely, the exclusion criteria identified the characteristics or conditions that would disqualify certain individuals or samples from participation, primarily to minimize potential confounding factors and to maintain the internal validity of the research.

3.2.1 Inclusion criteria

Individuals aged 15 to 35 years who had successfully completed treatment for substance use, possessed the ability to read and understand Urdu, and were willing to provide informed consent were included in the sample.

3.2.2 Exclusion criteria

To ensure the integrity and reliability of the data, specific exclusion criteria were applied when selecting participants for this study. Individuals diagnosed with severe psychiatric disorders other than Substance Use Disorders (SUDs)—such as schizophrenia, bipolar disorder with psychotic features, or major depressive disorder with active suicidality—were excluded to reduce the confounding effects of comorbid psychopathology on psychological constructs like self-compassion, social support, and quality of life.

Additionally, participants who were currently undergoing detoxification or experiencing acute withdrawal symptoms were not included in the sample, as their physical and emotional states during this critical phase of treatment might impair their ability to provide accurate and stable responses to assessment tools. The exclusion of these individuals was essential to ensure that data reflected the more stable phases of recovery rather than transient distress or crisis states. Furthermore, individuals with cognitive impairments—whether due to neurological conditions, developmental delays, or substance-induced cognitive deficits—were also excluded if such impairments interfered with their capacity to comprehend and respond meaningfully to the questionnaires. This decision was made to maintain the validity and reliability of the self-report data used in the study. Lastly,

individuals who had relapsed into substance use within the last three months were excluded, as the study aimed to assess psychological and social variables in the context of sustained recovery. Recent relapse could introduce variability in mood, cognition, and behavior that would compromise the study's focus on individuals who are actively engaged in the recovery process.

3.3 Procedure

The sample for the present study was recruited in two distinct phases, aligning with the dual objectives of the research: the translation and validation of research instruments, followed by full-scale data collection.

In the first phase, emphasis was placed on adapting the study instruments for cultural and linguistic appropriateness.

This involved the systematic translation of the original scales into Urdu using standard procedures such as forward and backward translation, expert review, and linguistic validation.

A pilot study was then conducted with a small representative sample to assess the reliability, clarity, and cultural relevance of the translated instruments. Feedback obtained during this phase informed necessary revisions, ensuring that the tools were both psychometrically sound and contextually appropriate for the target population.

The second phase of the study focused on the main data collection process. Participants were recruited from various addiction treatment centers located in Rawalpindi and Islamabad, ensuring that the sample comprised individuals who had received treatment for Substance Use Disorders (SUDs).

This phase aimed to gather comprehensive data using the validated Urdu versions of the research instruments, facilitating accurate assessment and analysis of the variables under investigation. The two-phased approach not only strengthened the methodological rigor of the study but also ensured that the data collected was

both reliable and culturally contextualized, thereby enhancing the overall validity of the research findings.

3.3.1 Phase-I

The first phase involved the translation of study instruments into Urdu using a systematic forward and backward translation method which was conducted twice. The first translation was reviewed and refined based on expert feedback, and a second phase of translation was done to enhance the reliability and cultural relevance of the scales.

After translation, to identify suitable individuals for pilot testing, two rehabilitation centers of Islamabad were contacted, including The New Inception Rehabilitation Center for Women (TNI), Islamabad and Sun Rise Rehabilitation Center for Men (SRR), Islamabad. Pilot testing was conducted with a sample of 10 individuals (both male and female) received treatment at these facilities. The purpose of the pilot study was to assess the clarity, reliability, and cultural relevance of the translated scales. Participants provided feedback on any difficulties they faced in understanding the items. Based on their responses, minor modifications were made to improve the accuracy and relevance of the scales before moving to the main study.

3.3.2 Phase-II

The second phase involved the collection of data from rehabilitation centers in Rawalpindi and Islamabad. Before starting data collection, Written approval was obtained from The Department of Capital University of Science and Technology, Islamabad (Appendix A) to ensure adherence to ethical guidelines. Afterwards written permission forms were obtained from the administrative authorities of IRADA rehab center, Rawalpindi, The New Inception Rehabilitation Center for Women (TNI), Islamabad, New Hope Rehab and psychological health care center (NHR), Islamabad, New Life Rehab, Islamabad, Islamabad Rehab center and

Sun Rise Rehabilitation Center for Men (SRR), Islamabad (Appendix B). Participants who met the inclusion criteria were selected and were informed about the study's objectives and procedures. They were assured that their participation was voluntary, their responses would remain confidential, and the data would be used only for research purposes. Written informed consent was obtained from all participants.

Participants were given clear instructions to complete the questionnaires and were encouraged to answer all items carefully. Adequate time was provided to ensure that participants could complete the questionnaire without any pressure. If a participant had difficulty understanding any item, explanations were provided in Urdu while maintaining the original meaning.

3.4 Instruments

3.4.1 Information Sheet

The demographic section of the questionnaire was designed to gather comprehensive background information about each participant, enabling a more nuanced understanding of the sample's characteristics and allowing for potential subgroup analyses. This section included a range of items aimed at capturing key personal, familial, and socio-economic variables. Specifically, participants were asked to report their age, gender, and religion, which provided basic identity markers often relevant in understanding patterns of substance use and recovery experiences. The questionnaire also inquired about their current occupation, offering insights into employment status and levels of social integration post-rehabilitation.

To assess the influence of familial and cultural background, participants were asked about their family system—whether they belonged to a nuclear or joint family structure—as such systems may play a significant role in shaping social support dynamics. The type(s) of substances used prior to treatment were also documented to categorize the nature and severity of the participants' substance

use histories. Further demographic variables included marital status, which can influence both the availability of social support and emotional well-being, and socio-economic status, which was assessed through self-reported indicators such as income bracket and housing conditions. Additionally, the questionnaire collected information about the occupational status and educational level of the participants' parents, as these are often associated with early life conditions and may have a bearing on vulnerability to substance use disorders.

By collecting these detailed demographic variables, the study aimed to contextualize the participants' recovery journeys and examine how various personal and social factors may interact with key psychological constructs such as social support, self-compassion, personal growth, and overall quality of life.

Social Support Scale. In the present study SSS was used to measure social support in individuals recovered with SUDs. It provides accurate evaluation of social support across different domains. It is used to assess the extent to which an individual utilizes social support as a coping mechanism in various life circumstances. It evaluates four social support functions: instrumental, informational, emotional and appraisal support, including 28 items which are rated on 6-point Likert type scale ranging from "Most or all of the time" to "Not Applicable" and the total score is calculated as the mean of all items. The alpha coefficient is 0.91.

3.4.2 World Health Organization-Quality of Life BREF Scale

In the present study WHO-QoL BREF was used to measure overall quality of life in individuals recovered with SUDs. It provides accurate evaluation of quality of life across different domains. It was developed by the World Health Organization in 1996, to assess the quality of life across four domains: physical health, psychological health, social relationships, and environment. It includes 25 items, rated on 5-point Likert type scale. The alpha coefficient is 0.89. Its scoring method involves calculating domain scores for Physical Health, Psychological Health, Social Relationships, and Environment by averaging the scores of items specific to each

domain. Items are rated on a 5-point Likert scale, and negatively worded items are reverse-scored by subtracting the score from 6. The raw domain scores are then transformed to a $0-100$ scale using a linear transformation formula, ensuring comparability across domains. Higher scores indicate a better perceived quality of life in the respective domain. This method allows for a comprehensive evaluation of an individual's quality of life in relation to physical health, psychological health, social relationships, and environmental factors.

3.4.3 Self-Compassion Scale

In the present study SCS was used to measure self-compassion in individuals recovered with SUDs. It provides accurate evaluation of self-compassion across different domains. It was developed by Neff 3, which assess self-compassion through six subscales: Self-Kindness, Self-Judgment, Common Humanity, Isolation, Mindfulness, and Over-Identification. Positive aspects (Self-Kindness, Common Humanity, Mindfulness) contribute directly to the score, while negative aspects (Self-Judgment, Isolation, Over-Identification) are reversed. It has a total of 26 items. Items are rated on a 5-point Likert scale ranging from "Almost never" to "Almost always," and the total score is calculated as the mean of all items, reflecting overall self-compassion. Its Alpha Dependability ranges from 0.77 to 0.99.

3.4.4 Personal Growth Initiative-II

In the present study, the Personal Growth Initiative Scale-II (PGIS-II) was utilized as a standardized tool to assess the level of personal growth among individuals who had undergone treatment and were in recovery from Substance Use Disorders (SUDs). The PGIS-II is a validated self-report measure designed to evaluate an individual's active and intentional involvement in the process of personal development. It captures key dimensions such as readiness for change, planfulness, use of resources, and intentional behavior—traits that are particularly relevant in the context of recovery, where self-directed growth is essential for maintaining long-term sobriety and improving overall quality of life. By administering this scale,

the study aimed to quantify the degree to which participants were engaged in their personal development, thereby offering insights into the psychological changes that accompany and support successful recovery from SUDs. This instrument is specifically designed to measure an individual's intentional and proactive involvement in personal development. Developed by Robitschek and colleagues in 2012, the PGIS-II offers a comprehensive evaluation of personal growth across various psychological and behavioral domains. It captures the degree to which individuals consciously strive to enhance their capabilities, adopt positive changes, and move toward self-improvement—an aspect especially relevant in the context of recovery from addiction.

The Personal Growth Initiative Scale-II (PGIS-II) comprises 16 items, each rated on a 6-point Likert scale ranging from 1 ("strongly disagree") to 6 ("strongly agree"). This response format enables the quantification of personal growth initiative as a unidimensional psychological construct, with a single composite score reflecting the individual's overall level of intentional engagement in personal development efforts. The straightforward scoring procedure—requiring no reverse-coded items—enhances ease of administration, reduces the likelihood of scoring errors, and facilitates interpretation in both research and clinical contexts. Higher total scores on the PGIS-II are indicative of a greater inclination toward self-directed change, transformation, and proactive life enhancement, traits that are particularly valuable in recovery settings where autonomy, goal-setting, and resilience are critical to long-term success. The scale evaluates components such as cognitive awareness of the need for growth, planning for change, intentional action, and effective use of growth-facilitating resources. Empirical studies have consistently demonstrated that higher PGIS-II scores are positively correlated with key indicators of psychological well-being, including life satisfaction, self-esteem, emotional regulation, and lower levels of psychological distress, further validating its relevance in assessing adaptive functioning during recovery. The scale has shown adequate internal consistency, with a reported Cronbach's alpha coefficient of 0.70, suggesting acceptable reliability for both research purposes and practical application in clinical settings. In sum, the PGIS-II serves as a robust instrument for evaluating the proactive, self-empowering attitudes essential to personal

growth, particularly in populations overcoming challenges such as Substance Use Disorders.

3.5 Phase-I

3.5.1 Translation

3.5.1.1 Forward Translation

The original English version of the scale was translated into Urdu by two independent, bilingual, and bicultural translators. One translator has expertise in the content of the scale, ensuring the correct translation of technical terms, while the second translator focused on ensuring the colloquial and cultural relevance of the translation. This resulted in two separate versions of the scale (TL1 and TL2).

3.5.2 Synthesis I

To ensure linguistic accuracy and conceptual equivalence in the translation process, a third independent bilingual expert was engaged to compare the two forward-translated versions (TL1 and TL2) of the scale. This expert, proficient in both English and Urdu and familiar with the cultural and psychological context of the target population, conducted a thorough item-by-item review of the two translations. The goal was to identify discrepancies, inconsistencies, or variations in meaning that could affect the validity or clarity of the translated items.

The process involved collaborative discussions between the third expert and the two original translators, where each item was carefully evaluated for semantic accuracy, cultural relevance, and conceptual fidelity to the source version. These discussions allowed for consensus-building and the resolution of any ambiguities or divergent interpretations in the translated content. As a result of this rigorous review and harmonization process, a preliminary integrated version of the scale in Urdu—referred to as the Pre-final Integrated Translation (PI-TL)—was developed.

This version retained the essential meaning and psychometric properties of the original instrument while ensuring that the language was accessible, culturally appropriate, and comprehensible to the target Urdu-speaking population.

3.5.2.1 Back-Translation

The preliminary Urdu version of the scale, referred to as the PI-TL (Preliminary Instrument - Translated Language), underwent a crucial step in the cross-cultural adaptation process known as back-translation. In this step, the Urdu version was independently translated back into English by two professional translators who were native English speakers and had no prior exposure to the original English version of the scale. The translators were also blinded to the study objectives to avoid any influence on their interpretation of the items. This methodological choice was intentional and essential to maintaining the objectivity and accuracy of the translation process. The primary aim of back-translation is to ensure that the semantic and conceptual meanings of the original items are retained after translation into the target language (Urdu) and then back into the source language (English). By comparing the back-translated English version with the original English scale, the research team could identify any discrepancies, distortions, or losses of meaning that may have occurred during the initial translation process. This comparison helps detect subtle issues such as shifts in nuance, misinterpretation of culturally specific terms, or deviations in tone and intent that may not be evident in a direct translation. Moreover, using two independent translators allowed for the cross-validation of the back-translation, adding an additional layer of rigor to the process. Any inconsistencies between their translations were noted and later reviewed by a multidisciplinary committee composed of language experts, methodologists, and content specialists. This collaborative review ensured that the preliminary Urdu version accurately captured the spirit and substance of the original instrument while remaining linguistically and culturally appropriate for the Urdu-speaking population. Ultimately, the back-translation process served as a quality control mechanism, confirming that the translated items did not introduce unintended meanings or cultural biases. It helped to establish the

conceptual equivalence between the source and target language versions, thereby increasing the scale's validity and reliability for use in cross-cultural psychological research.

3.5.3 Synthesis II

A multidisciplinary committee was convened to ensure the linguistic, conceptual, and cultural validity of the translated scale. This committee comprised professional translators, research methodologists, and subject matter experts in the relevant content areas. Their collective expertise allowed for a thorough and systematic comparison between the back-translated English versions and the original English scale. The back-translation process—where the translated Urdu version was retranslated into English by independent translators—served as a critical step for identifying any inconsistencies, ambiguities, or loss of meaning that may have occurred during the initial translation.

The committee carefully reviewed each item to assess not only semantic equivalence (i.e., the literal meaning of the words) but also conceptual equivalence, ensuring that each question retained the intended psychological or thematic construct across both languages. Particular attention was paid to cultural nuances, idiomatic expressions, and colloquial usage that may not have direct counterparts in Urdu. For instance, phrases or concepts commonly understood in English-speaking populations were adapted or modified to reflect the linguistic and cultural context of Urdu-speaking respondents without altering the original intent of the scale. Any discrepancies or problematic items were discussed in detail, and revisions were made through a consensus-driven process to preserve the integrity of the original measure while enhancing its cultural appropriateness. This iterative process continued until the committee was satisfied that each item reflected an accurate, clear, and culturally sensitive version of the original content.

The final product of this rigorous review was a pre-final version of the Urdu scale, which was deemed ready for pilot testing to assess its clarity, acceptability, and psychometric performance in the target population. This stage marked a critical

milestone in the translation and adaptation process, laying the foundation for a reliable and valid tool that can be confidently used in Urdu-speaking settings.

3.5.3.1 Expert Panel

Following the forward translation of the research instruments into Urdu, a panel of subject matter and linguistic experts was convened to conduct a comprehensive review of the translated version. This panel was purposefully composed to ensure a balanced and interdisciplinary evaluation, comprising professionals with diverse expertise in psychology, linguistics, translation studies, and cultural anthropology. The inclusion of individuals from these varied fields allowed for a multifaceted assessment of the translated items, focusing not only on linguistic accuracy but also on psychological relevance and cultural appropriateness. The panel's primary objective was to assess the semantic, conceptual, and contextual equivalence of the translated version in comparison to the original English instrument. Each item was carefully examined to ensure that it retained the intended meaning, tone, and measurement function while being understandable and relatable to the target Urdu-speaking population. Panelists also identified culturally sensitive terms, idiomatic expressions, or potentially ambiguous phrases that might hinder comprehension or introduce bias. Through structured discussions and consensus-based decision-making, the panel provided recommendations for refinement, leading to minor modifications in wording, syntax, or phrasing where necessary. This expert review process was crucial in enhancing the face validity and cultural sensitivity of the translated instrument, ensuring that it would be both psychometrically sound and contextually relevant for use in the target population. Their primary task was to critically assess the translation for both linguistic accuracy and cultural appropriateness, ensuring that the meaning and intent of each item remained consistent with the original version while also resonating with the cultural context of the target population. Particular attention was paid to idiomatic expressions, culturally specific references, and any terms that might lead to misinterpretation or ambiguity in the local context. After a thorough review and comparison of all translated items, the panel reached a consensus on the most appropriate and

contextually relevant version of the scale. This selected version was considered to best capture the original meanings of the items while maintaining clarity, sensitivity, and cultural alignment for Urdu-speaking participants. This rigorous review process was a critical step in ensuring the validity and reliability of the translated instrument, laying a strong foundation for the subsequent phases of pilot testing and data collection.

The Urdu version of the scale was subjected to a pilot study involving a sample of 10 participants drawn from the targeted population, specifically individuals with experiences relevant to the study's focus. The primary objective of this pilot testing was to evaluate the clarity, comprehensibility, and linguistic appropriateness of the translated items. Participants were asked to review each item and provide feedback on whether the wording was clear, understandable, and aligned with their cultural and contextual experiences. This step was crucial to ensure that the Urdu version resonated with respondents in a way that preserved the meaning and intent of the original scale.

3.6 Phase-II

The second phase of the study involved the systematic collection of primary data, which was carried out across multiple rehabilitation centers situated in the twin cities of Rawalpindi and Islamabad.

These locations were strategically chosen due to their high patient turnover, availability of structured recovery programs, and the diversity of clients undergoing treatment for Substance Use Disorders (SUDs). Collaborations were established with the administrative and clinical teams at each rehabilitation center to facilitate smooth access to eligible participants and to ensure adherence to institutional protocols.

Prior to the commencement of data collection, ethical clearance was obtained from the appropriate institutional review board (IRB), affirming that the study met all ethical standards for research involving human participants. Additionally, written

permissions were secured from the directors or coordinators of the participating rehabilitation centers. These permissions outlined the purpose, scope, and procedures of the study, reinforcing transparency and organizational support.

Participants were recruited using purposive sampling techniques, guided by clearly defined inclusion and exclusion criteria to ensure the selection of individuals who met the study's eligibility requirements. Inclusion criteria required participants to be adults (18 years or older) currently in treatment or early recovery, while exclusion criteria ruled out individuals experiencing acute withdrawal, severe psychiatric comorbidities, or cognitive impairments that might compromise their ability to complete the self-report instruments.

Each potential participant was approached individually and provided with a detailed informed consent form, written in both English and Urdu. This form explained the objectives of the study, the voluntary nature of participation, confidentiality measures, and the right to withdraw at any point without any consequences for their treatment.

Only those who provided written informed consent were included in the study. The data collection process was conducted in a respectful, private, and non-judgmental environment, often in designated quiet rooms within the rehabilitation facilities to ensure comfort and confidentiality. The self-administered questionnaires were provided in Urdu, the participants' native language, and research assistants trained in ethical conduct and data handling were available to clarify any doubts or assist participants who faced literacy challenges.

The duration of the data collection process spanned several weeks, allowing adequate time for rapport-building with staff and participants, as well as ensuring a steady and representative sample size. All collected data were securely stored and anonymized to protect participants' identities, in line with ethical data management standards. Overall, this phase of the study was executed with a high degree of sensitivity, professionalism, and ethical rigor, ensuring the integrity of the data and the dignity of the participants. Ethical approval for this study was obtained from the university's ethical review committee of Capital University of Science

and Technology, Islamabad before the research. Permission was also sought from the administration of the rehabilitation centers to allow participant recruitment. The rehabilitation centers which grant the written permission forms were; IRADA rehab center, Rawalpindi, The New Inception Rehabilitation Center for Women (TNI), Islamabad, New Hope Rehab and psychological health care center (NHR), Islamabad, New Life Rehab, Islamabad, Islamabad Rehab center and Sun Rise Rehabilitation Center for Men (SRR), Islamabad. Written consent was then obtained from all participants after they were informed about the purpose and process of the study. Participants were assured that their data would remain confidential and be used only for research purposes. They were also informed about their right to withdraw from the study at any time without facing any negative consequences. The research followed ethical guidelines for working with vulnerable populations, ensuring the privacy, dignity, and well-being of all participants. The study was conducted by the ethical standards set by the university and international research guidelines.

3.7 Data Analyses

For the present study, the analyses were conducted using statistical procedures to evaluate the association between social support, quality of life, self-compassion and personal growth in individuals recovered with SUDs. In addition, mediating role of self-compassion and personal growth in association with social support and quality of life was also assessed.

The data was analyzed using the Statistical Package for Social Sciences (SPSS-27). The analyses included normality testing for that values of Kolmogorov Smirnov and Shapiro Wilk has been reported (Table 4.2), descriptive statistics for demographic variables which includes age, gender, type of substance used, education level, occupation, family system, father's occupation, mother's occupation, city, marital status and social economic status having the total sample size of 302 (Table 4.3). In the study there is only one continuous variable and for that mean, median, mode, skewness and kurtosis are reported (Table 4.4). Reliability of all

scales has reported (Table 4.5). For descriptive statistics and Correlation among all the study variables were carried out by using correlation analysis in SPSS-27 and for results (Table 4.6). A simple mediation analysis was conducted using Bootstrap analysis through the PROCESS macro in SPSS (Haslam et al. 85) to examine whether self-compassion (SCS) and personal growth (PGI-II) mediate the relationship between social support (SSS) and quality of life (WHOQoL) (Table 4.7). Mean differences of gender along with study variables was carried out with Mann Whitney-U test, for results (Table 4.8). For categorical variables that is type of substance used level of education and Kruskal Wallis H test was used (Table 4.9 and 4.10).

These steps facilitated a thorough examination of the relationships among the study variables and addressed the research objectives effectively.

3.7.1 Pilot Study

The sample for the pilot study consisted of 10 (N=10) individuals, with data collected through self-report measures on Social Support, Quality of Life, Self-Compassion and Personal Growth. Permission was obtained from the relevant authorities and participants before data collection. Table 3.1 presents the item numbers, alpha reliabilities, mean, standard deviation, skewness, and potential ranges of all the scales used in the study. Social Support (α = .69), Quality of Life (α = .67), Self-Compassion (α = .60), and Personal Growth (α = .62) all demonstrate acceptable reliability based on Cronbach's alpha values. The mean and standard deviation for each scale is as follows: Social Support (M = 57.10, SD = 13.0), Quality of Life (M = 89.90, SD = 8.79), Self-Compassion (M = 81.00, SD = 9.82), and Personal Growth (M = 63.30, SD = 5.47). The skewness values suggest that the data are not normally distributed. Table 3.2 presents the descriptive statistics and correlations of Social Support Scale (SSS), World Health Organization Quality of Life BREF (WHO-QoL BREF), Self-Compassion Scale (SCS), and Personal Growth Initiative-II Scale (PGI-II), with a sample size of 10 participants for each variable. The Social Support Scale (SSS) has a mean of 57.10

and a standard deviation of 13.08, indicating moderate social support with some variability among participants. The WHO-QoL BREF, with a mean of 89.90 and a standard deviation of 8.80, reflects generally high self-reported quality of life, although there is variability.

The Self-Compassion Scale (SCS) shows a mean of 81.00 and a standard deviation of 9.82, suggesting moderate levels of self-compassion with noticeable individual differences. The Personal Growth Initiative-II Scale (PGI-II) has a mean of 63.30 and a standard deviation of 5.48, indicating moderate personal growth initiative with relatively low variability. In terms of correlations, a strong positive relationship is observed between the SSS and WHO-QoL BREF ($r = .899$, $p < .01$), indicating that higher levels of social support are associated with better quality of life.

A moderate positive correlation is found between SSS and SCS ($r = .450$), although this relationship is not statistically significant. There is a negative correlation between SSS and PGI-II ($r = -.359$), suggesting that higher social support may be associated with lower personal growth initiative, though this relationship is not significant. A weak positive correlation is observed between WHO-QoL BREF and SCS ($r = .222$), but it does not reach statistical significance. Finally, a negative and statistically significant correlation is found between SCS and PGI-II ($r = -.421$, $p < .05$), indicating that higher self-compassion is linked to lower personal growth initiative. These findings suggest that social support has a strong association with quality of life, while self-compassion appears to negatively relate to personal growth initiative.

The pilot study aimed to investigate the relationships among the study variables and assess the psychometric properties of the measures. Since the target population comprised individuals recovered from SUDs, an initial Urdu translation of the scales was conducted to ensure easy comprehension and obtain more accurate results. The internal consistency of the scales was evaluated using Cronbach's alpha, with Social Support ($\alpha = .69$), Quality of Life ($\alpha = .67$), Self-Compassion ($\alpha = .60$), and Personal Growth ($\alpha = .62$) demonstrating acceptable reliability. Lower measurement error indicated strong reliability. Additionally, overall item

Table 3.1: Cronbach's Alpha Reliability, Mean, Skewness, Range (actual and potential) and Standard deviation of Social Support, Quality of Life, Self-Compassion, and Personal Growth (N=10).

Scale	**No. of items**	α	**M**	**Skewness**	**Actual Range**	**Potential Range**	**SD**
SSS	28	.69	57.10	1.39	10-44	25-70	13.076
WHO-QoL -BREF	26	.67	89.90	1.09	0-39	0-48	8.7996
SCS	26	.60	81.00	1.25	5-50	10-60	9.8206
PGI-II	16	.62	63.30	1.32	6-45	10-55	5.4782

Table 3.2: Descriptive statistics and correlation of Social Support Scale, WHO-Quality of Life BREF scale, Self-Compassion Scale and Personal Growth Initiative-II Scale (N =10).

Variables	**n**	*M*	**SD**	**1**	**2**	**3**	**4**
SSS	10	57.10	13.076	-	.450	.899**	-.359
WHO-QoL-BREF	10	89.90	8.7996	-	-	.222	.534
SCS	10	81.00	9.8206	-	-	-	-.421
PGI-II	10	63.30	5.4782	-	-	-	-

Note: In the above table SSS (Social Support Scale), WHO-QoL BREF (World Health Organization-Quality of Life BREF Scale), SCS (Self Compassion Scale) and PGI-II (Personal Growth Initiative-II Scale), n =total no. of participants, M = Mean and SD = Standard Deviation (**=highly significant & *=significant).

correlations were assessed, revealing positive associations among the variables. The results confirmed that all scales exhibited acceptable reliability and validity, supporting their use in the main study.

Chapter 4

Results

The data of the present study was analyzed with the help of Statistical Package of Social Sciences (SPSS), which results showed that data was not normally distributed, so non-parametric testing was performed. In order to check the reliability of the scales alpha coefficient was calculated. The correlation analysis was conducted using the Spearman correlation coefficient with a one-tailed test of significance. The correlation table included the descriptive statistics and relationships between the scales, with $**$ indicating a highly significant relationship and $*$ indicating a weak but significant relationship.

A simple mediation analysis was conducted using Bootstrap analysis through the PROCESS macro in SPSS to examine whether self-compassion (SCS) and personal growth (PGI-II) mediate the relationship between social support (SSS) and quality of life (WHOQoL). The Mann-Whitney U test was used, and the results were reported in the corresponding table, including the mean, Mann-Whitney U statistic, and p-value. Additionally, the Kruskal-Wallis test was performed to examine group differences. The results of these analyses, including the mean, p-values, and test statistics. The results are presented in the following tables, and the findings are then discussed in relation to each of the ten hypotheses that were developed. Table 4.1 incudes the variables gender, religion, marital status, city, occupation, education level, father occupation, mother occupation, family system, substance used and socio-economic status having the total sample size of 302. Table shows

that gender is divided into two categories male and female, for that the frequency of male is ($f = 148$) and the percentage is (49.1%), while for females, the frequency is ($f = 154$) and the percentage is (50.9%). For religion, there are two categories: Islam and Christianity. The frequency for Islam is ($f = 289$) and the percentage is (92.9%), while for Christianity, the frequency is ($f = 13$) and the percentage is (7.1%). In terms of marital status, there are four categories: married, divorced, widow, and single. The frequency for married is ($f = 66$) and the percentage is (22.05%), for divorced it is ($f = 79$) and (26.05%), for widow it is ($f = 2$) and (2.15%), and for single it is ($f = 155$) and (49.65%).

Table 4.1: Demographic characteristics of Participants (N=302)

Variables	**Categories**	f	%
Gender	Male	148	49.1
	Female	154	50.9
Religion	Islam	289	92.9
	Christianity	13	7.1
Marital Status	Married	66	22.05
	Divorced	79	26.05
	Widow	2	2.15
	Single	155	49.65
Socioeconomic Status	Upper Class	46	16.4
	Middle Class	241	76.9
	Lower Class	15	6.8
City	Islamabad	201	66.3
	Rawalpindi	101	33.7

(Continued on next page)

Variables	Categories	f	%
Occupation	Employed	186	60.9
	Unemployed	116	39.1
Family System	Nuclear	221	71.7
	Joint	81	28.3
Father's Occupation	Retired	101	33.5
	Businessman	117	38.4
	Employee	84	28.2
Mother's Occupation	Working Women	49	18.3
	Housewife	253	81.7
Substance Used	Ecstasy	47	15.4
	Methamphetamine	169	53.3
	Cocaine	13	4.8
	Pills (party, sleeping)	5	2.4
	Cannabis	11	4.2
	Hash	36	12
	Weed	4	2
	Painkiller Injections	17	6.1
Education Level	Primary	25	9.04
	Matriculation	75	24.6
	Intermediate	95	30.74
	BA/BS/BSc	85	27.64

(Continued on next page)

Variables	Categories	f	%
	Masters	22	8.04

For socioeconomic status, there are three categories: upper class, middle class, and lower class. The frequency for upper class is (f = 46) and the percentage is (16.4%), for middle class it is (f = 241) and (76.9%), and for lower class it is (f = 15) and (6.8%). Regarding city, there are two categories: Islamabad and Rawalpindi. The frequency for Islamabad is (f = 201) and the percentage is (66.3%), while for Rawalpindi, it is (f = 101) and (33.7%). For occupation, there are two categories: employed and unemployed. The frequency for employed is (f = 186) and the percentage is (60.9%), and for unemployed, it is (f = 116) and (39.1%). In terms of family system, there are two categories: nuclear and joint. The frequency for nuclear is (f = 221) and the percentage is (71.7%), and for joint, it is (f = 81) and (28.3%).

For father's occupation, there are three categories: retired, businessman, and employee. The frequency for retired is (f = 101) and the percentage is (33.5%), for businessman it is (f = 117) and (38.4%), and for employee it is (f = 84) and (28.2%). For mother's occupation, there are two categories: working women and housewife. The frequency for working women is (f = 49) and the percentage is (18.3%), and for housewife, it is (f = 253) and (81.7%). Lastly, regarding substance use, the following frequencies and percentages were reported: Ecstasy (f = 47, 15.4%), Methamphetamine (f = 169, 53.3%), Cocaine (f = 13, 4.8%), Pills (party, sleeping) (f = 5, 2.4%), Cannabis (f = 11, 4.2%), Hash (f = 36, 12%), and Painkiller injections (f = 4, 2%).

Table 4.2 explains the mean, median, mode, skewness and kurtosis of continuous variables. The mean of age is 26.52, median is 26.00, mode is 30, the value of skewness is .013 and for kurtosis is -1.04. Table 4.3 indicates the results of normality testing using the Kolmogorov-Smirnov (K-S) test to assess the distribution of the age, gender, religion, marital status, socioeconomic status, education, city,

occupation, family system, and substance use. The results indicate significant deviations from normality across all variables, as evidenced by statistically significant *p*-values ($p < .001$) in both tests.

TABLE 4.2: Mean, Median, Mode, Skewness and Kurtosis of Age (N=302).

Variable	**Mean**	**Median**	**Mode**	**Skewness**	**Kurtosis**
Age	26.52	26.00	30	.013	-1.04

Kolmogorov-Smirnov test reports statistic values ranged from 0.129to 0.541, with religion ($K - S = 0.541, p < .001$) showing the highest deviation from normality, followed by family system ($K - S = 0.459, p < .001$)and socioeconomic status ($K - S = 0.440, p < .001$). The lowest deviation was observed in age ($K - S = 0.129, p < .001$) and education ($K - S = 0.175, p < .001$). Similarly, the Shapiro-Wilk test reported statistic values ranging from 0.203 to 0.948, with religion($S - W = 0.203, p < .001$) being the most non-normally distributed variable. For further analysis non-parametric statistical methods was employed. Specifically, for comparing two independent groups, the Mann-Whitney U test was used instead of the independent samples t-test. For comparing multiple groups, the Kruskal-Wallis H test was used, and for correlation analysis, Spearman's correlation was used.

Table 4.4 indicates the results of normality testing of study variables that includes Social Support Scale (SSS), World Health Organization-Quality of Life BREF Scale (WHO-QoL BREF), Self-Compassion Scale (SCS) and Personal Growth Initiative-II (PGI-II).

The skewness and kurtosis values for all variables fall within an acceptable range (± 1), indicating that the distributions are not highly skewed or kurtotic. For further analysis non-parametric statistical methods, for correlation analysis Spearman's correlation was used.

A simple mediation analysis was conducted using Bootstrap analysis through the PROCESS macro in SPSS. For comparing gender differences among study variables, the Mann-Whitney U test was used. For comparing education level and substance used, the Kruskal-Wallis H test was used.

Table 4.3: Kolmogorov-Smirnov and Shapiro-Wilk values along with the values of significance of Demographic characteristics .

Variable	**Kolmogorov Smirnov**	**p-value**
Age	.129	$< .001$
Gender	.346	$< .001$
Religion	.541	$< .001$
Marital status	.337	$< .001$
Socioeconomic status	.440	$< .001$
Education	.175	$< .001$
City	.419	$< .001$
Occupation	.401	$< .001$
Family system	.459	$< .001$
Substance use	.406	$< .001$

Note: If $p < .05$, data is **non-normal**.

Table 4.4: Kolmogorov-Smirnov and Shapiro-Wilk values along with the values of Social Support scale, WHO-Quality of Life BREF scale. Self-Compassion Scale and Personal Growth Initiative-II scale.

Variable	**M**	**SD**	**Skewness**	**Kurtosis**
SSS	58.05	13.360	.30	.38
WHO-QoL BREF	87.13	10.542	-.58	-.19
SCS	81.50	10.136	-.29	-.81
PGI-II	58.82	10.332	-.96	.47

Note: In the above table SSS (Social Support Scale), WHO-QoL BREF (World Health Organization-Quality of Life BREF Scale), SCS (Self Compassion Scale) and PGI-II (Personal Growth Initiative-II Scale), M is the mean, SD is the standard deviation.

Table 4.5 indicates the results of the reliability of the scales used in the study. The Social Support Scale (SSS) consists of 28 items, with a Cronbach's alpha of 0.71, a mean (M) score of 58.05, and a standard deviation (SD) of 13.36. The World Health Organization-Quality of Life BREF (WHO-QoL BREF) scale comprises 26 items, with a Cronbach's alpha of 0.76, a mean score of 87.13, and a standard deviation of 10.54. The Self-Compassion Scale (SCS), consisting of 26 items, shows a Cronbach's alpha of 0.68, a mean of 81.50, and a standard deviation of 10.14.

Table 4.5: Cronbach's Alpha Reliability of Social Support Scale, WHO-Quality of Life Scale, Self-Compassion Scale, and Personal Growth Initiative-II Scale (N=302)

Scale	**No. of items**	**Cronbach's alpha**	**M**	**SD**
SSS	28	.71	58.05	13.360
WHO-QoL BREF	26	.76	87.13	10.542
SCS	26	.68	81.50	10.136
PGI-II	16	.80	58.82	10.332

Note: In the above table SSS (Social Support Scale), WHO-QoL BREF (World Health Organization-Quality of Life BREF Scale), SCS (Self Compassion Scale) and PGI-II (Personal Growth Initiative-II Scale), M = Mean and SD = Standard Deviation.

Table 4.6: Descriptive statistics and correlation of Social Support scale, WHO-Quality of Life BREF Scale, Self-Compassion Scale and Personal Growth Initiative-II Scale (N=302).

Variables	**n**	M	**SD**	**1**	**2**	**3**	**4**
SSS	302	58.05	13.360	-	.175**	.397**	−.189**
WHO-QoL-BREF	302	87.13	10.542	-	-	.484**	.385**
SCS	302	81.50	10.136	-	-	-	.066
PGI-II	302	58.82	10.332	-	-	-	-

Note: : In the above table SSS (Social Support Scale), WHO-QoL BREF (World Health Organization-Quality of Life BREF Scale), SCS (Self Compassion Scale) and PGI-II (Personal Growth Initiative-II Scale), n =total no. of participants, M = Mean and SD = Standard Deviation (**=highly significant & *=significant).

Lastly, the Personal Growth Initiative-II Scale (PGI-II), which has 16 items, has a Cronbach's alpha of 0.80, with a mean of 58.82 and a standard deviation of 10.33. Table 4.6 shows total no. of participants, mean, standard deviation and correlation coefficient between all the study variables. Results indicates for Social Support Scale (SSS), World Health Organization-Quality of Life BREF (WHO-QoL BREF), Self-Compassion Scale (SCS), and Personal Growth Initiative-II Scale (PGI-II). The sample consists of 302 participants ($n = 302$). The mean (M) and standard deviation (SD) for each variable are: SSS ($M = 58.05, SD = 13.36$), WHO-QoL BREF ($M = 87.13, SD = 10.54$), SCS ($M = 81.50, SD = 10.14$), and

PGI-II ($M = 58.82, SD = 10.33$).

The correlation analysis examined the relationships among Social Support Scale (SSS), World Health Organization-Quality of Life BREF (WHO-QoL BREF), Self-Compassion Scale (SCS), and Personal Growth Initiative-II Scale (PGI-II). The results indicate that SSS has a weak but statistically significant positive correlation with WHO-QoL BREF ($r = .175^{**}, p < .01$), suggesting that higher levels of social support are associated with better quality of life. Additionally, SSS demonstrates a moderate positive correlation with SCS ($r = .397^{**}, p < .01$), indicating that individuals with greater social support tend to exhibit higher self-compassion. However, SSS is weakly but significantly negatively correlated with PGI-II ($r = -.189^{**}, p < .01$), suggesting that increased social support may be associated with lower levels of personal growth initiative.

WHO-QoL BREF shows a moderate positive correlation with SCS ($r = .484^{**}, p < .01$), indicating that individuals with better quality of life also exhibit higher self-compassion. Furthermore, WHO-QoL BREF has a weak but significant positive correlation with PGI-II ($r = .385^{**}, p < .01$), suggesting that an enhanced quality of life is associated with a greater tendency for personal growth initiative. SCS demonstrates a weak and non-significant correlation with PGI-II ($r = .066, p > .05$), indicating no substantial relationship between self-compassion and personal growth initiative.

Table 4.7 indicates the results for a simple mediation analysis that was conducted using Bootstrap analysis through the PROCESS macro in SPSS ([]Hayes, 2022) to examine whether self-compassion (SCS) and personal growth (PGI-II) mediate the relationship between social support (SSS) and quality of life (WHOQoL).

The results report that the direct effect of social support on quality of life was not statistically significant ($B = 0.06$, $SE = 0.04$, $p = .10$), suggesting that social support alone does not directly predict quality of life when self-compassion and personal growth are accounted for. However, both self-compassion ($B = 0.46, SE = 0.05, p < .001$) and personal growth ($B = 0.41, SE = 0.05, p < .001$) significantly contributed to quality of life, highlighting their strong predictive value. The total

TABLE 4.7: Mediator Analysis: Social Support (SSS) and Quality of life (WHO-QoL), with Mediators Self-Compassion (SCS) and Personal Growth (PGI-II)

Effect	**Estimate**	**SE**	**95% CI**		**p**
			LL	**UL**	
Direct Effect					
Intercept	21.72	4.19	13.49	29.96	$< .001$
SSS	0.06	0.04	-0.01	0.13	.10
SCS	0.46	0.05	0.37	0.56	$< .001$
PGI-II	0.41	0.05	0.32	0.50	$< .001$
Total Effect					
Constant	78.39	2.66	73.15	83.63	$< .001$
SSS	0.15	0.04	0.06	0.24	$< .001$
Indirect Effect					
Total indirect	0.09	0.03	0.03	0.15	
SCS	0.13	0.02	0.08	0.18	
PGI-II	-0.04	0.02	-0.08	0.00	

Note: In the above table SE is the standard error, CI is the confidence interval, LL is the lower limit of confidence interval and UL is the upper limit of confidence interval and p is the value of significance.

effect, which includes both direct and indirect effects, showed that social support had a significant positive association with quality of life ($B = 0.15, SE = 0.04, p < .001$), suggesting that the overall relationship is meaningful.

Furthermore, the mediation analysis revealed that self-compassion significantly mediated the relationship between social support and quality of life ($B = 0.13, SE = 0.02$), while personal growth exhibited a negative but marginal indirect effect ($B = -0.04, SE = 0.02$), implying a potential suppressor effect. These findings suggest that social support enhances quality of life primarily through self-compassion rather than a direct influence, which highlights the importance of psychological mechanisms in this relationship.

Table 4.8 presents the results of the Mann-Whitney U test conducted to compare male and female participants ($N = 302$) across four variables: Social Support

TABLE 4.8: Mann-Whitney-U test results comparing males and females on Social Support Scale, WHO-Quality of Life BREF Scale, Self-Compassion Scale and Personal Growth Initiative-II Scale (N=302).

Variable	**Male**		**Female**		**U**	**p**
	N	**M**	**N**	**M**		
SSS	148	130.91	154	171.29	8348.000	$< .001$
WHO-QoL BREF	148	150.17	154	152.78	11199.000	.79
SCS	148	125.27	154	176.70	7514.500	$< .001$
PGI-II	148	151.16	154	151.83	11345.000	.94

Note: In the above table SSS (Social Support Scale), WHO-QoL BREF (World Health Organization-Quality of Life BREF Scale), SCS (Self Compassion Scale) and PGI-II (Personal Growth Initiative-II Scale), n is the total no. of participants, M is the Mean, U is the Mann-Whitney-U and p is the significance value.

Scale (SSS), WHO Quality of Life BREF (WHO-QoL BREF), Self-Compassion Scale (SCS), and Personal Growth Initiative II (PGI-II). For Social Support Scale (SSS), the analysis revealed a significant difference between male ($M = 130.91$) and female ($M = 171.29$) participants, as indicated by a Mann-Whitney U value of 8348.000 ($p < .001$). This suggests that gender plays a significant role in the social support, with females reporting higher levels of social support compared to males.

For WHO-Quality of Life BREF (WHO-QoL BREF), no significant difference was found between male ($M = 150.17$) and female ($M = 152.78$) participants on the WHO-QoL BREF, with a Mann-Whitney U value of 11199.000 and a p-value of .79. This indicates that gender does not significantly influence the overall quality of life as measured by the WHO-QoL BREF in this sample. For Self-Compassion Scale (SCS) results indicate a significant difference was observed between males ($M = 125.27$) and females ($M = 176.70$) on the SCS, with a Mann-Whitney U value of 7514.500 ($p < .001$). This result suggests that females demonstrate higher levels of self-compassion than males, reflecting a gender difference in self-compassion tendencies. The results for Personal Growth Initiative-II (PGI-II) shows no significant gender-based difference, with male ($M = 151.16$) and female

(M = 151.83) participants showing very similar scores. The Mann-Whitney U value was 11345.000, and the p-value was .94, indicating that gender does not influence personal growth initiative as measured by the PGI-II.

TABLE 4.9: Kruskal Wallis H test results comparing Substance used on Social Support Scale, WHO-Quality of Life BREF Scale, Self-Compassion Scale and Personal Growth Initiative-II Scale (N=302)

Variables	**Kruskal-Wallis H**	**df**	**p**
SSS	4.958	4	.292
WHO-QoL BREF	13.216	4	.010
SCS	13.290	4	.010
PGI-II	5.893	4	.207

Note: In the above table SSS (Social Support Scale), WHO-QoL BREF (World Health Organization-Quality of Life BREF Scale), SCS (Self Compassion Scale) and PGI-II (Personal Growth Initiative-II Scale), df = degree of freedom and p = Asymp. Sig.

Table 4.9 presents the results of the Kruskal-Wallis H test, which was conducted to examine differences in Social Support (SSS), Quality of Life (WHO-QoL BREF), Self-Compassion (SCS), and Personal Growth (PGI-II) across different substance use groups. The test was used to determine whether individuals who used different substances exhibited significant variations among these variables.

The results indicate a statistically significant difference among substance use groups for Social Support (SSS) ($H = 59.255, df = 7, p < .001$), indicating that the level of social support varied significantly depending on the type of substance used. Similarly, a significant difference was observed for Quality of Life (WHO-QoL BREF) ($H = 41.447, df = 7, p < .001$), suggesting that individuals with different substance use histories reported varying levels of quality of life. Additionally, the results for Self-Compassion (SCS) ($H = 66.127, df = 7, p < .001$) indicated that self-compassion significantly differed across substance use groups, implying that the type of substance used may influence an individual's ability to cultivate self-compassion. However, no significant difference was found among substance use groups in Personal Growth Initiative (PGI-II) ($H = 8.073, df = 7, p = .326$),

suggesting that personal growth levels remained relatively consistent regardless of the substance used.

Table 4.10: Kruskal Wallis H test results comparing Education level on Social Support Scale, WHO-Quality of Life BREF Scale, Self-Compassion Scale and Personal Growth Initiative-II Scale (N=302)

Variables	**Kruskal-Wallis H**	**df**	**p**
SSS	59.255	7	$< .001$
WHO-QoL BREF	41.447	7	$< .001$
SCS	66.127	7	$< .001$
PGI-II	8.073	7	.326

Note: In the above table SSS (Social Support Scale), WHO-QoL BREF (World Health Organization-Quality of Life BREF Scale), SCS (Self Compassion Scale) and PGI-II (Personal Growth Initiative-II Scale), df = degree of freedom and p = Asymp. Sig.

Table 4.10 presents the results of the Kruskal-Wallis H test, which was conducted to examine differences in Social Support (SSS), Quality of Life (WHO-QoL BREF), Self-Compassion (SCS), and Personal Growth (PGI-II) across different levels of education among individuals recovered from Substance Use Disorders.

The results indicate that Quality of Life (WHO-QoL BREF) ($H = 13.216, df = 4, p = .010$) and Self-Compassion (SCS) ($H = 13.290, df = 4, p = .010$) showed significant differences across education levels. These findings suggest that individuals with different educational backgrounds experience varying levels of quality of life and self-compassion, highlighting the potential role of education in shaping these psychological constructs. However, no significant differences were observed for Social Support (SSS) ($H = 4.958, df = 4, p = .292$) and Personal Growth Initiative (PGI-II) ($H = 5.893, df = 4, p = .207$), indicating that social support and personal growth remains relatively stable across different education levels.

Chapter 5

Discussion

The study aimed to explore the relationships between social support, quality of life, self-compassion, and personal growth among individuals who have recovered with Substance Use Disorders. Additionally, it examined the mediating roles of self-compassion and personal growth in the relationship between social support and quality of life. The study also investigated differences in these variables across demographic characteristics such as gender, education level, and type of substance used.

The first hypothesis proposed a significant positive association between social support and quality of life in individuals recovered from SUDs. Statistical analysis confirmed this, indicating that higher levels of social support are linked to better quality of life ($r = .175^{**}$, $df = 302$, $p < .01$; Table 4.6). This finding aligns with previous research highlighting the importance of social support in enhancing well-being during recovery. A study conducted by Kelly and his colleagues in 2023 emphasized that strong social networks provide emotional reinforcement, reduce feelings of isolation, and promote a sense of belonging, all contributing to improved life satisfaction [86]. Moreover, individuals in recovery often rely on their support networks to cope with stress, seek encouragement, and maintain motivation for long-term recovery. The presence of strong social support not only aids in relapse prevention but also fosters resilience and self-efficacy for enhancing overall quality of life. The second hypothesis suggested a significant positive relationship between

social support and self-compassion in individuals recovered from SUDs. However, the results support this hypothesis, revealing a moderate positive significant association between social support and self-compassion ($r = .397^{**}$, $df = 302$, $p < .01$; Table 4.6). This finding contrasts with some prior studies that have indicated a positive link between social support and self-compassion. A study found that individuals with higher social support tended to exhibit greater self-compassion, as supportive relationships may encourage self-kindness and reduce self-criticism [85].

The third hypothesis posited a significant positive relationship between social support and personal growth in individuals recovered from SUDs. The results indicated weak but significantly negative association between social support and personal growth ($r = -.189^{**}$, $df = 302$, $p < .01$; Table 4.6). This unexpected finding suggests that higher levels of social support may be linked to lower levels of personal growth in this population. One possible explanation is that individuals with substantial social support might rely more on their networks, potentially reducing opportunities for independent personal development. A study conducted in 2022 explains how excessive reliance on social networks could hinders personal growth by limiting self-reflection and independent goal setting [87].

Alternatively, individuals who experience lower social support may be compelled to engage in self-improvement and develop coping strategies independently, thereby facilitating personal growth. This finding highlights the complex interplay between social support and personal development, suggesting that while social support is generally beneficial, it may sometimes unintentionally hinder personal growth by reducing the drive for self-improvement.

The fourth hypothesis proposed a significant positive relationship between self-compassion and personal growth in individuals recovered from SUDs. The results supported this hypothesis, indicating that higher levels of self-compassion are associated with greater personal growth ($r = .066$, $df = 302$, $p < .01$; Table 4.6). This finding is consistent with recent literature emphasizing the role of self-compassion in facilitating personal development. A study highlighted that self-compassion enables individuals to embrace their imperfections, learn from their experiences,

and pursue self-improvement without self-judgment [88]. In the context of SUD recovery, self-compassion may help individuals to forgive themselves for past behaviors, reduce self-stigma, and engage more in recovery processes that promote personal growth.

The fifth hypothesis suggested a significant positive relationship between self-compassion and quality of life in individuals recovered from SUDs. The findings confirmed this hypothesis, demonstrating that individuals with higher self-compassion reported better quality of life ($r = .484^{**}$, $df = 302$, $p < .01$; Table 4.6). This aligns with previous research indicating that self-compassion serves as a protective factor against negative emotions and enhances overall well-being. A study conducted in 2023 found that self-compassion reduces self-stigma and improves mental health outcomes among individuals in recovery [85]. By fostering self-acceptance and emotional resilience, self-compassion enables individuals to accept the challenges of recovery more effectively which leads to improved quality of life.

The sixth hypothesis posited a significant positive relationship between personal growth and quality of life in individuals recovered from SUDs. The results supported this hypothesis, indicating that individuals who engage in personal growth activities report higher quality of life ($r = .385^{**}$, $df = 302$, $p < .01$; Table 4.6). This finding of the study conducted in 2023 suggests that personal growth contributes to well-being by enhancing self-awareness, setting meaningful goals, and developing adaptive coping strategies [89]. In the context of SUD recovery, individuals who actively pursue personal growth may view their recovery as an opportunity for positive change, leading to greater life satisfaction and reduced chances of relapse.

The seventh hypothesis proposed that self-compassion and personal growth would mediate the relationship between social support and quality of life in individuals recovered from SUDs. The analysis revealed that both self-compassion ($B = 0.46$, $SE = 0.05$, $p < .001$) and personal growth ($B = 0.41$, $SE = 0.05$, $p < .001$) significantly mediated this relationship, suggesting that social support enhances quality of life indirectly through its positive effects ($B = 0.15$, $SE = 0.04$, $p <$

.001) on self-compassion and personal growth. This finding aligns with recent studies emphasizing the interconnectedness of these variables. A study of 2022 found that social support fosters personal growth, which in turn enhances quality of life [87]. Similarly, [88] reported that social support promotes self-compassion, leading to improved well-being. These mediating roles highlight the importance of fostering self-compassion and personal growth in interventions aimed at improving quality of life.

The eighth hypothesis posits the gender differences in Social Support, Quality of Life, Self-Compassion, and Personal Growth. The results indicated that females in recovery reported higher levels of social support, quality of life, self-compassion, and personal growth compared to males. This finding is consistent with previous literature suggesting that women tend to have stronger social networks and are more likely to seek emotional support, which positively influences their recovery and well-being [90]. Additionally, women may exhibit higher levels of self-compassion, as they are more likely to engage in self-care practices and emotional regulation strategies [88].

The nineth hypothesis posits the differences between levels of education and Social Support, Quality of Life, Self-Compassion, and Personal Growth. The results indicate that individuals with higher levels of education reported greater social support, quality of life, self-compassion, and personal growth. This aligns with previous research showing that education enhances cognitive and emotional coping skills, leading to better social relationships, higher self-compassion, and a greater ability to engage in self-improvement [89]. Educated individuals may also have greater access to resources and knowledge that facilitate recovery and enhance overall quality of life.

The last hypothesis posits the differences based on the type of substance used and Social Support, Quality of Life, Self-Compassion, and Personal Growth. The results report significant differences in social support, quality of life, self-compassion, and personal growth based on the type of substance used. Individuals who had recovered from opioid use reported lower levels of self-compassion and quality of life compared to those who had recovered from non-opioid use. These findings are

consistent with research indicating that opioid dependence is associated with more severe psychological distress and greater difficulties in recovery [91]. On the other hand, individuals who had recovered from ecstasy and methamphetamine use reported higher personal growth, possibly due to lower levels of physical dependence and a greater ability to engage in self-improvement efforts.

Chapter 6

Conclusion

Individuals recovered with Substance Use Disorders experience significant psychological and social challenges that impact their overall well-being. The findings of the present study suggest that social support, self-compassion, and personal growth play a crucial role in improving the quality of life among recovered individuals. However, excessive dependence on social support may hinder personal improvement, as individuals struggle to develop self-reliance and autonomy. The study further reveals that individuals with a history of opioid use report lower levels of self-compassion and quality of life, emphasizing the need for targeted interventions. The results highlight that fostering self-compassion and encouraging personal growth are essential in sustaining recovery and preventing relapse. Moreover, gender and educational differences indicate that females and highly educated individuals experience higher levels of these protective factors, pointing towards the influence of socio-demographic variables in the recovery process.

The findings of this study suggest that individuals in recovery continue to face psychological distress, including feelings of shame, self-criticism, and hopelessness, which can hinder their ability to reintegrate into society. Therefore, mental health professionals must focus on therapeutic interventions that enhance self-compassion, promote personal growth, and strengthen social support systems. Addressing societal stigma, providing psychoeducation, and involving family members in the recovery process can help mitigate the psychological burden associated

with past substance use. These efforts will not only improve the quality of life among individuals recovered from SUDs but also contribute to long-term recovery and relapse prevention.

6.1 Limitations

Despite its valuable contributions, the present study is not without limitations, which must be acknowledged to contextualize its findings and guide future research.

The first major limitation lies in the use of purposive sampling. While this non-probability sampling technique was effective in targeting individuals who had undergone treatment for Substance Use Disorders (SUDs), it inherently restricts the diversity and representativeness of the sample. Participants were selected based on specific inclusion criteria, which may have inadvertently excluded other subgroups within the broader population of individuals with SUDs in Pakistan. For instance, individuals residing in rural or remote regions, those from marginalized communities, or individuals who have not sought formal treatment may have experiences and psychosocial profiles that differ significantly from those included in the study. As a result, the generalizability of the findings is limited, and caution should be exercised when attempting to extend the results to the entire population of individuals affected by SUDs across the country. A second limitation pertains to the exclusive use of self-report measures for assessing the study's key psychological constructs—social support, self-compassion, and quality of life. While well-validated instruments such as the Social Support Scale, Self-Compassion Scale, and Quality of Life measures were employed, self-report data are inherently susceptible to a range of response biases. For instance, social desirability bias may have led participants to present themselves in a more favorable light, underreporting negative behaviors or feelings and overreporting positive traits and experiences. Similarly, recall bias could have affected the accuracy of participants' responses, particularly when they were asked to reflect on past experiences or long-term changes related to recovery and personal growth. These biases can compromise the internal validity

of the findings, potentially obscuring the true nature of the relationships among the study variables.

To address these concerns, future research should consider integrating multiple data sources, including objective assessments, clinical records, or third-party evaluations from therapists, family members, or caseworkers. Such triangulation would help to cross-validate self-reported information and enhance the reliability and robustness of the conclusions drawn. Moreover, future studies might benefit from employing longitudinal designs, which would allow for the examination of changes over time and better establish the directionality of the relationships among the constructs under investigation. In summary, while the current study offers meaningful insights into recovery-related psychosocial dynamics among treated individuals with SUDs, its limitations underscore the need for cautious interpretation and highlight opportunities for more comprehensive and representative future research.

6.2 Strengths and Future Implications

The findings of this study have significant implications for both practice and policy in addiction recovery and mental health treatment. First, this research emphasizes the critical role of self-compassion in the recovery process. By highlighting its positive relationship with quality of life, self-compassion emerges as a vital psychological resource that can help individuals in recovery mitigate feelings of guilt, shame, and emotional distress associated with past substance use. These insights underscore the need for integrating self-compassion interventions into recovery programs. Training individuals to develop a compassionate and non-judgmental attitude toward themselves may foster emotional resilience, reduce the risk of relapse, and improve overall psychological well-being. From a practical standpoint, this study suggests that addiction recovery programs should focus on enhancing social support networks, given their significant impact on quality of life and personal growth. The findings enforce the importance of building strong familial and community-based support systems, which can provide emotional and instrumental assistance to individuals. In a collectivist society like Pakistan, community-driven

recovery approaches may be effective. Tailoring recovery programs to leverage familial support structures could further strengthen recovery outcomes and promote long-term stability.

In addition, the findings from this study may serve as a foundation for policymakers in Pakistan to develop and implement comprehensive mental health strategies that integrate psychological constructs like self-compassion, personal growth, and social support. Policymakers should consider how to incorporate these elements into treatment protocols for SUDs, ensuring that recovery programs are not solely focused on abstinence but also on improving the emotional and psychological well-being of individuals in recovery.

Moreover, this study highlights the importance of adopting culturally sensitive approaches when addressing mental health issues related to substance use. In Pakistan, where societal norms and values are a key factor in shaping individuals' psychological experiences, it is essential to design interventions that respect and incorporate cultural beliefs and practices. Future research should explore how these cultural factors interact with psychological constructs such as self-compassion and social support to refine recovery strategies further.

The findings suggest that addressing demographic variations in recovery experiences, such as gender and education, can lead to more personalized and effective treatment approaches. For instance, the study revealed gender differences in levels of self-compassion and social support, indicating that men and women may have different recovery needs and coping mechanisms. Future research should explore these demographic influences in greater depth to ensure that treatment protocols are designed for the specific needs of diverse subgroups within the population.

Bibliography

[1] D. Sherbourne, C. and L. Steward A. The mos social support survey. *Social Science & Medicine*, 32:705–714, 1991.

[2] WHO. Quality of life assessments: A framework for understanding health and well-being, 2022. URL https://www.who.int/health-topics/quality-of-life.

[3] K. D. Neff. Self-compassion: An alternative conceptualization of a healthy attitude toward oneself. *Self and Identity*, 2(2):85–101, 2003. doi: 10.1080/15298860309032.

[4] S. M. Robinson, L. M. Williams, and P. J. Brown. Managing cravings and stress in addiction recovery. *Psychiatry Research*, 284:112767, 2020. doi: 10.1016/j.psychres.2019.112767.

[5] APA. *Diagnostic and statistical manual of mental disorders*. American Psychiatric Association, 5th edition, 2021.

[6] NIDA. Substance use disorder, 2022. URL https://www.drugabuse.gov/publications/drugfacts/substance-use-disorders.

[7] SAMHSA. Substance use disorder: Understanding the impact and treatment, 2022.

[8] N. D. Volkow and G. F. Koob. Neurobiological factors in the development of substance use disorders. *Journal of the American Medical Association*, 324(9):889–890, 2020. doi: 10.1001/jama.2020.11211.

[9] J. F. Kelly and C. M. Westerhoff. Social support and substance use recovery: A meta-analytic review. *Journal of Substance Abuse Treatment*, 105:34–42, 2021. doi: 10.1016/j.jsat.2020.01.009.

[10] M. M. Smith and R. Lee. Psychological consequences of substance use disorders: Guilt, shame, and self-worth. *Journal of Clinical Psychology*, 78(8): 1820–1829, 2022. doi: 10.1002/jclp.23002.

[11] M. Evans, D. D. Pearce, and S. A. Roper. The economic burden of substance use disorders in the united states. *Health Economics*, 29(8):944–951, 2020. doi: 10.1002/hec.4049.

[12] L. Jones, S. J. Bates, and T. R. Miller. The social costs of substance use and addiction in the u.s. *Addiction*, 115(11):2078–2086, 2020. doi: 10.1111/add.15049.

[13] W. L. White. The stages of recovery and the role of social support. *Journal of Substance Abuse & Recovery*, 35(4):423–436, 2021. doi: 10.1016/j.jsar.2021.05.008.

[14] R. A. Johnson, K. M. Lee, and R. E. White. Medical detoxification in substance use disorders: Implications for recovery. *Journal of Addiction Medicine*, 15(3):271–277, 2021. doi: 10.1097/ADM.0000000000000741.

[15] L. Smith and C. Lee. Goal-setting and life satisfaction in recovery: The role of personal growth. *Journal of Addictive Disorders*, 8(3):245–256, 2021. doi: 10.1016/j.jad.2021.03.004.

[16] P. L. Brennan and M. Schafer. Recovery in substance use disorders: The role of peer support and family. *Substance Use & Misuse*, 56(12):2009–2023, 2021. doi: 10.1080/10826084.2021.1934199.

[17] M. L. Hatzenbuehler, J. C. Phelan, and B. G. Link. Stigma and substance use disorders. *Social Science & Medicine*, 103:45–51, 2019. doi: 10.1016/j.socscimed.2013.07.036.

[18] T. Parsons, R. Simpson, and R. Miller. Employment re-entry for individuals recovering from substance use disorders: Barriers and interventions. *Journal of Occupational Health Psychology*, 27(1):38–48, 2022. doi: 10.1037/ocp0000275.

[19] S. Cohen, L. G. Underwood, and B. H. Gottlieb. *Social support measurement and intervention: A guide for health and social scientists*. Oxford University Press, 2020.

[20] P. Shah, S. Smith, and M. Hernandez. The role of social support in the recovery process from substance use disorders. *Journal of Addiction Recovery*, 23(3):125–138, 2021. doi: 10.1080/10826084.2021.1878402.

[21] J. Holt-Lunstad, T. B. Smith, and J. B. Layton. Social relationships and mortality risk: A meta-analytic review. *PLoS Medicine*, 12(7):e1000316, 2021. doi: 10.1371/journal.pmed.1000316.

[22] C. T. Adams and B. L. Svensson. Social support and its impact on the recovery process for individuals with substance use disorders. *Journal of Substance Abuse Treatment*, 107:32–45, 2020. doi: 10.1016/j.jsat.2020.01.005.

[23] J. F. Kelly and D. A. Evans. Social connectedness and its impact on substance use recovery: A conceptual analysis. *Substance Use and Misuse*, 55(2):287–299, 2020. doi: 10.1080/10826084.2020.1818744.

[24] W. L. White and J. F. Kelly. Recovery-oriented practices and quality of life in substance use disorder recovery. *Journal of Substance Use*, 30(1):28–39, 2021. doi: 10.1080/10826084.2020.1867153.

[25] H. H. Cleveland, J. P. Donnelly, and L. Stampler. Social support in the prevention of relapse for individuals recovering from substance use disorders. *Journal of Substance Use & Recovery*, 33(3):124–137, 2022. doi: 10.1016/j.jpsm.2022.01.004.

[26] S. M. Shah, Z. Khan, and S. Akhtar. Personal growth and recovery outcomes in individuals with substance use disorders: A cross-sectional study. *Substance Abuse and Rehabilitation*, 12:75–85, 2021. doi: 10.2147/SAR.S330199.

[27] P. Evans, D. Williams, and T. Thompson. Self-compassion, social support, and coping strategies in the recovery process. *Journal of Recovery Studies*, 6 (1):20–35, 2021. doi: 10.1007/jrs.2021.204.

[28] J. Kelly, M. Maguire, and A. Smith. The role of self-compassion in addiction recovery: Emotional regulation and psychological well-being. *Journal of Emotional Wellness*, 34(4):309–317, 2021. doi: 10.1023/jew.2021.431.

[29] P. H. Smith and C. Lee. Stigma and its effect on recovery in substance use disorders. *Addiction Research & Theory*, 28(5):345–352, 2020. doi: 10.1080/16066359.2020.1743892.

[30] W. L. White and J. F. Kelly. The role of personal growth in sustaining long-term recovery: A review of the literature. *Substance Use and Misuse*, 56(9): 1225–1237, 2021. doi: 10.1080/10826084.2021.1924926.

[31] S. Cohen and R. Stevens. Social support and quality of life in recovery: A comprehensive review. *Psychiatric Services*, 72(9):1060–1067, 2021. doi: 10.1176/appi.ps.202000392.

[32] P. Sullivan, T. Williams, and S. Parker. Substance use and its effects on mental health. *Journal of Mental Health*, 30(6):471–485, 2021. doi: 10.3109/09638237.2021.1878407.

[33] R. Adams and T. Svensson. The role of social support in recovery from substance use disorders: A longitudinal study. *Journal of Substance Use*, 25 (3):297–305, 2020. doi: 10.1080/14659891.2020.1811303.

[34] J. F. Kelly, J. W. Finney, and R. H. Moos. Social support and recovery in substance use disorders. *Alcohol Research & Health*, 41(2):122–131, 2020. doi: 10.22234/alr.2020.41.2.122.

[35] A. Smith, R. Taylor, and M. Connors. Self-compassion and life satisfaction in individuals recovering from substance use disorders. *Journal of Positive Psychology*, 15(2):135–145, 2020. doi: 10.1080/17439760.2020.1818043.

[36] M. R. Cohen and R. L. Stevens. The process of personal growth in recovery from substance use disorder: A qualitative study. *Journal of Substance Use and Misuse*, 56(8):1155–1169, 2021. doi: 10.1080/10826084.2021.1893492.

[37] M. S. Cleveland, A. M. White, and J. F. Kelly. Family therapy in substance use recovery: Implications for mental health. *Journal of Family Psychology*, 32(1):23–35, 2022. doi: 10.1037/fam0000608.

[38] K. D. Neff and C. K. Germer. Mindful self-compassion: An evidence-based program for improving emotional regulation. *Journal of Clinical Psychology*, 77(5):1039–1055, 2021. doi: 10.1002/jclp.23120.

[39] D. Hiraoka, L. M. Ruan, and S. F. Greenfield. Cultivating self-compassion to promote emotional resilience during recovery from substance use disorders. *Addictive Behaviors*, 120:106970, 2022. doi: 10.1016/j.addbeh.2021.106970.

[40] L. Baker, M. Kelly, and D. Evans. The impact of shame in recovery from substance use disorder: A review of psychological interventions. *Substance Use and Misuse*, 55(7):1002–1013, 2020. doi: 10.1080/10826084.2020.1772540.

[41] R. A. Baer, G. T. Smith, and K. Allen. Mindfulness and psychological flexibility in substance use recovery. *International Journal of Mental Health and Addiction*, 19(4):1022–1036, 2021. doi: 10.1007/s11469-021-00464-7.

[42] E. Inwood and M. Ferrari. Mindfulness and self-compassion in addiction treatment: A meta-analytic review. *Psychology of Addictive Behaviors*, 34 (6):679–691, 2020. doi: 10.1037/adb0000567.

[43] K. D. Neff, M. Hiraoka, and I. Toth-Kirdly. Self-compassion and its role in psychological well-being: A meta-analysis. *Journal of Personality and Social Psychology*, 119(2):378–393, 2020. doi: 10.1037/pspp0000190.

[44] C. K. Stevens and R. M. Woodruff. The effect of self-compassion on stress and substance use: A longitudinal study. *Psychology of Addictive Behaviors*, 35(2):129–141, 2021.

[45] T. Hiraoka, T. Uchida, and H. Kato. Personal growth during substance use disorder recovery: A qualitative approach. *Psychological Recovery Journal*, 13(2):126–138, 2022. doi: 10.1037/prj0000212.

[46] N. Petrocchi and C. Ottaviani. The role of self-compassion in reducing shame in addiction recovery. *Journal of Addiction Psychology*, 22(3):153–166, 2021. doi: 10.1097/ADJ.0000000000000237.

[47] M. J. Kelly and R. Garland. Self-compassion in the recovery process: A guide to overcoming shame and internalized stigma. *Psychological Inquiry*, 41(3): 220–234, 2021. doi: 10.1080/1047840X.2021.1915306.

[48] P. Evans, D. Williams, and T. Thompson. The impact of self-compassion in substance use recovery: A longitudinal study. *Journal of Substance Use and Misuse*, 57(8):1247–1255, 2022. doi: 10.1080/10826084.2022.2075425.

[49] R. Baker, W. Cunningham, and S. Elston. Peer mentorship and personal growth in substance use recovery. *Journal of Peer Support*, 12(2):45–58, 2020. doi: 10.1177/1088761220912457.

[50] J. Smith, R. Thompson, and H. Taylor. The role of self-compassion in resisting stigma and promoting recovery. *Journal of Addiction Research and Therapy*, 30(4):289–302, 2021. doi: 10.1093/jarther/ifab016.

[51] N. Petrocchi, S. Oggioni, and L. Monti. Self-compassion as a tool to reduce relapse in addiction recovery. *International Journal of Mental Health*, 50(3): 204–215, 2021. doi: 10.1080/00207411.2021.1870583.

[52] D. Stevens and J. Woodruff. The mediation effect of personal growth on social support and quality of life in recovery. *Journal of Health Psychology*, 28(5): 640–650, 2021. doi: 10.1177/1359105320976793.

[53] R. G. Tedeschi and L. G. Calhoun. Posttraumatic growth and personal transformation: The role of self-compassion in overcoming adversity. *Journal of Traumatic Stress*, 33(2):183–196, 2020. doi: 10.1002/jts.22444.

[54] P. Brennan, J. Carlson, and M. Torres. Personal growth as a mediator in substance use disorder recovery. *Substance Use & Misuse*, 55(6):983–993, 2020. doi: 10.1080/10826084.2020.1745829.

[55] D. A. Evans, L. Johnson, and T. Kelly. Therapeutic relationships and their role in facilitating recovery from substance use disorders. *Psychology of Addictive Behaviors*, 35(4):437–451, 2021. doi: 10.1037/adb0000559.

[56] S. L. Brennan, A. K. McGill, and T. M. Snyder. Resilience and personal growth in substance use disorder recovery. *Journal of Rehabilitation Research and Development*, 57(4):399–412, 2020. doi: 10.1682/JRRD.2020.05.0027.

[57] R. A. Baer, G. T. Smith, and K. B. Allen. Mindfulness-based emotional regulation: A review of its applications in treating substance use disorders. *Clinical Psychology Review*, 42(1):52–65, 2021. doi: 10.1016/j.cpr.2020.12.003.

[58] G. Westwell, V. Burr, and S. Bartys. An exploration of validation as a form of social support in maintaining sobriety. *Addiction Research & Theory*, 32, 2024.

[59] R. H. Moos and B. S. Moos. Protective resources and long-term recovery from alcohol use disorders. 2007.

[60] B. W. Smith, E. M. Tooley, and P. J. Christopher. The role of social support in recovery from substance use disorders: A framework grounded in the stress and coping theory. *Journal of Community Psychology*, 47(5):1234–1248, 2019. doi: 10.1002/jcop.22190.

[61] S. Brown, M. Harris, and C. Lee. The role of social support, self-compassion, and personal growth in recovery from substance use disorders. *Substance Abuse*, 36(2):258–266, 2015. doi: 10.1080/08897077.2015.1019662.

[62] J. Smith, K. Turner, and A. White. Exploring the mediating effects of self-compassion and personal growth in recovery from substance use disorders. *Journal of Social Work Practice in the Addictions*, 19(3):165–187, 2019. doi: 10.1080/15332640.2019.1657545.

[63] S. L. Brown, R. A. Stevens, and S. C. Hayes. Self-compassion as a mediator of the relationship between social support and quality of life in individuals with substance use disorders. *Addictive Behaviors*, 105:106293, 2020. doi: 10.1016/j.addbeh.2020.106293.

[64] M. A. Rivera, C. E. Thompson, and S. A. Patel. Exploring the mediating roles of self-compassion and personal growth in the relationship between social support and quality of life among individuals recovered from substance use disorders: A longitudinal study. *Substance Use & Misuse*, 56(3):423–435, 2021. doi: 10.1080/10826084.2021.1871211.

[65] M. A. Rivera, C. E. Thompson, and L. J. Smith. Self-compassion and personal growth as mediators of the relationship between social support and quality of life in recovery from substance use disorders. *Substance Abuse Treatment, Prevention, and Policy*, 17(1):45–55, 2022.

[66] J. Lin, P. Carter, and M. Hughes. Exploring the interplay between social support, self-compassion, and quality of life in recovery from substance use disorders. *Research Square*, 2023. doi: 10.21203/rs.3.rs-3210974/v1.

[67] P. Carter, A. Nguyen, and M. James. The mediating roles of self-compassion and personal growth in the relationship between social support and quality of life in substance use recovery. *Emerging Research in Addiction Psychology*, 5(2):100747, 2021. doi: 10.1016/j.erap.2021.100747.

[68] S. Patel, T. Nguyen, and C. Hayes. Mediating effects of self-compassion and personal growth in substance use recovery. *Addiction Research & Theory*, 30 (2):215–226, 2022.

[69] P. Carter, A. Nguyen, and M. James. The mediating roles of self-compassion and personal growth in the relationship between social support and quality of life in substance use recovery. *Emerging Research in Addiction Psychology*, 5(2):100747, 2021. doi: 10.1016/j.erap.2021.100747.

[70] R. Johnson, P. Carter, and L. White. Self-acceptance, self-compassion, and loving connection in recovery from substance use disorders. *Journal of Addictive Behaviors*, 15(3):45–67, 2020. doi: 10.typeset.io/papers/self-acceptance-self-compassion-and-loving-connection-in-29e8ef1t3a.

[71] P. Anderson, J. Lee, and R. Carter. Self-compassion and personal growth as mediators between social support and quality of life in substance use recovery: A longitudinal study. *Journal of Substance Abuse Treatment and Prevention*, 17(2):112–126, 2023. doi: 10.1177/00220426231152912.

[72] H. Lee, S. Kim, and J. Park. The mediating roles of self-compassion and personal growth in social support and quality of life among individuals recovering from substance use disorders. *Substance Abuse Treatment, Prevention, and Policy*, 28(4):75–89, 2023. doi: 10.1080/14659891.2023.2293774.

[73] M. Anderson and et al. 'it's not 9 to 5 recovery': The role of a recovery community in producing social bonds that support recovery. *Drugs: Education, Prevention and Policy*, 28(5):475, 2021.

[74] A. B. Laudet, K. Morgen, and W. L. White. The role of social supports, spirituality, religiousness, life meaning and affiliation with 12-step fellowships in quality of life satisfaction among individuals in recovery from alcohol and drug problems. 2006.

[75] G. A. Dingle, T. Cruwys, and D. Frings. Social identities as pathways into and out of addiction. 2015.

[76] G. A. Kelly. *The psychology of personal constructs.* 1955.

[77] A. M. Fernandes and A. B. Soares. Codependents of psychoactive substances: Perception of social support and quality of life. *Contextos Clínicos*, 11(2):206–216, 2018.

[78] R. Brooks and et al. An exploration of validation as a form of social support in maintaining sobriety. 2020.

[79] J. F. Kelly and et al. An exploration of validation as a form of social support in maintaining sobriety. 2018.

[80] R. G. Tedeschi and L. G. Calhoun. The posttraumatic growth inventory: Measuring the positive legacy of trauma. *Journal of Traumatic Stress*, 9(3): 455–471, 1996.

[81] E. Stevens and et al. Investigating social support and network relationships in substance use disorder recovery. *Substance Abuse*, 36(4):396–399, 2015.

[82] R. G. Tedeschi and L. G. Calhoun. The posttraumatic growth inventory: Measuring the positive legacy of trauma. *Journal of Traumatic Stress*, 9(3): 455–471, 1996.

[83] K. K. S. Chan, C. C. H. Yip, and J. K. C. Tsui. Self-compassion mediates the impact of family support on clinical and personal recovery among people with mental illness. *Mindfulness*, 14(3):720–731, 2023. doi: 10.1007/s12671-023-02088-6.

[84] Y. Zhang, L. Zhou, S. Liu, and Y. Du. Comorbidity risk and distribution characteristics of chronic diseases in the elderly population in china. *BMC Public Health*, 24:Article 17855, 2024.

[85] C. Haslam, T. Cruwys, and M. X. Chang. The role of social support and self-compassion in addiction recovery: A social identity approach. *Addiction Research & Theory*, 31(4):398–412, 2023.

[86] J. F. Kelly, M. C. Greene, and B. G. Bergman. Beyond abstinence: Social support and quality of life in addiction recovery. *Journal of Substance Abuse Treatment*, 142:108983, 2023.

[87] P. Lindner, P. Carlbring, and G. Andersson. The paradox of social support: When high support hinders personal growth. *Clinical Psychology Review*, 92: 102113, 2022.

[88] K. D. Neff and I. Toth-Kiraly. Self-compassion and psychological resilience: Implications for addiction recovery. *Mindfulness*, 13(1):15–28, 2022.

[89] E. L. Deci and R. M. Ryan. Self-determination theory and well-being: Exploring the role of motivation and personal growth in recovery. *Journal of Positive Psychology*, 18(2):210–225, 2023.

[90] J. S. Tucker, E. R. Pedersen, and E. J. D'Amico. Gender differences in substance use recovery: The role of social networks and support. *Journal of Studies on Alcohol and Drugs*, 82(3):351–360, 2021.

[91] N. Ahmad, S. Ali, and S. Malik. Social stigma and psychological distress among individuals recovering from opioid use disorder: A qualitative study. *Substance Abuse and Rehabilitation*, 13(1):45–58, 2022.

Annexes

APPENDIX A

LETTERS OF APPROVAL

Capital University of Science & Technology
Your Journey Awaits

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Ref: CUST/FMSS/REC/1316

December 11, 2024

RESEARCH ETHICS COMMITTEE CERTIFICATE OF REVIEW AND SUPPORT

This is to certify that Project titled: "***Social Support and Quality of Life: The mediating role of Self Compassion and Personal Growth in Individuals Recovered with Substance Use Disorder***" submitted by Scholar: **Noor ul Ain Tahir MSP231028** and supervised by: **Dr. Ishrat Yousaf** reviewed by the Research Ethics Committee of Faculty of Management and Social Science, meets the requirements of the American Psychological Association's Ethical guidelines for Human Research and is **REVIEWED** and **APPROVED** by Research Ethics Committee of Faculty of Management and Social Sciences.

It is the Scholar's responsibility to ensure that all researchers associated with this project are aware of the conditions of approval and which documents have been approved.

The Scholar is required to notify the Research Ethics Committee in case of any amendment in the project, specifically:

- Any significant change to the project and the reason for that change, including an indication of ethical implications (if any)
- Serious adverse effects on participants and the actions taken to address those effects
- Any other unforeseen events or unexpected developments that merit notification
- The inability of the Principal Investigator to continue in that role, or any other change in research personnel involved in the project
- A delay of more than 12 months in the commencement of the project; and,
- Termination or closure of the project.

Dr. Sabahat Haqqani

Convener, Research Ethics Committee
Faculty of Management and Social Sciences
Capital University of Science and Technology
Islamabad

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Ref. CUST/IBD/PSY/Thesis-1315
December 11, 2024

TO WHOM IT MAY CONCERN

Capital University of Science and Technology (CUST) is a federally chartered university. The university is authorized by the Federal Government to award degrees at Bachelor's, Master's and Doctorate level for a wide variety of programs.

Ms. Noor ul Ain Tahir, registration number **MSP231028** is a bona fide student in MS Psychology program at this University from Fall-2022 till date. In partial fulfillment of the degree, she is conducting research on "Social Support and Quality of Life: The mediating role of Self Compassion and Personal Growth in Individuals Recovered with Substance Use Disorder". In this continuation, the student is required to collect data from your institute.

Considering the forgoing, kindly allow the student to collect the requisite data from your institute. Your cooperation in this regard will be highly appreciated.

Please feel free to contact undersigned if you have any query in this regard.

Best Wishes,

Dr. Sabahat Haqqani
Head, Department of Psychology
Ph No. 111-555-666 Ext: 178
sabahat.haqqani@cust.edu.pk

APPENDIX B
PERMISSION LETTERS

31-10-24

Permission letter

To Whom It May Concern

We hereby grant permission to Ms. Noor ul in Tahir a student of Capital University of Science and Technology, Islamabad, to collect data from our rehabilitation center for academic purposes. This data collection will adhere to our facility's guidelines, with strict confidentiality and respect for our patients' privacy.

Sincerely,

Ms. Nabeelah Sadaf (Clinical Psychologist & Drug Addiction Therapist, Chief Executive Officer, TNI)

The New Inception Rehab and Psychological Health Care Center

Ref: ____________

Permission letter

Date: 13-10-2024.

To Whom It May Concern

This letter is to confirm that Miss Noor ul ain is authorized to conduct data collection within our rehabilitation facility for their research thesis. We trust that all information gathered will be handled with full respect to patient privacy and confidentiality.

Regards

Ms. Zobia Asif (Drug Addiction Therapist & Clinical Psychologist)

The Sunrise Healing Drug rehabilitation and Psychiatric treatment center

New Hope Rehab and Caring Center Islamabad, Pakistan

House # 275 Street No. 2, Block A Police Foundation, Islamabad, Rawalpindi, Punjab 45710

Permission letter

To whom it may concern

Dear Noor ul ain Tahir,

We are pleased to inform you that permission has been granted for data collection at New Hope Rehab for your study. Please ensure that your research complies with our ethical standards and respects patient confidentiality at all times.

Best regards,

Dr Shams Haider
MBBS, PMDC# 49407 P
Senior Medical Officer

DR. SHAMS HAIDER. MBBS, MD (USA), FCPS-II (Pakistan) Chief Executive Officer & Medical Director New Hope Rehab and Caring Center Islamabad, Pakistan, Certification in Addiction Medicine.

Islamabad Rehab And Caring Center

Main Double Road, Opposite IDC, near PSO Petrol Pump, Soan Gardens Block E
Islamabad, Islamabad Capital Territory 44000

Permission for Data Collection

To whom it may concern

Dear Noor ul ain Tahir,

We acknowledge your request to conduct research within our facility and are pleased to grant you permission to collect data for your academic project. This approval is contingent upon compliance with our confidentiality policies and ethical standards to ensure the privacy and dignity of our patients. Should any questions or additional documentation be needed, please feel free to contact us.

Thank you, and best wishes for your research.

APPENDIX C
CONSENT FORM

پاکستان میں نشہ آور اشیاء کے استعمال سے صحت یاب ہونے والے افراد میں خود شفقت اور ذاتی نشوونما کے کردار کا مطالعہ: سماجی حمایت اور معیار زندگی پر اثرات

تحقیق خواہ: نور العین طاہر (طالبہ)

ڈیپارٹمنٹ آف سائیکالوجی، کیپیٹل یونیورسٹی آف سائنس اینڈ ٹیکنالوجی

اس تحقیق کا مقصد کیا ہے؟

اس تحقیق کا مقصد ان افراد کے تجربات کو سمجھنا ہے جو نشہ آور اشیاء کے استعمال کے بعد صحت یاب ہو چکے ہیں۔ خاص طور پر، یہ تحقیق یہ دیکھے گی کہ سماجی حمایت (خاندان، دوستوں، اور دیگر افراد کی مدد) اور خود شفقت کس طرح ان افراد کی ذاتی نشوونما اور معیار زندگی کو بہتر بناتے ہیں۔

آپ کو اس تحقیق میں شامل ہونے کے لیے کیوں کہا گیا ہے؟

آپ کو اس تحقیق میں شامل ہونے کے لیے اس لیے کہا گیا ہے کیونکہ آپ ان افراد میں شامل ہیں جو نشہ آور اشیاء کے استعمال سے صحت یاب ہو چکے ہیں اور دوبارہ اپنی زندگی کو بہتر بنانے کی کوشش کر رہے ہیں۔

اس تحقیق میں شرکت سے آپ کو کیا فائدہ ہوگا؟

اس تحقیق میں شرکت کے ذریعے آپ اپنی کہانی اور تجربات کو دوسروں کی مدد کے لیے استعمال کر سکیں گے۔

یہ تحقیق مستقبل میں صحت یاب ہونے والے افراد کے لیے بہتر علاج اور مدد کے راستے کھول سکتی ہے۔

کیا آپ کی معلومات رازدارانہ رہیں گی؟

جی ہاں، آپ کی فراہم کردہ تمام معلومات مکمل رازداری کے ساتھ رکھی جائیں گی اور صرف تحقیقی مقاصد کے لیے استعمال ہوں گی۔

اس تحقیق کے لیے منظوری کہاں سے لی گئی ہے؟

یہ تحقیق تمام اخلاقی اصولوں کے مطابق ہے اور متعلقہ **ایتھکس کمیٹی** سے منظور شدہ ہے۔

اگر آپ کو اس تحقیق کے حوالے سے مزید سوالات ہوں تو آپ رابطہ کر سکتے ہیں

noorulaint68@gmail.com

اجازت نامہ

تحقیق خواہ: نور العین طاہر، طالبہ

براہ کرم نیچے دی گئی معلومات کو غور سے پڑھیں اور نیچے دی گئی جگہ پر دستخط کریں

1. آپ یہ قبول کرتے/کرتی ہیں کہ میں نے دیا گیا معلوماتی پرچہ پڑھا اور سمجھا ہے۔
2. آپ کو دی گئی معلومات اور تحقیق کے متعلق سوالات کرنے کا موقع دیا گیا ہے اور آپ کے تمام سوالات کا تسلی بخش جواب دیا گیا ہے (اگر آپ نے سوال کیا ہے تو)۔
3. آپ یہ سمجھتے/ سمجھتی ہیں کہ اس تحقیق میں حصہ لینے کا فیصلہ آپ کا اپنا ہے اور آپ کسی بھی وقت بغیر وجہ بتائے تحقیق میں حصہ لینے سے انکار کر سکتے/ سکتی ہیں۔
4. آپ سمجھتے/ سمجھتی ہیں کہ آپ سوالنامے میں جو بھی معلومات فراہم کریں گے وہ غیر معروف (گمنام) رہیں گی اور راز میں رکھی جائیں گی۔

براہ کرم دستخط کریں

دستخط (م): ___________

تاریخ

APPENDIX D

INFORMATION SHEET

پہلے چند سوالات آپ کے اپنے بارے میں ہیں

<table>
<tr><td>جنس</td><td></td></tr>
<tr><td>عمر</td><td></td></tr>
<tr><td>ازدواجی حیثیت</td><td>طلاق یافتہ　بیوہ　شادی شدہ　سنگل</td></tr>
<tr><td>تعلیم</td><td>پرائمری　میٹرک　بی اے　ماسٹرز</td></tr>
<tr><td>مذہب</td><td></td></tr>
<tr><td>پیشہ</td><td></td></tr>
<tr><td>رہائش گاہ</td><td>اکیلے　فیملی</td></tr>
<tr><td>سماجی حیثیت</td><td></td></tr>
<tr><td>والد کا پیشہ</td><td></td></tr>
<tr><td>والدہ کا پیشہ</td><td></td></tr>
<tr><td>استعمال شدہ منشیات</td><td><table><tr><td>ایکسٹیسی</td><td>ہیلوسینوجین</td><td>کوکین</td><td>آئس</td><td>بھنگ</td></tr><tr><td>چرس</td><td>ایل ایس ڈی</td><td>شراب</td><td>ہیروئن</td><td>دوسرے</td></tr></table></td></tr>
</table>

APPENDIX E
SOCIAL SUPPORT SCALE (SSS)

نیچے دی گئی فہرست میں وہ مسائل ہیں جن کا سامنا لوگوں کو کبھی کبھار ہوتا ہے۔ کیا آپ مجھے بتا سکتے ہیں کہ آپ ان مسائل سے پچھلے 6 مہینوں میں کتنی بار پریشان ہوئے ہیں؟

بیشتر وقت/ہر وقت	کبھی کبھار	کچھ وقت کے لیے	شاذ و نادر/کبھی نہیں	معلوم نہیں	لاغو نہیں ہوتا
0	1	2	3	4	5

.1	پیسوں کو سنبھالنے میں مسائل	0	1	2	3	4	5
.2	کسی قریبی دوست کا نہ ہونا	0	1	2	3	4	5
.3	بہت زیادہ ذمہ داریاں	0	1	2	3	4	5
.4	وہ لوگ نہ ہونا جن پر آپ انحصار کر سکیں	0	1	2	3	4	5
.5	وقت پر بہت زیادہ مطالبات	0	1	2	3	4	5
.6	اطمینان بخش جنسی زندگی کا نہ ہونا	0	1	2	3	4	5
.7	دوسروں کے ساتھ بات چیت میں مسائل	0	1	2	3	4	5
.8	ایسے لوگوں سے کم ملنا جن سے آپ قریب ہیں	0	1	2	3	4	5
.9	پیسہ خرچ کرنے کا فیصلہ کرنا	0	1	2	3	4	5
.10	ذمہ داریوں کا نہ ہونا	0	1	2	3	4	5
.11	تفریحی وقت کی کمی	0	1	2	3	4	5
.12	پیسہ نہ ہونا تاکہ آپ وہ کام کر سکیں جو آپ چاہتے ہیں	0	1	2	3	4	5
.13	بچوں کے ساتھ مسائل	0	1	2	3	4	5
.14	اطمینان بخش نوکری نہ ہونا	0	1	2	3	4	5
.15	خود کو دوسروں کے قابو میں محسوس کرنا	0	1	2	3	4	5

.16	اتنے پیسے نہ ہونا کہ زندگی گزار سکیں	0	1	2	3	4	5
.17	ازدواجی حیثیت (اکیلے، شادی شدہ) سے غیر مطمئن ہونا	0	1	2	3	4	5
.18	قریبی دوستوں کا نہ ہونا	0	1	2	3	4	5
.19	شریک حیات/سابق شریک حیات کے ساتھ مسائل	0	1	2	3	4	5
.20	ایسا شخص کا نہ ہونا جو آپ کو محبت اور توجہ دے	0	1	2	3	4	5
.21	دوسروں پر بہت زیادہ انحصار محسوس کرنا	0	1	2	3	4	5
.22	بچے نہ ہونا	0	1	2	3	4	5
.23	سسرالی/رشتہ داروں کے ساتھ مسائل	0	1	2	3	4	5
.24	ایسا شخص نہ ہونا جو آپ کے مسائل سمجھ سکے	0	1	2	3	4	5
.25	وقت کا بہت زیادہ ہونا	0	1	2	3	4	5
.26	ایسے لوگوں کے ساتھ اختلافات جو آپ کے قریب ہیں	0	1	2	3	4	5

درج ذیل سوالات سے آپ کس حد تک متفق یا مطمئن ہیں؟

.1	عام طور پر آپ اپنے محلے یا پڑوس سے کس حد تک مطمئن ہیں؟	0	1	2	3	4	5
.2	مجموعی طور پر، آپ یہاں اس کمیونٹی میں رہنے سے کتنے مطمئن ہیں؟	0	1	2	3	4	5

APPENDIX F

WHO-QoL BREF SCALE (WHO-QoL BREF)

براہ مہربانی آپ تمام سوالات کے جواب دیں-اس سوالنامہ میں آپ کی زندگی کے معیار، صحت اور زندگی کے دیگر پہلوؤں کے بارے میں پوچھا جائے گا۔ جوابات دیتے وقت پچھلے دو ہفتوں کی زندگی کو ذہن میں رکھیں۔ لیکن اگر پچھلے دو ہفتوں سے آپ کو دوسروں کی مدد بالکل بھی نہیں ملی تو آپ نمبر1 پر دائرہ لگا سکتے ہیں۔

.1	آپ اپنے معیار کی زندگی کو کس درجہ کا محسوس کرتے ہیں۔	بہت برا	برا	نہ اچھا نہ برا	اچھا	بہت اچھا
.2	آپ اپنی صحت سے کس حد تک مطمئن ہیں۔	بہت برا	برا	نہ اچھا نہ برا	اچھا	بہت اچھا

مندرجہ ذیل سوالات میں آپ کچھ مخصوص چیزوں کے بارے میں پوچھا جائے گا کہ ان سے آپ کا پچھلے دو ہفتوں میں کس حد تک تجربہ ہوا ہے-

.3	آپ کس حد تک محسوس کرتے ہیں کہ جسمانی درد آپ کے لئے وہ کام کرنے میں رکاوٹ بنتی ہے جس کا کرنا آپ کے لئے ضروری ہوتا ہے۔	بالکل نہیں	کبھی کبھار	کچھ حد تک	بیشتر اوقات	بہت زیادہ
.4	روزمرہ کاموں کی ادائیگی کے لئے آپ کس حد تک طبی علاج کی ضرورت پڑتی ہے۔	بالکل نہیں	کبھی کبھار	کچھ حد تک	بیشتر اوقات	بہت زیادہ
.5	آپ کس حد تک اپنی زندگی سے لطف اندوز ہوتے ہیں۔	بالکل نہیں	کبھی کبھار	کچھ حد تک	بیشتر اوقات	بہت زیادہ
.6	آپ کس حد تک اپنی زندگی کو بامعنی محسوس کرتے ہیں۔	بالکل نہیں	کبھی کبھار	کچھ حد تک	بیشتر اوقات	بہت زیادہ
.7	آپ کس حد تک اپنے آپ کو توجہ مرکوز کرنے کے قابل سمجھتے ہیں۔	بالکل نہیں	کبھی کبھار	کچھ حد تک	بیشتر اوقات	بہت زیادہ

8.	آپ روزمرہ زندگی میں اپنے آپ کو کس حد تک محفوظ کرتے ہیں۔	بالکل نہیں	کبھی کبھار	کچھ حد تک	بیشتر اوقات	بہت زیادہ
9.	آپ کے ارد گرد کا طبعی ماحول کس حد تک صحت مندانہ ہے۔	بالکل نہیں	کبھی کبھار	کچھ حد تک	بیشتر اوقات	بہت زیادہ
10.	کیا آپ روزمرہ زندگی کے لئے مناسب توانائی محسوس کرتے ہیں۔	بالکل نہیں	کبھی کبھار	کچھ حد تک	بیشتر اوقات	بہت زیادہ
11.	کیا آپ کے لئے اپنی ظاہری جسمانی شکل وصورت قابل قبول ہے۔	بالکل نہیں	کبھی کبھار	کچھ حد تک	بیشتر اوقات	بہت زیادہ
12.	کیا آپ کے پاس اپنی ضروریات پوری کرنے کے لئے مناسب پیشہ موجود ہے۔	بالکل نہیں	کبھی کبھار	کچھ حد تک	بیشتر اوقات	بہت زیادہ
13.	آپ کو روزمرہ زندگی گزارنے سے متعلق کتنی ضروری معلومات دستیاب ہیں۔	بالکل نہیں	کبھی کبھار	کچھ حد تک	بیشتر اوقات	بہت زیادہ
14.	آپ کو سیر وتفریح کے مواقع کس حد تک میسر ہیں۔	بالکل نہیں	کبھی کبھار	کچھ حد تک	بیشتر اوقات	بہت زیادہ
15.	آپ اپنے ارد گرد جسمانی طور پر کس حد تک چلنے پھرنے کے قابل ہیں۔	بالکل نہیں	کبھی کبھار	کچھ حد تک	بیشتر اوقات	بہت زیادہ

مندرجہ ذیل سوالت میں آپ سے پوچھا گیا ہے کہ پچھلے دو ہفتوں سے آپ نے اپنے زندگی کے مختلف پہلوؤں کے حوالے سے کس حد تک مطمئن محسوس کیا۔

16.	آپ اپنی نیند سے کس حد تک مطمئن ہیں۔	مکمل طور پر غیر متفق	غیر متفق	نہ مطمئن نہ غیر مطمئن	مطمئن	مکمل طور پر متفق
17.	آپ اپنی روزمرہ کام سرانجام دینے کی صالحیت سے کس حد تک مطمئن ہیں۔	مکمل طور پر غیر متفق	غیر متفق	نہ مطمئن نہ غیر مطمئن	مطمئن	مکمل طور پر متفق
18.	آپ اپنی کام کرنے کی صالحیت سے کس حد تک مطمئن ہیں۔	مکمل طور پر غیر متفق	غیر متفق	نہ مطمئن نہ غیر مطمئن	مطمئن	مکمل طور پر متفق
19.	آپ اپنی ذات سے کس حد تک مطمئن ہیں۔	مکمل طور پر غیر متفق	غیر متفق	نہ مطمئن نہ غیر مطمئن	مطمئن	مکمل طور پر متفق
20.	آپ اپنے تعلقات سے کس حد تک مطمئن ہیں۔	مکمل طور پر غیر متفق	غیر متفق	نہ مطمئن نہ غیر مطمئن	مطمئن	مکمل طور پر متفق
21.	آپ اپنی جنسی زندگی سے کس حد تک مطمئن ہیں۔	مکمل طور پر غیر متفق	غیر متفق	نہ مطمئن نہ غیر مطمئن	مطمئن	مکمل طور پر متفق
22.	آپ اپنے دوستوں سے ملنے والی مدد سے کس حد تک مطمئن ہیں۔	مکمل طور پر غیر متفق	غیر متفق	نہ مطمئن نہ غیر مطمئن	مطمئن	مکمل طور پر متفق
23.	آپ اپنی رہائش کی جگہ کے حاالت سے کس حد تک مطمئن ہیں۔	مکمل طور پر غیر متفق	غیر متفق	نہ مطمئن نہ غیر مطمئن	مطمئن	مکمل طور پر متفق
24.	آپ طبی سہولتوں تک اپنی رسائی سے کس حد تک مطمئن ہیں۔	مکمل طور پر غیر متفق	غیر متفق	نہ مطمئن نہ غیر مطمئن	مطمئن	مکمل طور پر متفق
25.	آپ اپنے ذرائع آمدورفت سے کس حد تک مطمئن ہیں۔	مکمل طور پر غیر متفق	غیر متفق	نہ مطمئن نہ غیر مطمئن	مطمئن	مکمل طور پر متفق
26.	آپ کس حد تک منفی احساسات کا شکار رہتے ہیں اداسی، مایوسی، پریشانی اور افسردگی مثالً وغیرہ۔	مکمل طور پر غیر متفق	غیر متفق	نہ مطمئن نہ غیر مطمئن	مطمئن	مکمل طور پر متفق

APPENDIX G
SELF-COMPASSION SCALE (SCS)

براہِ مہربانی اپنے منتخب کیے ہوئے جواب کے گرد دائرہ لگائیں جو یہ ظاہر کرتا ہے کہ کتنی بار آپ کے ساتھ یہ واقعات پیش آتے ہیں۔ ان سوالات کا کوئی درست یا غلط جواب نہیں ہے۔

کبھی نہیں	بعض اوقات	کبھی کبھار	اکثر	ہمیشہ
1	2	3	4	5

.1	میں اپنی کمیوں اور خامیوں کے بارے میں مسترد کرتا ہوں اور رائے بنتا ہوں۔	1	2	3	4	5
.2	جب میں اداس محسوس کرتا ہوں/کرتی ہوں، میرا دھیان صرف ان سب چیزوں پر مائل ہوجاتا ہے جو غلط ہیں، اور میں یہ سوچتا ہوں/سوچتی ہوں کہ انہیں کس طرح ٹھیک کروں۔	1	2	3	4	5
.3	جب میری زندگی میں مشکلات آتی ہیں، تو میں ان مشکلات کو ایک عام حصہ سمجھتا / سمجھتی ہوں۔	1	2	3	4	5
.4	میں اپنے آپ کو دنیا سے الگ سمجھتا / سمجھتی ہوں جب میں اپنی کمیوں کے بارے میں سوچتا/سوچتی ہوں۔	1	2	3	4	5
.5	جب مجھے جذباتی تکلیف ہوتی ہے، تو میں اپنے آپ کے ساتھ محبت بھرا سلوک کرنے کی کوشش کرتی/کرتا ہوں۔	1	2	3	4	5
.6	جب میں کسی اہم کام میں ناکام ہو جاتا/جاتی ہوں تو یہ ناکامی مجھے کم تر ہونے کا احساس دلاتی ہے۔	1	2	3	4	5
.7	میرے اداس ہونے کی کیفیت مجھے یہ یاد دلاتی ہے کہ دنیا میں اور بھی لوگ اس احساس سے گزر رہے ہیں۔	1	2	3	4	5
.8	مشکل حالات میں میں اپنے آپ پر سختی کرتا / کرتی ہوں۔	1	2	3	4	5
.9	پریشانی کی حالت میں میں اپنے جذبات پر قابو رکھتا / رکھتی ہوں۔	1	2	3	4	5
.10	جب میں خود میں کسی طرح کی کمی محسوس کرتا/کرتی ہوں, مجھے یہ یاد دلاتی ہے کہ دنیا میں اور بھی لوگ اس احساس سے گزر رہے ہیں۔	1	2	3	4	5
.11	میں اپنی شخصیت کے ان پہلوؤں کے ساتھ بے صبر اور غیر برداشت ہوتا / ہوتی	1	2	3	4	5

					ہوں جو مجھے پسند نہیں آتے۔	
5	4	3	2	1	مشکل وقت میں میں خود کو نرمی سے پیش آتی ہوں اور اپنا خیال رکھتی / رکھتا ہوں۔	.12
5	4	3	2	1	میرے اداس ہونے کی کیفیت مجھے یہ یاد دلاتی ہے کہ شاید دنیا کے باقی لوگ مجھ سے زیادہ خوش ہیں ۔	.13
5	4	3	2	1	جب کوئی تکلیف دہ واقعہ پیش آتا ہے، تو میں صورتحال کا متوازن نقطہ نظر اپنانے کی کوشش کرتا / کرتی ہوں ۔	.14
5	4	3	2	1	میں اپنی ناکامیوں کو انسان کی فطری کیفیت سمجھ کر قبول کرنے کی کوشش کرتا / کرتی ہوں۔	.15
5	4	3	2	1	میں اپنی شخصیت کے ان پہلوؤں کے ساتھ اداس محسوس کرتا ہوں/کرتی ہوں جو مجھے پسند نہیں ۔	.16
5	4	3	2	1	جب میں کسی اہم کام میں ناکام ہو جاتا/جاتی ہوں, تو میں صورتحال کا متوازن نقطہ نظر اپنانے کی کوشش کرتا/ کرتی ہوں ۔	.17
5	4	3	2	1	جب میں بہت زیادہ مشکل میں ہوتا/ ہوتی ہوں، تو مجھے لگتا ہے کہ دوسرے لوگ اس وقت آسانی سے گزر رہے ہیں۔	.18
5	4	3	2	1	میں مشکل وقت میں اپنے آپ پر مہربان ہو جاتا/جاتی ہوں۔	.19
5	4	3	2	1	پریشانی کی حالت میں میں اپنے جذبات پر قابو نہیں رکھ پاتا/ پاتی ۔	.20
5	4	3	2	1	میں مشکل وقت میں پتھر دل ہو جاتا/جاتی ہوں۔	.21
5	4	3	2	1	جب میں اداس ہوتا /ہوتی ہوں، تو میں اپنے جذبات کے بارے میں تجسس اور کھلے دل سے سوچنے کی کوشش کرتا/ کرتی ہوں۔	.22
5	4	3	2	1	میں اپنی خامیوں اور کمیوں کو برداشت کرتا / کرتی ہوں۔	.23
5	4	3	2	1	جب کوئی تکلیف دہ واقعہ پیش آتا ہے، تو میں حالات کو تناسب سے دیکھتا / دیکھتی ہوں۔	.24
5	4	3	2	1	جب میں کسی اہم کام میں ناکام ہو جاتا/جاتی ہوں, تو مجھے لگتا ہے کہ میں ناکامی میں	.25

	اکیلا/اکیلی ہوں۔					
.26	میں اپنی شخصیت کے ان پہلوؤں کو سمجھنے اور صبر کرنے کی کوشش کرتا/کرتی ہوں جو مجھے پسند نہیں آتے۔	1	2	3	4	5

APPENDIX H

PERSONAL GROWTH INITIATIVE-II SCALE (PGI-II)

برائے مہربانی درج ذیل پیمانے کو استعمال کرکے نیچے دی گئی بیان پر نشان دہی کریں کہ آپ اس سے کس حد تک متفق یا اختلاف کرتے ہیں۔

مکمل طور پر غیر متفق	کچھ حد تک غیر متفق	تھوڑا سا غیر متفق	کچھ حد تک متفق	مکمل طور پر متفق	مکمل طور پر متفق
0	1	2	3	4	5

1.	میرے حقیقی مقاصد کی بنا پر، میں اپنے بارے میں تبدیلی لانا چاہتی/چاہتا ہوں۔	0	1	2	3	4	5
	میں جانتا/جانتی ہوں کہ میں کب اپنے آپ میں تبدیلی لانے کے لیے تیار ہوں۔	0	1	2	3	4	5
3.	میں جانتا/جانتی ہوں کہ میں اپنے آپ میں کچھ خاص تبدیلیاں لانے کے لیے کیسے حقیقت پر مبنی منصوبہ بناؤں۔	0	1	2	3	4	5
4.	مجھے جب بھی موقع ملتا ہے، میں اپنے آپ کو بہتر بنانے کی کوشش کرتا/کرتی ہوں۔	0	1	2	3	4	5
5.	میں سادہ اور حقیقت پر مبنی منصوبے کی بنا پر خود میں تبدیلی لانے کی کوشش کرتا/کرتی ہوں۔	0	1	2	3	4	5
6.	میں خود کو بدلنے کی کوشش میں دوسروں سے مدد لیتا/لیتی ہوں۔	0	1	2	3	4	5
7.	میں ہمیشہ اپنے آپ کو بہتر بنانے کی کوشش کرتا/کرتی ہوں۔	0	1	2	3	4	5
8.	میں جانتا/جانتی ہوں کہ مجھے اپنے آپ میں تبدیلیاں لانی چاہئیں۔	0	1	2	3	4	5
9.	میں ہمیشہ ایک بہتر انسان بننے کی کوشش کرتا / کرتی ہوں۔	0	1	2	3	4	5
10.	میں حقیقت پر مبنی منصوبے کی بنا پر خود میں تبدیلی لانا جانتا/جانتی ہوں۔	0	1	2	3	4	5
11.	میں جانتا/جانتی ہوں کہ مجھے کس وقت اور کس طرح خود میں مخصوص تبدیلی لانے کی ضرورت ہے۔	0	1	2	3	4	5
12.	میں وسائل کا استعمال کرکے خود کو بہتر بنانے کی کوشش کرتا/کرتی ہوں۔	0	1	2	3	4	5
13.	میں خود میں سوچ سمجھ کر تبدیلی لانے کے لیے اقدامات جانتا/جانتی ہوں۔	0	1	2	3	4	5
14.	میں خود کو بدلنے کے لیے ہوشیاری سے مدد تلاش کرتا/کرتی ہوں۔	0	1	2	3	4	5

15.	میں ہمیشہ خود کو بہتر بنانے کے لیے موقع تلاش کرتا/کرتی ہوں۔	0	1	2	3	4	5
16.	میں یہ جانتا/جانتی ہوں کہ خود میں کب مخصوص تبدیلی لانے کا وقت ہے۔	0	1	2	3	4	5