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The Role of Family Functioning, Self-Efficacy and Perceived Social Support in Quality of Life among Males with Substance Use Disorder

by

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CERTIFICATE OF APPROVAL

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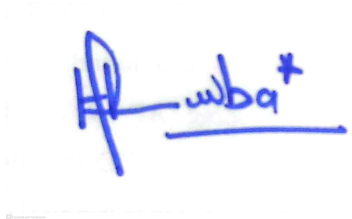

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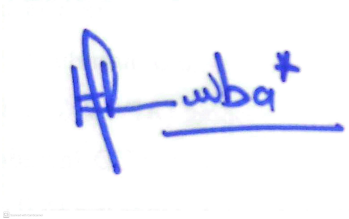

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(Haseeba Abbas)

Abstract

The aim of the current research was to determine the correlation between family functioning, self-efficacy, perceived social support and quality of life in male substance users. It was hypothesized based on available literature that these psychosocial variables would highly predict quality of life. The sample was made up of 300 male substance users who were recruited on the basis of convenience sampling. The participants differed in terms of marital status, education level, and employment status and type of substance use. A set of data was gathered by the use of standardised instruments such as the Family Assessment Device (FAD), Multidimensional Scale of Perceived Social Support (MSPSS), General Self-Efficacy Scale (GSE), and World Health Organization Quality of Life Scale (WHOQOL-BREF). Non-parametric tests, reliability analysis and descriptive statistics were used because the data were not normally distributed. The rho correlation analysis by Spearman demonstrated that self-efficacy and perceived social support had significant and positive relationships with all domains of quality of life (p ¡ .01), although family functioning had weak and mostly non-significant relationships. The multiple regression analysis showed that the entire model was statistically significant and explained 33 per cent of the variance in the quality of life (R^2 = .33, F(11, 288) = 13.00, p ¡ .001). General self-efficacy (= .34, p ¡ .001), support of significant others (= .20, p = .025), and friends (= .22, p = .009) were the key positive predictors, but the family functioning dimensions and family support did not significantly predict quality of life. In addition, Kruskal-Wallis H tests revealed that demographic variables, including the level of education and marital status, did not significantly affect the quality of life (p ¿ .05).The results emphasize the primary role of personal psychological resources, especially self-efficacy, and selective features of social support in promoting the quality of life among substance users. The research has significant clinical intervention implications, as it suggests that interventions that aimed at enhancing the quality of life should focus on strengthening the self-efficacy and supportive social networks.

Keywords: Substance Use Disorder, self-efficacy, social support, family functioning, quality of life.

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Abbreviations

AI	Affective Involvement
AR	Affective Responsiveness
BC	Behaviour Control
C	Communication
D1	Physical Quality of Life
D2	Psychological Quality of Life
D3	Social Relationships
D4	Environmental Quality of Life
FAD	Family Assessment Device
FAM	Family Support
FR	Friends Support
GFF	General Family Functioning
GSE	General Self-Efficacy
MSPSS	Multidimensional Scale of Perceived Social Support
PS	Problem Solving
R	Roles
SO	Significant Other Support
UNODC	United Nations Office on Drugs and Crime
WHOQOL-BREF	World Health Organization Quality of Life
WHO	World Health Organization

Chapter 1

Introduction

1.1 Background of the Study

Substance use disorder is regarded as one of the most urgent societal issues affecting many facets of life, regardless of geographic location, gender, age, education level, religion, race, ethnicity, or economic standing (Masese, 2020). A lot of research indicates that substance use disorder is a worldwide issue (Farooqi and Shahid, 2022; MacMillan et al., 2022; Votaw et al., 2019). Drug addiction affects about 35 million individuals worldwide, according to the World Health Organization (WHO). Substance use disorder has become a significant social issue because it is related to the increased risk of suicidal thoughts and infectious diseases like HIV, as well as various comorbid medical and psychological conditions, and in the worst-case scenario, it can even result in the death of the substance user (Ellis et al., 2020).

The availability of illegal drugs, willingness to use them, curiosity, stress, family problems, and peer pressure are some of the reasons that have been connected to the rise in drug addiction (Siddiqui et al., 2024).Various administration methods that are commonly used to consume have been highlighted over the years. Smoking, huffing, intravascular injections, sniffing, or inhaling medications. According to Ellis et al. (2020), injecting is the deadliest of these.

A use of drugs in Pakistan and other nations in the area has affected individuals from a variety of backgrounds (Imtiaz et al., 2024). The United Nations Office on Drugs and Crime estimates that almost 7.4 million Pakistani people are drug users, and this figure is continuously growing because of the approximately 40,000 new cases of drug users annually (United Nations Office on Drugs and Crime, 2017; Shahid and Asmat, 2024). The increase in the severity of this problem also became the focus of a news story published in early 2024 (The Nation, 2024).

Demographic trends also further show that drug use is quite prevalent among men, who form about 78 per cent of the population affected. Early in 2024, a news report stated (The Nation, 2024). Because of the yearly increase, Pakistan is presently regarded as one of the most impacted nations in the world due to a rise of 40,000 new addicts.

The consumption of drugs has turned out to be a social issue that has become acute and has dire effects in Pakistan (Batool, 2023). It is assumed that every day, about 700 people die because of disease and overdoses, leading to over 250,000 deaths annually (United Nations Office on Drugs and Crime, 2020).

In Pakistan, heroin dependence is still a significant issue, as the United Nations Office on Drugs and Crime estimates that over 800,000 adult individuals between 15 and 64 years of age use heroin regularly, leading to about 44 tons of heroin consumption each year. According to recent reports, cannabis is the most popular substance, and its number of users reaches 4.03 million, which is 3.6 per cent of the population (Siddiqui et al., 2024).

Moreover, a very powerful substance, methamphetamine, that is frequently manufactured with a low cost of chemicals, has become one of the drugs of choice, with 52.5 per cent of the population of addicts indicating its use (Siddiqui et al., 2024).

Studies have found that some of the components that contribute to the growing trend in drug use are easy accessibility, low prices, peer pressure, curiosity, stress-related factors, and misconceptions, especially the fact that cannabis is not a religiously forbidden substance (Siddiqui et al., 2024; Farooqi and Shahid, 2022). It is

a common problem that can affect presentative of all socioeconomic backgrounds, and it affects men and women of all ages and is common in both rural and urban regions (Farooqi and Shahid, 2022). A recent study that was carried out in Pakistan indicated that individuals with substance use disorder were substantially more prone to relapse if they experienced dysfunctional family backgrounds and displayed a lesser degree of confidence in their ability to avoid using drugs.

The findings highlight the significance of positive family dynamics and enhancing self-efficacy during the development of rehabilitation and relapse prevention programs (Saleem and Masood, 2024).

A Pakistani study reported that better family functioning compared to poor functioning was associated with lower relapse rates due to the increased psychological capital. This implies that favorable family settings can contribute to internal coping and reduce the frequency of substance use (Jan et al., 2023).

Family functioning is seen to be correlated with psychological well-being, besides relapse and abstinence amongst addicts.According to an international study, in illicit drug users, better functioning in the family was correlated negatively with depression mediated by increased self-esteem, with the emphasis on family as a protective mechanism against the mental health deterioration of substance-using communities (MDPI, 2024).

Perceived social support is the idea that a person has or thinks that he or she has people around them who are able to care, help, and can be depended on when necessary. It has nothing to do with the support that is actually provided but the level of support that you feel. Perceived social support, especially that of family members, is very important in addiction recovery. The research indicates that more negative emotions in families correlate with higher relapse rates.

Conversely, relapse rates are lower when an individual perceives greater family support (Atadokht et al., 2015). The World Drug Report indicates that approximately 292 million individuals in the world in 2022 consumed drugs, which was twice the number of drug consumers in the previous decade (United Nations Office

on Drugs and Crime, 2024).Family has a critical role to play in the rehabilitation of drug users, as it is a source of social support. The roles played by a family in the creation of the environment needed to support the development of its members, including communication, emotional response, and involvement, are what are known as family functioning (Steevenson-Hinde & Akister, 1995).

The morale within the household and the sense of support by the individual have a great influence on substance addiction. Recovery from addiction is safeguarded by strong perceived social support, especially from the family, whereas highly expressed emotion by the family increases the hazard of a relapse (Atadokht et al., 2015).

The importance of social support and family role in drug addicts' recovery and quality of life improvement is vital because drug addicts have high levels of relapse, making it one of the key challenges in treating such patients.

Social and psychological functioning are also affected by drug addiction, and thus recovery is hard when the drug addict is undergoing treatment. Psychosocial resources such as social support and self-efficacy could maintain the stable functioning of drug users and mitigate their adverse effects on them, and it is essential since the relapse usually ruins the family relationship and emotional bonds (Malik et al., 2023).

1.2 Gap Analysis

Research on substance use disorder has largely focused on Western populations, where cultural and family systems differ significantly from collectivist societies like Pakistan (Shahid and Asmat, 2024). In Western literature, psychosocial variables such as family functioning, self-efficacy, and social support have been widely studied, but their combined role in determining quality of life remains underexplored in South Asian contexts (Masese, 2020). In Pakistan, limited research has examined substance use disorder from a holistic psychosocial perspective, particularly

in rehabilitation settings (World Health Organization, 2022).Most available local studies focus on treatment outcomes or relapse prevention rather than quality of life as an outcome variable (Fazaldad et al., 2023).

Additionally, very few studies have integrated family functioning, self-efficacy, and perceived social support together within a single predictive framework (Saleem and Masood, 2024).The existing literature also indicates that psychosocial resources play a significant role in recovery, yet their collective influence on quality of life remains insufficiently investigated in Pakistan (Malik et al., 2023).Furthermore, culturally specific evidence is limited despite the fact that family structure and social bonds are central to psychological adjustment in Pakistani society (Masese, 2020).

Therefore, there is a clear need for context-specific research that examines these variables together to better understand quality of life among individuals with substance use disorder in rehabilitation settings (World Health Organization, 2022).

1.3 Problem Statement

Substance use disorder is a growing public health concern that affects individuals' physical, psychological, and social functioning worldwide (World Health Organization, 2020).Despite the availability of treatment services, relapse rates remain high, indicating challenges in sustaining long-term recovery (UNODC, 2011). In Pakistan, individuals undergoing rehabilitation often experience psychological distress and social difficulties that negatively affect their quality of life (Shaarif, Usman, Saleem, 2025).

Factors such as low self-efficacy, weak family functioning, and insufficient social support have been identified as major challenges during the recovery process (Saleem et al., 2021). Previous research suggests that strong family involvement and higher self-efficacy are associated with better psychological adjustment and

improved treatment outcomes (Malik et al., 2023).Similarly, perceived social support plays a significant role in enhancing coping abilities and maintaining stability during rehabilitation (Fazaldad et al., 2023). However, in Pakistan, these psychosocial factors are not systematically addressed in rehabilitation programs due to limited resources and a lack of integrated psychological interventions (World Health Organization, 2020).

As a result, there is a need to investigate how family functioning, self-efficacy, and perceived social support collectively influence the quality of life among males with substance use disorder in the local context (Masood & Sahar, 2014).Understanding these relationships will help in developing more effective and culturally relevant rehabilitation strategies to improve overall well-being in this population (World Health Organization, 2022).

1.4 Rationale of the Study

The most recent statistics show that over 800,000 Pakistani people between the ages of 15 and 64 years are habitual heroin users, and they consume about 44 tons each year (The Nation, 2024). Cannabis is still the widely used drug, and the use of ice (methamphetamine) is also on the increase (Siddiqui et al., 2024).

Other factors contribute to the rate of drug use in Pakistan, and they include dysfunctional family environments, low self-efficacy, absent social support, peer pressure, psychological distress, economic instability, low educational attainment, convenient access to drugs, interpersonal conflicts, and relationship breakdowns (Imtiaz et al., 2024).

The prevalence of drug addiction, especially among young men of youngmene, is an increasing problem in Pakistan, and the consequences of this issue include difficult physical health, psychological issues, social relations, and the quality of life (United Nations Office on Drugs and Crime, 2017).

Although a great focus has been directed towards prevalence rates, medical treatment and relapse, psychosocial factors, which define the quality of life among drug users, have not been adequately examined (Saleem et al., 2021).

The Pakistani culture is a collectivistic society where family and societal relations take the centre of the life of an individual. Poor communication, dysfunctional families, and lack of emotional support have been proposed to be associated with worse recovery and increased substance misuse (Jan et al., 2023).

On the other hand, the patients, who are provided with good emotional and social support by relatives and loved ones, have the possibility of adjusting successfully, having less recurrence, and leading a better life (Atadokht et al., 2015).One of the most fundamental psychological processes of addiction recovery is self-efficacy, which is the belief that an individual can handle the problem.

With increased levels of self-efficacy, there is a better coping skill, a higher ability to stay with treatment and a more successful long-term recovery (Masood and Sahar, 2014).The Social Cognitive Theory suggests that the interplay between personal convictions, such as self-efficacy, and environmental variables, such as family functioning and perceived social support, affects behaviour and well-being and is especially applicable in Pakistan because resources on rehabilitation are scarce (Malik et al., 2023).

Even though the literature on international research has conducted a comprehensive investigation into the roles of family functioning, self-efficacy, and social support in the process of addiction recovery, no studies have been conducted in Pakistan, particularly in the context of their joint influence on the quality of life of male drug users (Zeng and Tan, 2021).

The proposed research is expected to close this gap by exploring the role of synergy of a strong family functioning, high levels of self-efficacy, and perceived social support in enhancing the quality of life of Pakistani male drug addicts (Khazaee-Pool et al., 2025). It is assumed that the findings will inform mental health practitioners and rehabilitation facilities in developing culturally sensitive, family-centred,

psychologically instructive interventions to improve the results of recovery and overall well-being (Fazaldad et al., 2023).

1.5 Theoretical Framework

The social cognitive theory (SCT) is the theory that was developed to explain human behavior based on the interplay between individual factors, environmental factors, and effects of the behavior (Bandura, 1986).
The Social Cognitive Theory (SCT) assumes that behavior is the outcome of reciprocal determinism, meaning that self-efficacy, social environments (i.e., family functioning and perceived social support), and behavioral outcomes (i.e., quality of life) are continuously interacting and influencing each other (Reciprocal determinism, n.d.). This model is commonly used in the field of addiction studies to describe how cognitive and environmental influences interact to influence the recovery and the general well-being (Azami et al., 2014).

One of the primary aspects of SCT is self-efficacy, which refers to a person having faith in his or her capability to plan and engage in activities required to manage difficult situations (Bandura, 1986).

Higher self-efficacy levels imply that such individuals are more persistent, use more adaptive coping styles and are less susceptible to relapse and overall have better opportunities to attain a successful recovery process or have a better quality of life in the context of addiction (Azami et al., 2014).

SCT is also dependent on environmental factors, including family functioning as well as the perceived social support. The healthy family background, giving emotional warmth, role clarity, and effective communication, contributes to the emergence of coping skills, especially belief in self-beliefs, and psychological well-being (Sim, 2025). Likewise, perceived family, friend, or healthcare social support increases confidence, decreases stress, stimulates positive behaviours, and leads to

an improved quality of life (Sim, 2025). Empirical research on the application of SCT in addiction consistently demonstrates that there is an interaction between self-efficacy and social support, which enhances the recovery outcome. The people who have better social support are more likely to develop higher self-efficacy and improve adaptive behaviours, reduce relapse rates, and provide a higher quality of life (Azami et al., 2014). On this theoretical basis, the present study hypothesises that the combination of good family functioning, a high level of self-efficacy, and perceived social support would positively affect the quality of life among male drug addicts. Measures that can help to intensify self-con convictions and social support systems, particularly family support, are therefore likely to facilitate recovery, resilience, and overall well-being in such a population.

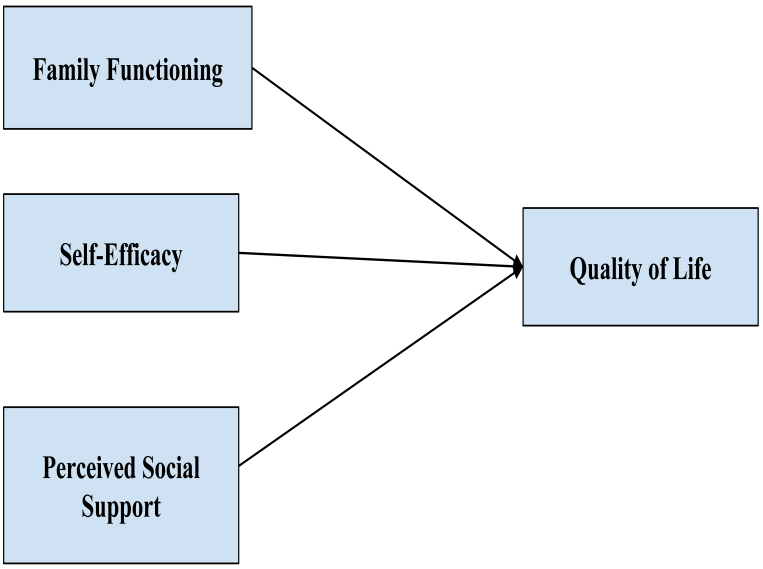

FIGURE 1.1: Conceptual Model of the Study

1.6 Research Objectives

The following are the research objectives of the study:

i. To examine the relationship between family functioning, self-efficacy, perceived social support , and quality of life among males with substance use disorders.

ii. To examine the relationship of education level and marital status with quality of life among males with substance use disorders.

1.7 Research Hypotheses

H1: Increased family functioning (problem-solving, communication, roles, affective responsiveness, affective involvement, behaviour control, and general family functioning) is associated with better quality of life among males with substance use disorder.

H2: Males with substance use disorder who reported better Self-efficacy will report better quality of life.

H3: Males with substance use disorder who perceived more social support (family, friends, significant others) are more likely to perceive better quality of life.

H4: Family functioning, self-efficacy, and perceived social support predict the quality of life among males with substance use disorder.

H5: Males with substance use disorder who have higher education level and are married are more likely to report better quality of life.

Chapter 2

Literature Review

According to the World Health Organization (WHO), substance use disorder is the repeated use of psychoactive substances to the point of intoxication and compulsive behavior towards a favored drug. Additionally, he is committed to using psychoactive drugs at all costs and finds it difficult to stop using them freely.

Substance use disorder is thought to be a worldwide issue that has claimed millions of lives worldwide (Siddiqui et al., 2024). According to a 2020 Elsevier article, people frequently begin smoking cigarettes for enjoyment and happiness. Their need for more dopamine eventually leads them to get addicted to drugs.

The piece also emphasized how drugs are frequently praised and glamorized in film, which makes them more alluring to young people. Drug usage in Pakistan is continuing to rise at an alarming rate despite all the attempts (United Nations Office on Drugs and Crime, 2017) to inform the public about the dangerous effects of drugs on mental and physical health.

These disorders can be treated only through medical treatment; nevertheless, psychosocial factors also affect their recovery. Specifically, family functioning, self-efficacy, and perceived social support may be important factors in improving addicts' quality of life. The association between these psychosocial characteristics

and the rehabilitation and well-being of male drug users is examined in this review of the literature.

2.1 Family Functioning and Quality of Life

The members of low-functioning families might feel negative feelings, which may cause them to resort to substances as a stress coping method (Hiratsuka et al., 2021). The family functioning is crucial to the addict's recovery, as the more flexible and cohesive the household, the more minor drug, psychological, and familial issues the household buffers. It has been identified that the influence of family dynamics on the results of the treatment of drug users has risen to up to 52 per cent of family-related issues, which can be put in place by the fluency of cohesiveness within the family (Costantini et al., 1992).

The positive and well-beating family environment lowers problem behaviors and encourages coping skills, and excellent functioning of the family is critical to mitigate the risk of relapse. Moreover, such psychological processes as self-efficacy mediate this association, and emotional and psychological family support improve the resilience and recovery (Zeng and Tan, 2021).

A dysfunctional family, which is marked by poor communication, conflict, neglect, etc., is related to increased substance use and psychological distress. Conversely, healthy families have high emotional attachment, are flexible, good at resolving problems, and supportive backgrounds, which rehabilitate individuals with addictions better (Khattak et al., 2024).

Comparative studies, including those of addicts of amphetamine against non-addicted controls, indicate that addicts report worse family functioning and worse quality of life. Normalized tests reveal that family role disruptions and behavioral control explain 17 per cent of the discrepancy in the quality of life, implying that poorer family performance is strongly related to lower life satisfaction among the

drug users (Afkari et al., 2013).

Thus, it is also endorsed in literature that family functioning is among the most significant determinants of the development of and recovery from drug addiction since a well-functioning family support system offers emotional, informational, and practical resources that assist a person to manage stress, emotional distress, and cravings, which in the end will provide the person with better psychological well-being. Studies of drug addictions have revealed that positive family help in the form of emotional care, support, and effective communication could enhance the results of mental and physical health, boost coping skills, and encourage prolonged recovery, as opposed to low family support being associated with worse well-being and dependence on drugs (Cai and Wang, 2022).

One of the psychosocial factors that define the outcome of substance is family functioning. Family functioning is the type of quality of interactions that are observed in a family system including communication patterns, emotional involvement, assigned roles, and problem-solving abilities and behavioral control Epstein et al. (1983).

It was always disclosed that the quality of life of the patient of substance use disorder is considerably worse in comparison to the one of the general population. Such omissions are particularly noticeable in the psychological well being, social interactions, as well as emotional comfort (Laudet et al., 2009). Reduced quality of life and consequent rate of relapse to drug users, low treatment compliance and low recovery rates have been listed hence the need to identify psychosocial protective factors that can boost satisfaction on life.

Empirical studies indicate that quality of life is very much associated with family functioning in addicted groups of people. According to a research by Afkari et al. (2013) , who compared amphetamine users and non-users, they have found that the group of addicts has demonstrated significantly less family functioning in many aspects, including but not limited to communication, role fulfillment, emotional

involvement, and others. It was also established that there was positive association between healthy functioning of the family and quality of life which dictated the fact that the well functioning family system individuals had better physical and psychological wellbeing.

It is also possible to refer to the family support as an influential factor that can define the quality of life of drug users. Lin et al. (2011) were able to find in their study about clients who were under methadone maintenance treatment that the perceived family support was well connected with the improved quality of life and reduced use of co-occurring drugs. The results can particularly be applied to male addicts who comprise a large portion of groups seeking treatment even though the sample was of both genders. The results highlight the fact that good family environments can balance the negative social and psychological effects of addiction therefore enhancing the overall satisfaction in life.

Further evidence would support the fact that decreasing the quality of life is not the only effect of limited family functioning, but it the one that exposes the person to the risk of psychological distress as well as relapse. Zeng and Tan (2021) determined that dysfunctional family environments significantly predicted the relapse tendencies of substance use disorders in people. The mediator of this association was psychological capital and argument that an efficient functioning of the family results in emotional resilience and adaptive coping styles that are critical in the quality of life. These data prove that the family dynamics influence the quality of life indirectly because of the influence on the emotional stability and long-term recovery.

As seen in gender-based literature, family dysfunction may be especially risky when it comes to drug users of the male gender due to cultural norms of masculinity, emotional repression, and family. Communication and family support are also incredibly crucial to the psychological well-being and life contentment of men due to their lower probability of exhibiting emotional distress (MacMillan et al., 2022). The addict being isolated, stressed, and guilty may be more in conflictual

or otherwise strained family relationships situations, and this further worsens the quality of life.

2.2 Self-Efficacy and Quality of Life

Studies have always demonstrated that self-efficacy is a decisive psychosocial aspect that determines the quality of life of an addict. The connection between self-efficacy and the quality of life of drug users is not directly studied, and even in cases where it appears, the study lacks true evidence on the relation between well-being and life satisfaction, as it can be supported by the evidence of addiction research (Abdollahi et al., 2014). Increasing self-efficacy is associated with making people more psychologically resilient, stimulating adaptive coping, and boosting healthier behaviors, which ultimately leads to the improvement of the quality of life. Patients who have a higher level of self-efficacy in the rehabilitation environment focus on stress management and recovery motivation and have the capabilities of sustaining their emotional stability in the context of persistent issues associated with addiction (Kamarudin et al., 2020).

Those with less self-efficacy, on the contrary, find it more difficult to manage substance use and address the barriers of addiction. Research shows that there is a probable negative association between self-efficacy and the level of addiction, wherein self-efficacy has a higher likelihood of an individual being resolute about altering addictive behaviors and being in control of using drugs (Torrecillas et al., 2015).

In general, self-efficacy is one of the most crucial determinants of recovery and the outcome of life among drug users. Advantages of higher self-efficacy include a lower chance of relapse, improved stress coping, and behavioral and functional improvements, whereas disadvantages include increased relapse possibility and decreased recovery, making it suitable in rehabilitation as well as quality of life (Khazaee-Pool et al., 2025).

Self-efficacy studies of drug addicts have indicated that it is greatly associated with the severity of the addiction and treatment success, and the higher the self-efficacy, the greater the ability to cope with craving and successful adjustment to treatment. Low self-efficacy, in contrast, is linked with the increased inability to control addiction and maintain recovery, which has a considerable influence on addiction outcomes and psychosocial functioning (Xu, 2023).

Addiction psychology studies point out that self-efficacy is one of the major connections between recovery motivation and quality of life. Both persons with greater self-efficacy levels show increased motivation toward recovery behaviours, and also have better overall quality of life and are less likely to relapse. To put it another way, the desire to change is correlated with positive recovery results through self-efficacy, which means that the more an addict believes in their ability to tolerate the temptation to use drugs and overcome the difficulties, the more it positively influences their psychological, social, and physical health (Valencia and Peters, 2025).

According to classical addiction studies, self-efficacy is a powerful predictor of treatment results and prevention of relapse. Individuals who possess higher self-efficacy possess better coping mechanisms and have lower chances of relapse (Kadden and Litt, 2011a). Kadden and Litt (2011b) indicated the significance of self-efficacy when dealing with substance use disorders. In their review, they suggested that individuals with a higher level of self-efficacy will be more effective in addressing high-risk situations and abstinence and hence healthier and more functional in their daily life.

Role of self-efficacy in recovery of addiction is also evidenced on research. The studies have found that self-efficacy (general and coping-related) plays a significant role in the results of the recovery process, and the rise in self-efficacy is associated with the expansion of the resources to cope with the process of the relapse and the enhanced ability to overcome relapses among patients with opioid dependence (Bhullar and Gupta, 2023).

Though quality of life is not measured per se, such studies as that by Yang et al. (2019) have demonstrated that in case of individuals with substance use disorder self-efficacy is directly correlated with resilience, self-esteem and other psychosocial variables. This is because the higher the self-efficacy the more positive the outcome of psychosocial and hence, the more positive are associated with higher quality of life.

Additional literature indicates that the self-efficacy and psychosocial protective variables have a synergistic impact on the recovery and life satisfaction that enhanced the adverse drug related behaviors, amplified the stress coping processes and engagement in the supportive activities which contribute to improve the psychological and the social well-being Xu (2023).

Many studies have found out that the quality of life of people who have substance use disorders is much less than those without clinical conditions; especially, on the psychological and social dimensions (Laudet et al., 2009). The reduced quality of life in this population has been cited to be due to emotional distress and hopelessness and the high relapse risk. Therefore, the clinical importance of the study of psychological resources that may enhance quality of life of drug users is of interest.

The empirical research has always shown that there is a positive relationship between the self-efficacy and quality of life in substance use disorders. Laudet et al. (2009) have found out that higher level of recovery self efficacy was strongly linked with better quality of life and long term remission. Those individuals who also believed that they could cope with the challenges which had appeared in the process of recovery were more contented with their lives, had improved emotional state and improvement in social functioning.

On the same note, treatments have found that abstinence self-efficacy is a forecaster of psychological wellness and life quality. The study by Majer et al. (2002) established that individuals with high-self-efficacy were more emotionally regulated, fewer cases of depressive symptoms, and enhanced their daily functioning

in the recovery. These psychological benefits are core aspects of the quality of life and it means that self-efficacy is a protective buffer to the adverse psychosocial effects of the addiction.

The existing sources on male drug users indicate that self-efficacy may be especially decisive in this case due to the recruitment into the gender pressures. Men have to struggle with social norms according to which men are expected to be macho and independent, which restricts their readiness to seek assistance or external manifestation of emotions (McKay et al., 2013).

In the mentioned circumstances, the ineffectiveness may arise out of low self-efficacy which leads to feeling powerless and lacks satisfaction in life. Conversely, the enhanced self-efficacy also enables the male addicts to believe that they can overcome it effectively and enhance the psychological state, as well as, the perceived quality of life.

Furthermore, the mediation effect of self-efficacy on the outcome of the treatment engagement and quality of life have also been proved. Changing on the dimension of coping efficacy self-efficacy, a study conducted by Moos and Moos (2006) found out that patients who attained more efficacy of coping during the treatment phase had improved long-term adjustment, and improved life quality after the treatment. These findings indicate that people recovering substance use disorders can have self-efficacy strengthening interventions to enable them to have improved long-term quality of life.

2.3 Perceived Social Support and Quality of Life

Social support plays an important role in deterring cravings and relapse in recovering addictive individuals. According to research, not all substance users are provided with appropriate social support by the surrounding environment (Atadokht et al., 2015). Social support can be generally understood as the degree to

which an individual feels that he/she is taken care of, loved, respected, attentive, and helped by his/her family, friends, or other important people.

Consistent and early social support proved to be the most effective strategy to decrease cravings, reduce the rates of relapses, and positively affect the overall quality of life of drug users (Jia et al., 2024; Atadokht et al., 2015; Nashee et al., 2014).

The perceived social support, or subjective assessment of the presence and sufficiency of support that an individual possesses, is always associated with improved mental health, physical well-being, and life satisfaction of people who recover from alcoholism (Ali et al., 2018).

As an example, one study in Rawalpindi and Islamabad showed that the outcomes in terms of quality of life were found to be better among addicted and non-addicted adolescents who had a high level of social support (Saleem et al., 2021). International studies also confirm that social support is a stress reduction factor and psychological resilience in high-risk groups (Berkman et al., 2014).

Even outside addiction-related research, there is a positive relationship between perceived social support and the acquisition of coping, less stressful symptoms, and better mental health, which influences improved quality of life indirectly (Acoba, 2024).

In populations experiencing substance use disorders, the perceived social support, in particular, their family and friends, has been directly associated with an improved quality of life in various domains, such as individuals with alcohol, opiate, and cannabis use disorders (Ates et al., 2019a).

Studies in Pakistan focus on social support in recovery as well, indicating that it has a positive influence on relapse and psychosocial outcomes, and is strongly related to different aspects of quality of life among rehabilitation patients (Shaarif et al., 2025). All in all, the evidence helps to emphasize that social support is one

of the most important psychosocial resources contributing to resilience, recovery, and a better life experience of those who manage to surpass substance addiction. Multicenter studies on family cohesion and social support evidence show that both social support and family cohesion were positively connected with QoL among individuals with SUDs (however, the outcomes are more of an association than causation) (Birkeland et al., 2021a).

The familiarity of health, mental health, social relationships, and environmental satisfaction are some of the fields where drug users will tend to fall victim to due to the health issues, social stigma, loss of employment, social deprivation, and family conflict(Saleem et al., 2021)). In males, the effects may be worse since drug users, especially male users, experience the effects of the expectations of working and family life on the impact of addiction, leading to lower perceptions of life satisfaction.

In the perspective of an individual, social support is the perception that a person can seek support and assistance of the family, friends and other significant others during the times of need (Zimet et al., 1988). Unlike tangible or objective support, the perceived social support is applied in order to concentrate on the subjective measure of emotional, informational as well as practical help. According to the buffering hypothesis, social support can buffer people against the adverse effect of stress since it can increase the capacity to adapt to stress and build emotional strength (Cohen, 1988). Perceived social support has also been labeled as a critically required psychosocial resource in the context of substance use as a factor of recovery, decrease in the threat of relapse, and overall functioning (Torrecillas et al., 2015).

It has always been empirically demonstrated that quality of life in individuals with substance use disorder correlates positively with perceived social support. To illustrate this, Zhou et al. (2017) have found that patients in the country that were under methadone maintenance treatment and reported a greater perception of social support also had a greater health-related quality of life, particularly in

the psychological and social domains.
Similarly, reported by Ates et al. (2019b), perceived social support significantly predicted quality of life among men with alcohol, opioid, and cannabis use disorders, due to the critical importance of family support in the enhancement of the psychological condition and social networks.

These results are also evidenced by the evidence existing in other cultural contexts. Laudet et al. (2009) reported that strong social support networks were also instrumental in the provision of better life satisfaction and long term recovery of substance dependent individuals in the United States. The researchers of the Social Identity Model of Recovery (SIMOR) indicated that the supportive relationships provided within the framework facilitated the positive social identity change that, in turn, improved the overall well-being and satisfaction with life in the course of recovery (Best et al., 2016). According to such studies, social relations are apt to enhance emotional well being in addition to providing people with a sense of belonging and purpose.

The perceived social support which is mediated by psychosocial variables is also indirectly related to quality of life. Indicatively, Cao and Liang (2020) were able to define that self-esteem and loneliness mediated the relationship between perceived social support and life satisfaction among drug users. The more supported ones reported to have less loneliness and a higher self-esteem that resulted in a better subjective well-being. Similarly, Yu et al. (2020) observed that social support was associated with resilience, mediating the relationship between the former and life satisfaction, and it was concluded that supportive relationships might strengthen internal resources of coping, thereby making life better.

Certain studies that have been conducted on the issue of gender show that social support may be of particular assistance to male drug users due to the social norms that do not promote expression of feelings and help-seeking attitude.It was found by Kelly et al. (2011) that the qualities of the social networks served as the good predictors of the abstinence outcomes especially in men and the intervention

of family and attendance of peer recovery programs such as Narcotics Anonymous contributed to the psychological functioning and satisfaction in life. Social isolation and substance peer affiliation, conversely, were identified to be associated with poorer quality of life and higher risks of relapse (Tarekegn et al., 2022).

The family systems can be protective in such a country as Pakistan, where the use of drugs is the key social health concern as it can be the source of stress caused by culture. Saleem et al. (2021) found out that perceived social support was positively correlated with the quality of life of people addicted to drugs, and the higher the perceived social support, the more developed the psychological and social functioning.

Due to the collectivistic nature of the Pakistani society, family support and favorable attitude to the rehabilitation programs may enhance the success of the recovery process and increase life satisfaction of the male drug users.

2.4 Demographic Factors and Quality of Life

In the studies conducted on drug addicts, demographic factors, including age, sex, education level, and mode of drug use, are likely to have an effect on the quality of life among addicted individuals. To exemplify, in a study conducted in an obligatory drug rehabilitation institution, sex (gender), age, and mode of drug abuse were found to be critical determinants of overall scores on the quality of life, with various demographic subgroups exhibiting either lower or higher scores on quality of life (Ma et al., 2022).

Equally, demographic data have reported that similar studies have found age and education level have a considerable relationship with quality of life, such that older people or less educated people are more likely to report poor quality of life than younger people or more educated people (Barati et al., 2021a). Applying structural equation modelling in another study with youths who used substances showed

that age, sex, employment status, and loss of family members had a strong significance with the health-related quality of life, which means that demographic and life situations influence individual perceptions of wellbeing (Tarekegn et al., 2022).

These results highlight that demographic variables need to be included in evaluating life quality experienced by individuals suffering substance use disorders since they are useful in explaining differences in physical, psychological, and social well-being (Ma et al., 2022). Similarly, Armoon et al. (2022) have concluded that individuals with SUD tend to report worse life quality (across different domains), and that mental health symptoms and social support are more likely to predict life quality than such simplistic demographic variables as age or social background in patients receiving SUD treatment.

Also, Birkeland et al. (2021b) have discovered that psychological comorbidity, family conflict, and distress were more predictive of life quality than such demographic variables as age or social background in individuals receiving treatment of SUD.It means that the cumulative impact of the substance use may prevail over the impact of the degree of education or marital status among the users in determining the results of the quality of life. Karow et al. (2008a) also determined that the personality disorders and interpersonal conflict issues, rather than the sociodemographic issues, were found to be closer to the quality of life issues among opiate addicts.

As an independent variable, social support is now a significant predictor of life satisfaction in people with substance use disorders, even outside of psychological and clinical predictors. Although social support was perceived to be correlated with life satisfaction in individuals with SUD, Cao and Zhou (2021)) indicated that this correlation was positive, which explains why the impact of social networks and internal resources was far more significant than other demographic variables (such as education or marital status). Zhou et al. (2017) also revealed that both the received and perceived social support were related to the improved outcomes of health-related quality of life in patients undergoing a methadone maintenance

treatment, and again social support was demonstrated to be a contributory factor towards life quality outcomes. Including gender differences, additional research uncovers that quality of life may be established to be influenced by other aspects in either gender with the only exception being demographic status. Indicatively, the research conducted by Barati et al. (2021b) showed that the quality of life of women with substance use disorders was to be correlated with social and psychological conditions regardless of their demographic backgrounds.

Chapter 3

Research Methodology

3.1 Research Design

The design used in this study was a quantitative cross-sectional study as it sought to examine how family functioning, self-efficacy, perceived social support, and quality of life were intertwined in male dwith substance use disorder in Islamabad and Rawalpindi.

The participants who have arrived at rehabilitation centres and attended them at one time point provided the data needed to conduct an efficient analysis of associations between variations in psychosocial factors and differences in quality of life (Creswell and Creswell, 2018).

3.2 Sampling Procedure

Convenience sampling was used to recruit the participants who were in rehabilitation centres in Islamabad and Rawalpindi. A priori power calculation relying on the GPower 3.1 (Faul et al., 2009) on the variables of family functioning, self-efficacy, perceived emotional support, and demographic variables implied a minimum sample of 208 individuals to generate adequate statistical power (

0.050.80.15). The sample size was expanded to 300 participants in order to enhance accuracy and deliver strong results to the study, as the sample size is representative and reliable.

3.3 Time Horizon, Study Setting and Data Collection Procedures

The time horizon in this study was cross-sectional, and the data were collected at one time only among male drug addicts who were admitted to the selected rehabilitation centres in Rawalpindi and Islamabad.

The Departmental Ethics Review Committee at the Capital University of Science and Technology approved the research undertaken, and permission was given by the administrations of the rehabilitation centres that participated.

All the participants were informed about the purpose of the study, voluntary participation, and confidentiality of responses. The informed consent signed by each participant was in writing.

They encouraged the participants that their answers would not be publicised, that no personal data would be seen and that they were free to drop out of the study without any repercussions. The information was gathered in small group sessions (3 to 5 members per group) in a quiet and intimate place within the rehabilitation centres.

The researcher described the process, gave directions on filling out the questionnaires, cleared his doubts, and was also available throughout the process. The questionnaires required between 40 and 45 minutes to complete. Upon completion, the participants were debriefed regarding the study and were thanked for collaborating.

Informed consent, confidentiality, voluntary participation, and minimal risk were all strictly adhered to according to APA (2017) ethical requirements.

3.4 Sample Characteristics

The sampling has been performed on male participants aged between 18 and 65 years old and undergoing drug addiction therapy, and the data has been collected.

3.4.1 Inclusion Criteria

The following were the inclusion criteria of the study:

i. The participants were found to have a substance use disorder, which was evaluated under DSM-5.
ii. The participants had been taken into a rehabilitation program.
iii. The participants had the opportunity to fill in self-report surveys.
iv. Informed consent was obtained through the voluntary participation of the respondents.

3.4.2 Exclusion Criteria

The study eliminated the following participants:
i. Mentally debilitated patients who had impaired comprehension were excluded.
ii. Participants who were undergoing the detoxification process at the time of data collection were not included, as they could not provide reliable information.

3.5 Ethical Considerations

The ethics committee of the Faculty of Management and Social Sciences at Capital University of Science and Technology approved this research. The administrations

of the involved rehabilitation centres were also provided with permission.
All the participants were made well aware of the intent of the study, and informed consent was signed by each participant before data collection. The subjects took part on their own free will and had the option of stopping the study at any time without any repercussions. All the information about the participants was highly confidential and was never used in a different context other than in the present study.

3.6 Instruments

3.6.1 Demographic Information Sheet

Background information of the participants was collected using a demographic sheet that comprised age, educational level, marital status, socioeconomic status, years of substance use and type of substances used. This data was a summary of the social and personal attributes of the participants, which proved to be critical in interpreting the connection between family functioning, self-efficacy, perceived social support and quality of life among male drug addicts.

3.6.2 Family Assessment Device

The assessment level of family functioning was conducted with the help of the Family Assessment Device (FAD), which was created by Epstein, Baldwin and Bishop (1983) as the continuation of the McMaster Model of Family Functioning.FAD is a self-report measure that is very popular and is used to determine not only the whole functioning of the family but also the particular dimensions of family interaction. It has 60 items and seven subscales: Problem Solving, Communication, Roles, Affective Responsiveness, Affective Involvement, Behaviour Control, and General Family Functioning. The answers are scored on a 4-point Likert scale with the choices being 1 (strongly agree) to 4 (strongly disagree). Greater scores

show poor functioning of the family, whereas lower scores show the presence of healthy functioning of the family. The scale has been widely applied both in clinical and non-clinical populations, such as patients with substance use disorders, which is why it is suitable to use it in the present study. The FAD has proven reliable and valid across different populations. Cronbach alpha coefficients for subscales have been reported to range from .72 to .92 in previous studies, indicating satisfactory to excellent internal consistency (Epstein et al., 1983; Miller et al., 1985). Construct and discriminant validity of the instrument have also been good, with the instrument successfully differentiating between healthy and dysfunctional family systems. In the current research, the Family Assessment Device was translated into Urdu so that the participants can understand it better. The translation process was done in accordance with the normal forward-back translation, and the version in Urdu was used after making sure that the concepts were equivalent to the original English scale.

In the present study, the Family Assessment Device (FAD) was translated into Urdu to ensure better understanding among participants. The translation was completed using the forward–backward translation approach based on the Brislin (1970) method. First, bilingual professionals translated the original English scale into Urdu. Afterwards, another set of independent bilingual translators back-translated the Urdu version into English to check for accuracy and conceptual similarity. Differences identified during the process were carefully reviewed and resolved to maintain semantic and conceptual equivalence with the original instrument. Once the final Urdu version was finalized, it was presented to the research committee for approval, and the tool was used only after receiving official approval.

3.6.3 General Self-Efficacy Scale

The General Self-Efficacy Scale-Urdu (GSE-U) was used to measure self-efficacy. Tabassum, Rehman, Schwarzer, and Jerusalem (2003) translated the General Self-Efficacy Scale to Urdu by adapting the original version of the scale, the General

Self-Efficacy Scale. The GSE-U is a self-report tool that aims to evaluate how a person believes that he or she can handle the challenging situations and events in life.

GSE-U has 10 items, and answers have to be answered on a 4-point scale based on the Likert scale of 1 (not at all true) to 4 (exactly true). The overall score is between 10 and 40, with the higher the score, the greater the general self-efficacy. The scale has found a wide range of applications in clinical, educational, and research environments, such as those involving mental health and substance-using groups. The Urdu language version of the scale has been shown to have good psychometric properties. In existing studies, it was found that the high internal consistency with the Cronbach's alpha of (.87) and good test-retest reliability (r =.84) were found, meaning that the scale yielded consistent and stable results over time (Tabassum et al., 2003). Construct validity of the GSE-U has also proven to be high since the scores are positively associated with other psychological constructs related to the score, including self-esteem and locus of control.

3.6.4 Multidimensional Scale of Perceived Social Support

The Multidimensional Scale of Perceived Social Support (MSPSS) is a short self-report scale that is intended to measure the perception of social support of an individual by three participants, including Family, Friends, and a Significant Other. Zimet, Dahlem, Zimet, and Farley (1988) first developed it and were able to publish in the Journal of Personality Assessment. The scale has 12 items, 4 of which represent each subscale. The Urdu version of the MSPSS was used in this study, whereby the version was translated to Urdu by Tahira Jibeen, and this was so that the respondents could be in a position to understand the items. All the items are rated on a 7-point Likert scale, with ends of the scale being 1 (Very Strongly Disagree) and 7 (Very Strongly Agree), and higher scores demonstrate higher levels of perceived social support. MSPSS has been extensively researched and has proved to be a good psychometric instrument. It demonstrates high internal consistency,

with a Cronbach alpha of 0.85 to 0.94 for the total scale and 0.81 to 0.93 for the subscales.

The total scale test-retest reliability is between 0.73 and 0.85, with subscales ranging between 0.64 and 0.89, which means that the scale remains stable over time. It is believed that this scale can be used with a wide range of population including Urdu-speaking people, as the scale is valid and reliable in the measurement of perceived social support.

3.6.5 World Health Organization Quality of Life-BREF

World Health Organization Quality of Life-BREF (WHOQOL-BREF) is a self-report measure designed by Dr J. Orley, Dr W. Kuyken, Prof. S. Sabazo (1996), and the WHOQOL Group, with the leadership of the World Health Organization (WHO), to evaluate the quality of life of a person related to different domains. It is a reduced form of the initial WHOQOL-100 and has 26 items, which are categorised into four scales, viz. Physical Health, Psychological Health, Social Relationships, and Environment.

All of them are evaluated by 5 points Likert scale, where high scores imply a superior quality of life. WHOQOL-BREF has found extensive application in non-clinical and clinical populations across the globe. To guarantee that the participants would understand and relate the questionnaires with the cultural context, the Urdu version of the WHOQOL-BREF, which was translated and validated by Touseef Khalid and Dr Rukhsana Kausar (PhD, 2006), was utilised.

WHOQOL-BREF has proved to have good psychometric qualities. The domain's internal consistency lies between 0.66 and 0.84, which is acceptable to good reliability, and the test-retest reliability of the instrument is good across time. The scale is also identified to be good with respect to construct validity, which correlates well with the other related measurements of health and well-being. WHOQOL-BREF

is also known to be a valid and reliable instrument that measures the quality of life in various groups of people, and the Urdu version will make sure that it can be used in the current study.

3.7 Data Analyses

The collected data were statistically analysed with the help of the Statistical Package of Social Sciences (SPSS, Version 26) on N = 300 participants, who had substance use disorders. The first was calculating descriptive statistics of the variables to give the demography of the participants (age, education level, and marital status) in terms of frequencies and percentages. The main variables of the study, which were family functioning,self-efficacy, perceived social support, and quality of life, were summarized and the values of mean, standard deviation, skewness, and kurtosis were calculated.

Before testing the hypothesis, it was tested on the normality of the data was tested by the Kolmogorov-Smirnov (K-S) test. In situations where the normality assumption was not achieved, the non-parametric statistical procedures were used. Cronbach's alpha coefficient was used to measure the internal consistency and reliability of all study scales and subscales. The rho correlation coefficients of the family functioning, perceived social support, self-efficacy, and quality of life were determined using Spearman correlation coefficients.

Multiple regression analyses were done to determine the predictive value of family functioning , self-efficacy and perceived social support on quality of life. The non-parametric tests were applied to compare the differences in quality of life between demographic variables (e.g. education level and marital status) with the help of the Mann-Whitney U test and Kruskal-Wallis test. To test the hypotheses of the study, all the statistical tests were assessed with p ¡.05 as a level of significance.

Chapter 4

Results

This section presents the results of the statistical tests that were performed to test the study hypotheses that examined the relationship of family functioning, self-efficacy and also perceived social support with quality of life in male substance addicts.Pearson product-moment correlation tests were conducted in order to test the relations between family functioning and quality of life, self-efficacy and quality of life, and perceived social support and quality of life.

Moreover, the inferential analyses, such as independent samples t-tests and one-way analysis of variance (ANOVA), were performed to determine the effects of demographic factors (age, education, marital status, and years of addiction) on the quality of life. The findings are given based on each hypothesis.

Table 4.1 shows the demographic variables of the respondents. In terms of marital status, the greatest number of the participants were divorced (25.0%), unmarried (23.3%), widowed (21.7%), married (18.3%), and single (11.7%). This distribution signifies the divergence of marital statuses of the participants. The majority of the respondents in the educational attainment had attained secondary education (30.0%), followed by primary education (28.3%). The proportion of college education was less (21.7) and university-level education (20.0), which implies that most of them had basic to intermediate levels of education. In terms of employment

TABLE 4.1: Frequencies of the demographic characteristics of the study sample ($N = 300$)

Variable	**Category**	**F**	**%**
Marital Status	Married	55	18.3
	Unmarried	70	23.3
	Widowed	65	21.7
	Divorced	75	25.0
	Single	35	11.7
Education Level	Primary	85	28.3
	Secondary	90	30.0
	College	65	21.7
	University	60	20.0
Employment Status	Employed	165	55.0
	Unemployed	135	45.0
Type of Drug	Cannabis	70	23.3
	Heroin	65	21.7
	Cocaine	55	18.3
	Alcohol	80	26.7
	Other	30	10.0

Note. F = Frequency; % = Percentage; N = Total sample size.

status, over half of the participants had a job (55%), whereas 45% did not.

Regarding substance use, alcohol was the most frequently reported substance (26.7%), then cannabis (23.3%), heroin (21.7%), and cocaine (18.3%). A lesser percentage of respondents (10.0) used other substances.

The descriptive statistics of the Family Assessment Device (FAD), Multidimensional Scale of Perceived Social Support (MSPSS), General Self-Efficacy Scale (GSE), and World Health Organization Quality of Life (WHOQOL) domains are given in Table 4.2. The measures of central tendency (mean, median and mode),

TABLE 4.2: Descriptive Statistics and Normality Analysis of Study Variables

Scales and Subscales	**Mean**	**Median**	**Mode**	**SD**	**Skew.**	**Kurt.**	**K.S**
Family Assessment							
Problem Solving	15.00	15.00	6.00	5.98	0.01	-1.29	< .00
Communication	22.50	23.00	36.00	9.06	-0.00	-1.26	< .00
Roles	27.50	27.50	11.00	11.19	-0.02	-1.34	< .00
Affective Responsiveness	15.00	15.00	24.00	6.17	-0.00	-1.34	< .00
Affective Involvement	17.50	18.00	28.00	7.09	-0.00	-1.33	< .00
Behavior Control	22.50	23.00	9.00	7.09	-0.02	-1.28	< .00
General Family Functioning	30.00	30.50	15.00	8.99	-0.04	-1.31	< .00
Multidimensional Scale of Perceived Social Support							
Total Social Support	47.88	48.00	51.00	17.78	0.05	-0.91	.01
Significant Other Support	12.95	13.00	5.25	5.27	-1.00	0.28	< .00
Family Support	12.96	13.25	7.25	5.27	-1.00	0.28	.00
Friends Support	12.98	12.75	14.50	5.24	0.10	-0.92	.06
General Self-Efficacy	24.94	25.00	23.00	8.31	-0.01	-1.02	< .00
Quality of Life							
Physical Quality of Life	20.97	21.00	18.00	4.05	0.07	-0.85	< .00
Psychological Quality of Life	17.96	18.00	18.00	4.77	-0.04	-1.03	< .00
Social Quality of Life	8.97	9.00	7.00	3.54	0.10	-1.09	< .00
Environmental Quality of Life	20.95	21.00	25.00	7.71	0.02	-1.07	< .00

. Mean = arithmetic average, Median = middle value, Mode = most frequently occurring value, SD = standard deviation, Skew. = skewness, Kurt. = kurtosis, K.S = Kolmogorov–Smirnov test of normality, significant Kolmogorov–Smirnov values indicate deviations from normality.

dispersion (standard deviation), and normality were discussed.
The Kolmogorov-Smirnov (K-S) test showed large degrees of non-normality with regard to all variables of the study (p ¡.05). Thus, the normality assumption was not satisfied, and the inferential analysis was continued using a non-parametric method of analysis.The median scores of the FAD subscales, which included Problem Solving, Communication, Roles, Affective Responsiveness, Affective Involvement, Behaviour Control, and General Family Functioning, were in proximity to the respective means, indicating consistency in the central tendencies.Nevertheless, the importance of the KS values demonstrates that the distributions were not normally distributed. Subscale, variability was moderate, which implies that there are differences in individual's perceptions of family functioning.

In like manner, MSPSS total and subscale scores had moderate dispersion and central tendencies, but using the K-S test, the results were non-normal distributions. This implies that there is variability in perceived social support of significant others like friends and family amongst the participants.The General Self-Efficacy Scale (GSE) also exhibited moderate variance with central measures of tendency showing homogeneous levels of self-efficacy among the participants. However, the K-S statistic was very high, indicating that the distribution was not normal.

Measures of central tendency were consistent across all WHOQOL domains, and the variability was low-moderate. Regardless, the outcomes of the K-S tests showed that there were non-normal distributions of the domains.

Because it was established that the assumptions of normality were regularly violated across variables, inferential tests were used when dealing with non-parametric statistics, and Spearman's rho was utilised to perform correlation analyses, and rank-based tests were used when comparing different groups. This method was used to have a strong and sound statistical interpretation as per the distributional properties of the data.

Table 4.3 shows the coefficients of reliability, descriptive statistics, and actual

TABLE 4.3: Descriptive Statistics and Reliability Coefficients of Study Variables

Scales and Subscales	**n**	α	**Mean**	**SD**	**Actual Range**	**Potential Range**
Family Assessment	60	.88	150.00	23.83	–	–
Problem Solving	6	.94	15.00	5.98	6–24	6–24
Communication	9	.97	22.50	9.06	9–36	9–36
Roles	11	.97	27.50	11.19	11–44	11–44
Affective Responsiveness	6	.96	15.00	6.17	6–23	6–24
Affective Involvement	7	.96	17.50	7.09	7–28	7–28
Behavior Control	9	.96	22.50	7.09	9–36	9–36
General Family Functioning	12	.97	30.00	8.99	14–46	12–48
Perceived Social Support	12	.92	47.88	17.78	12.08–77.58	12–84
Significant Other Support	4	.81	15.94	6.41	8–22.7	4–28
Family Support	4	.80	15.96	6.34	6.2–22.7	4–28
Friends Support	4	.80	15.98	6.37	6.2–22.7	4–28
General Self-Efficacy	10	.90	24.94	8.31	10–40	10–40
Quality of Life	26	.96	–	–	–	–
Physical Quality of Life	7	.76	20.97	4.05	12–31	7–35
Psychological Quality of Life	6	.76	17.96	4.77	8–29	6–30
Social Quality of Life	3	.78	8.97	3.54	3–15	3–15
Environmental Quality of Life	4	.90	20.95	7.71	7–35	7–40

(observed) and hypothetical (theoretical) ranges of scores of all measures of the study. Generally, the internal consistency of the instruments was good to excellent, with subscale of the Family Assessment Device (FAD) Cronbach alpha of between .88-97, Multidimensional Scale of Perceived Social Support (MSPSS)

Cronbach alpha of .92, General Self-Efficacy Scale (GSE) Cronbach alpha of.90 and WHOQOL-BREF total scale of.96.

These results show that the target constructs were well measured using the measures in the study.Regarding family functioning, the FAD total score had a mean of 150.00 (SD = 23.83), and the family functioning difficulties in the sample were moderate.

Mean values of FAD sub scales, such as problem solving (M = 15.00, SD = 5.98), communication (M = 22.50, SD = 9.06), roles (M = 27.50, SD = 11.19), affective responsiveness (M = 15.00, SD = 6.17), affective involvement (M = 17.50, SD = 7.09), behavior control (M = 22.50, SD = The theoretical ranges of the observed scores in all the FAD subscales were within their theoretical ranges, and therefore played well with the scale.

The mean score of perceived social support measured using the MSPSS is 47.88 (SD = 17.78), which implies that there was a moderate level of perceived social support among the participants. Likewise, the self-efficacy scores indicated an average confidence in coping skills with a mean score of 24.94 (SD = 8.31). Both MSPSS and GSE ranges were not out of range of their potential score ranges, indicating that both are free of ceiling and floor effects.

The domain scores measured on the WHOQOL-BREF revealed moderate scores in all the domains of quality of life. Physical health (Domain 1) had a mean of 20.97 (SD = 4.05), a mean of 17.96 (SD = 4.77) on psychological health (Domain 2), a mean of 8.97 (SD = 3.54) on social relationships (Domain 3) and 20.95 (SD = 7.71) on environmental quality of life (Domain 4). The actual scores of all domains were within the theoretical limits, which justifies the suitability of the data to conduct further statistical analysis. On the whole, the correspondence of the observed and possible score ranges, as well as acceptable reliability coefficients, revealed that the functions of the study measures served the purpose and were appropriate to proceed with the inferential analyses thereof.

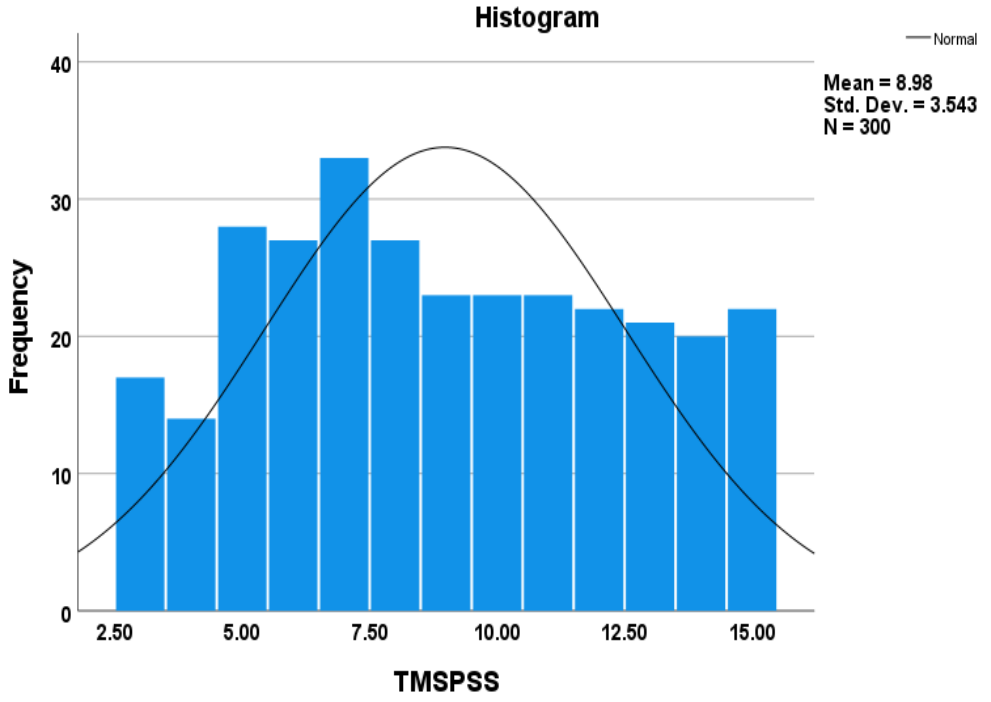

FIGURE 4.1: Histogram with normality curve for perceived social support (MSPSS)

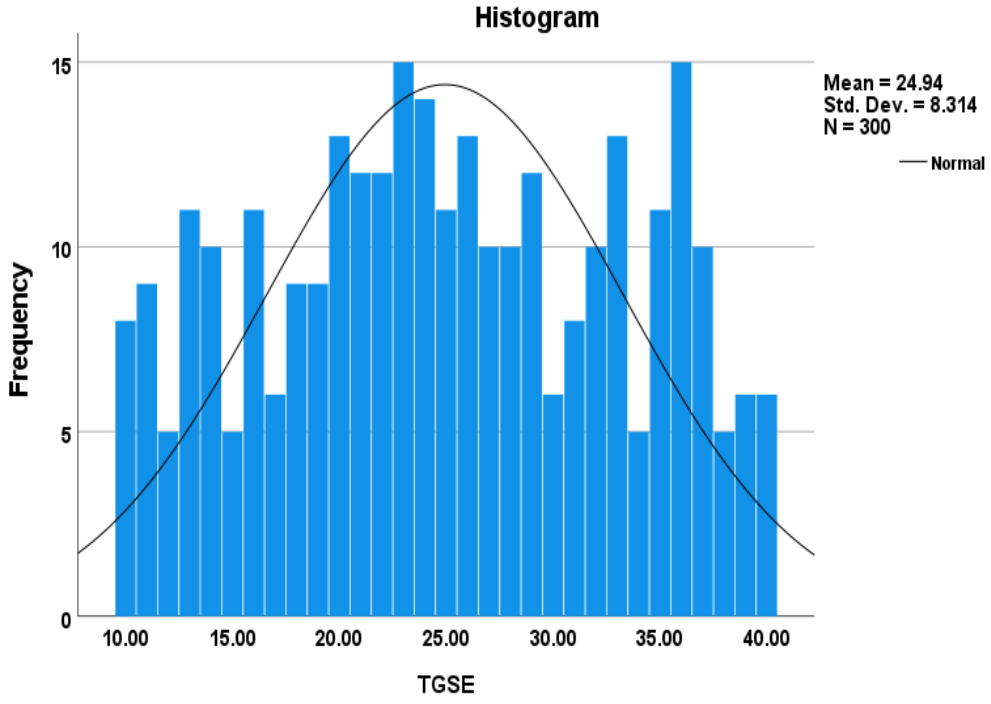

FIGURE 4.2: Histogram with normality curve for significant other (N=300)

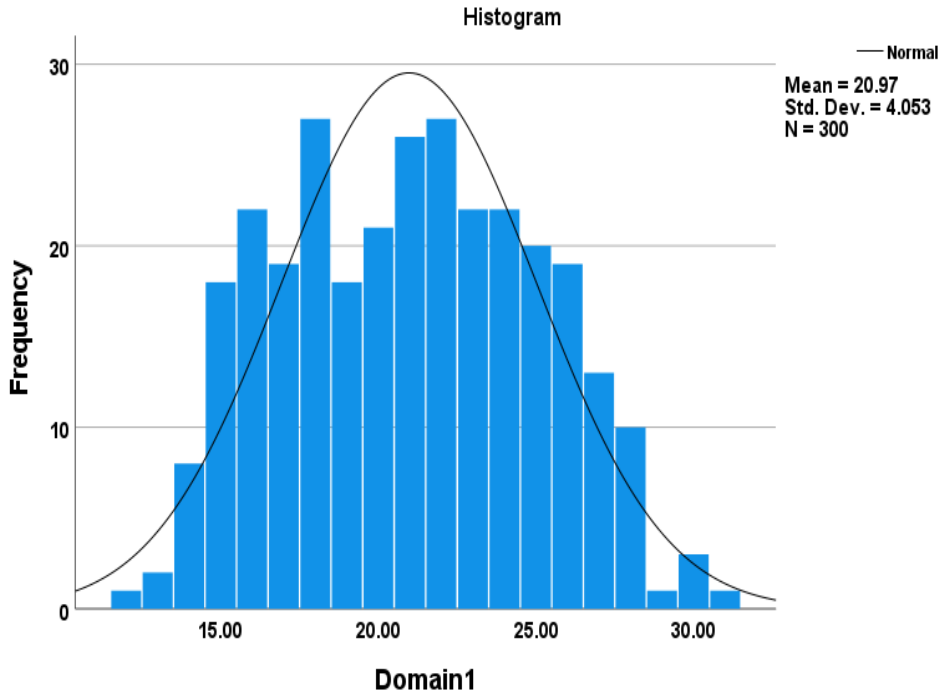

FIGURE 4.3: Histogram with normality curve for family (N=300)

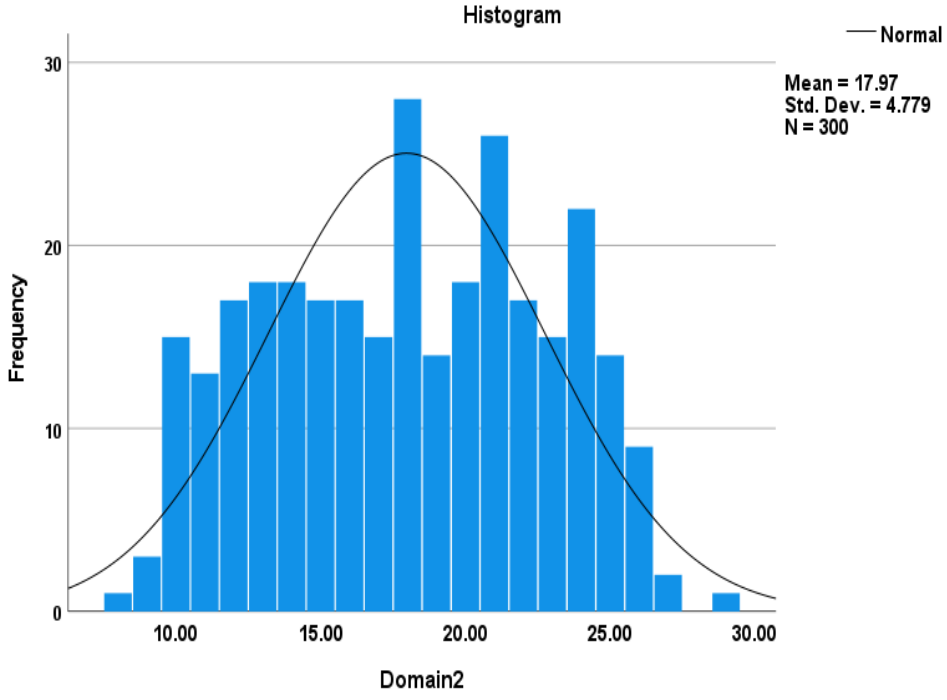

FIGURE 4.4: Histogram with normality curve for friends (N=300)

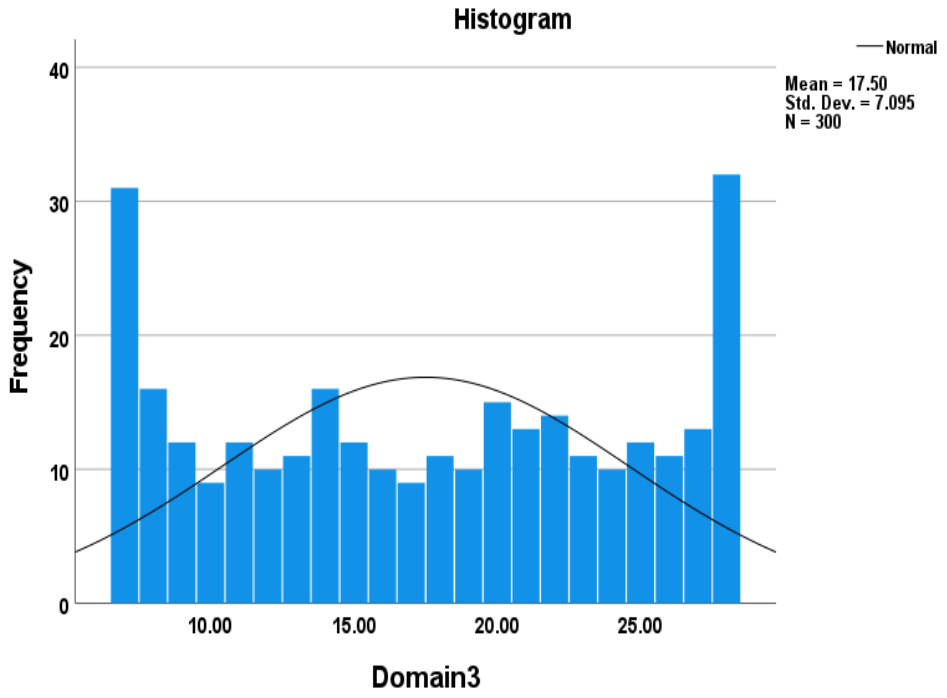

FIGURE 4.5: Histogram with normality curve for general self-efficacy (N=300)

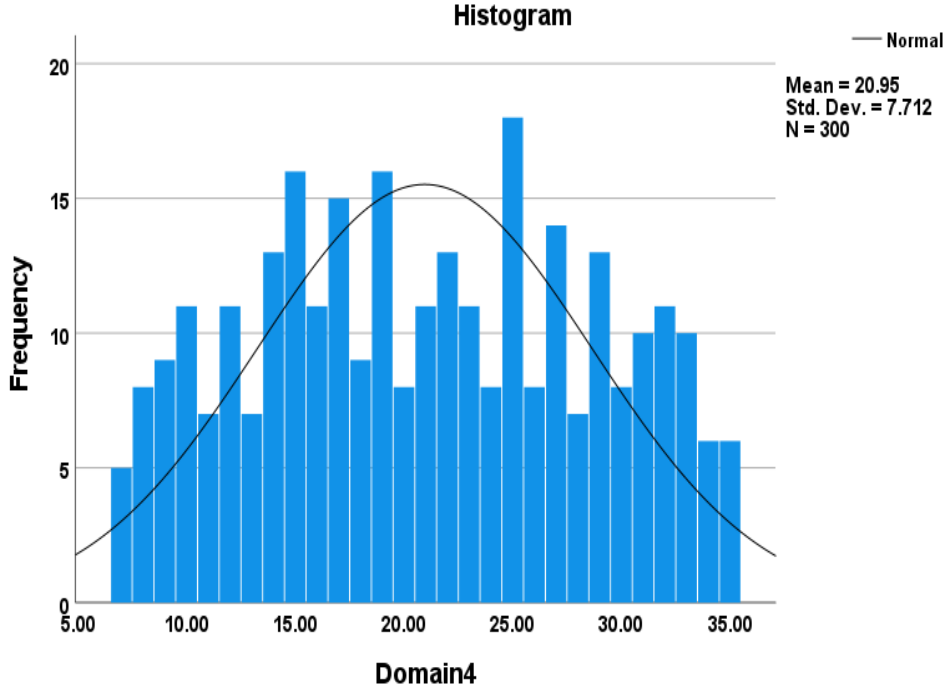

FIGURE 4.6: Histogram with normality curve for QoL domain 1 (N=300)

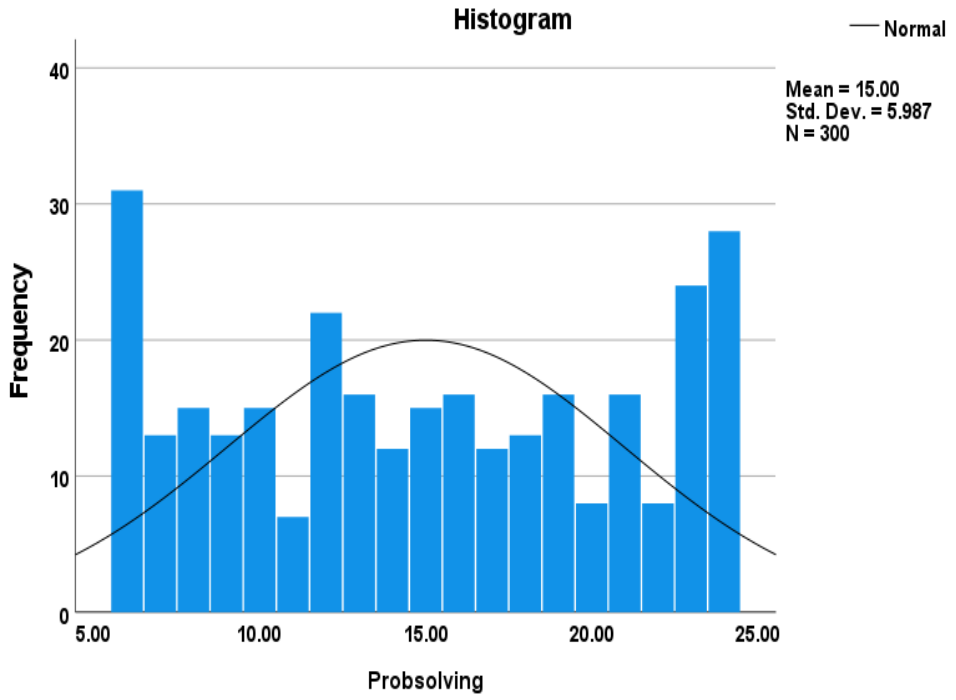

FIGURE 4.7: Histogram with normality curve for QoL domain 2 (N=300)

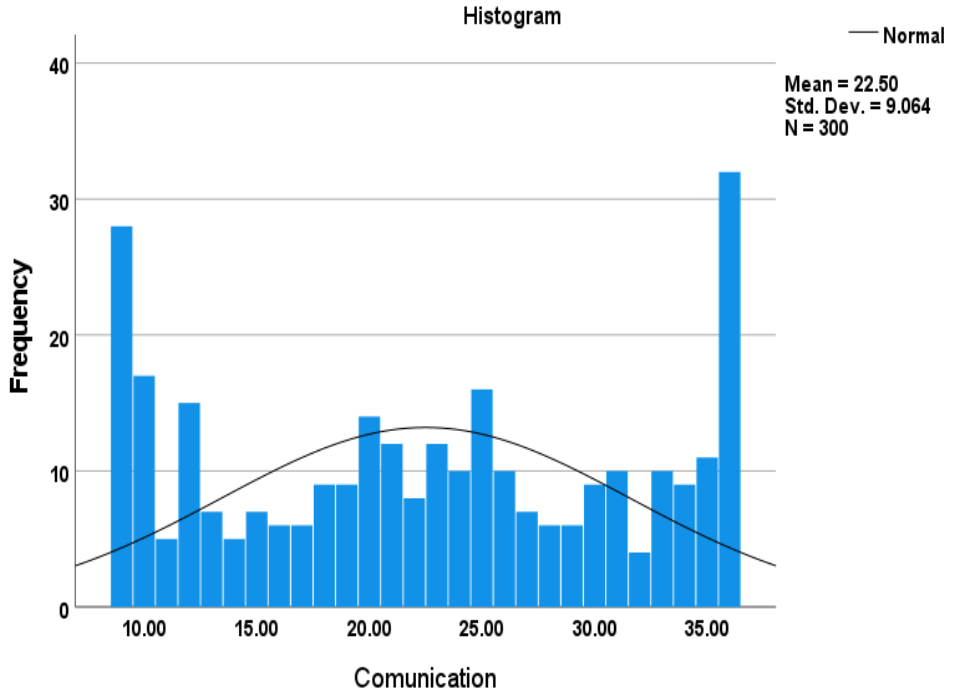

FIGURE 4.8: Histogram with normality curve for QoL domain 3 (N=300)

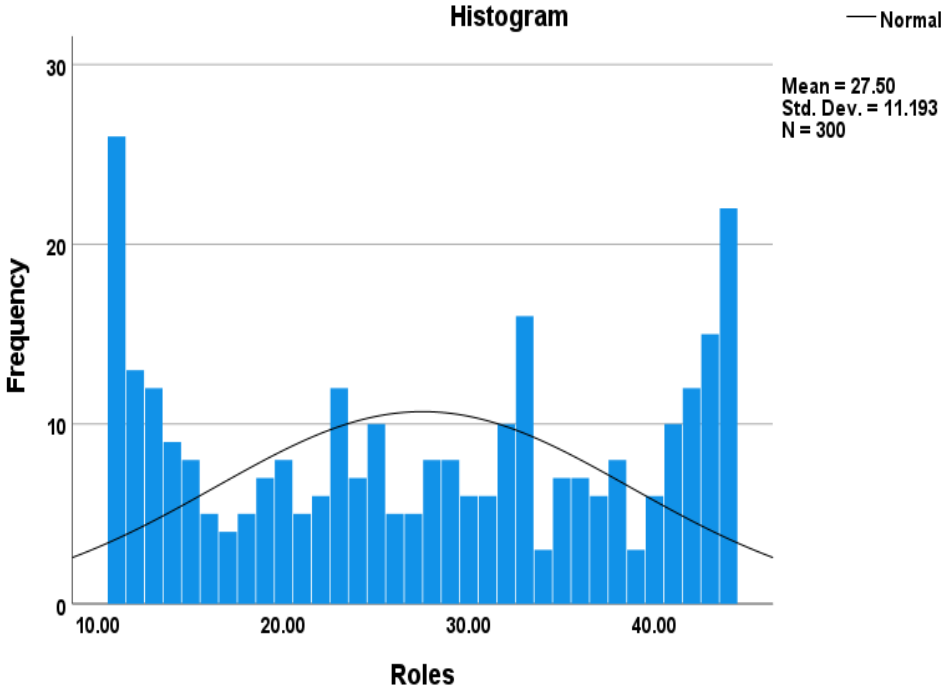

FIGURE 4.9: Histogram with normality curve for QoL domain 4 (N=300)

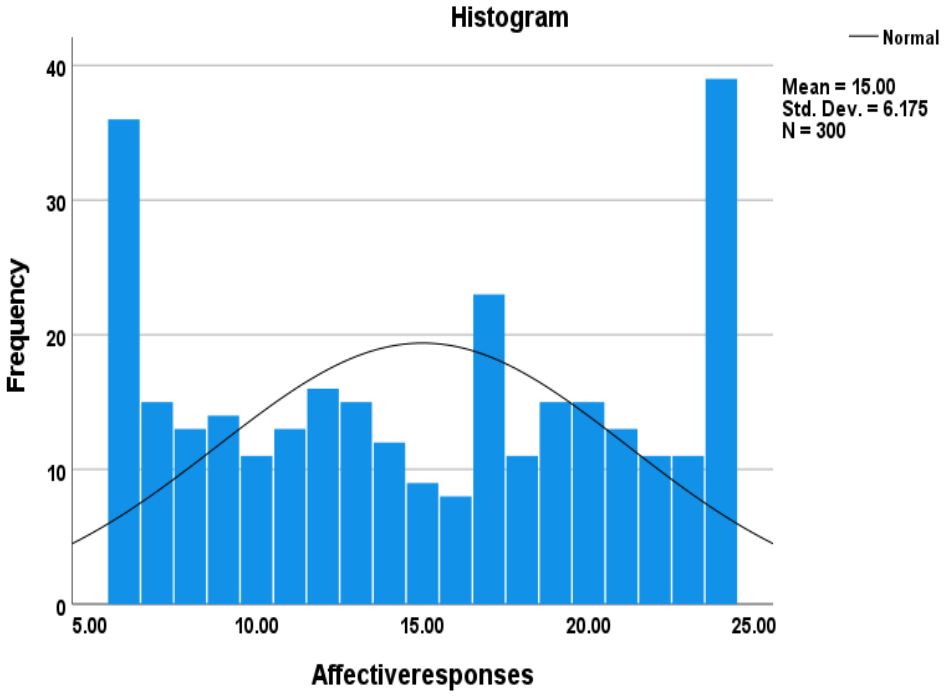

FIGURE 4.10: Histogram with normality curve for problem-solving (FAD) (N=300)

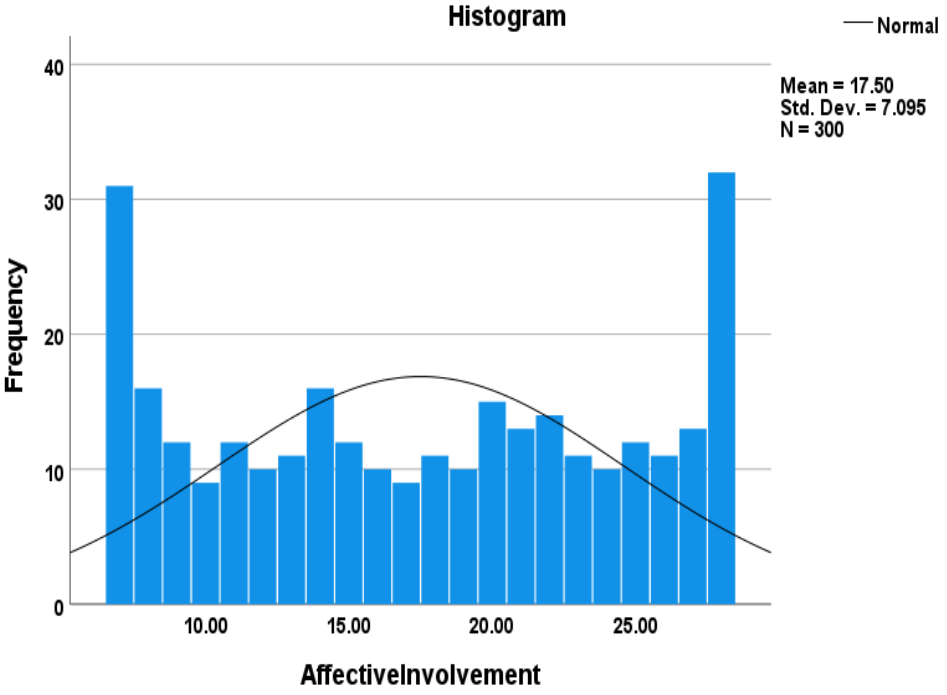

FIGURE 4.11: Histogram with normality curve for communication (FAD) (N=300)

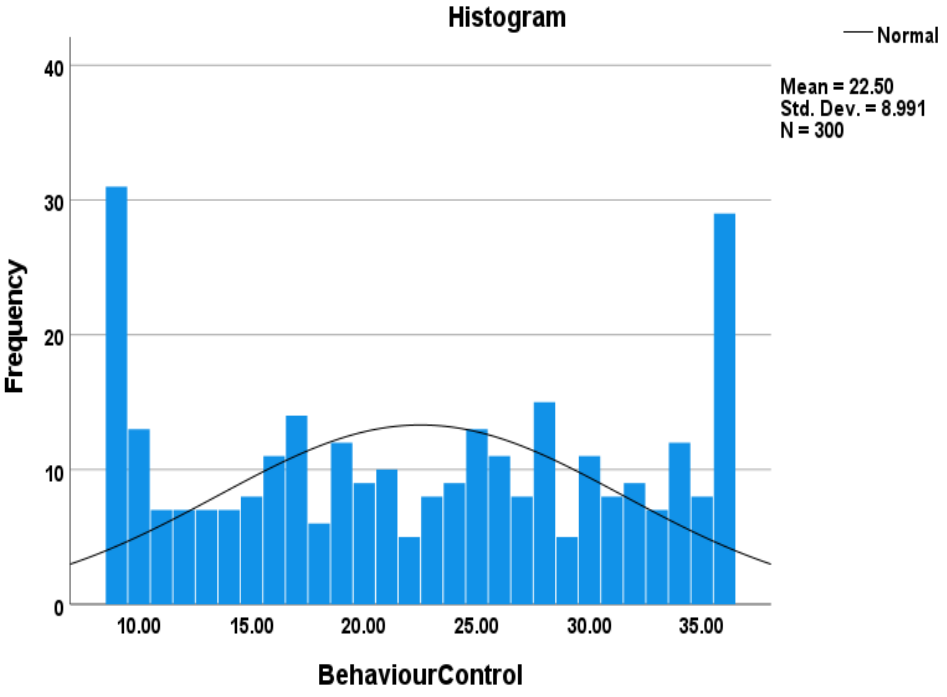

FIGURE 4.12: Histogram with normality curve for roles (FAD) (N=300)

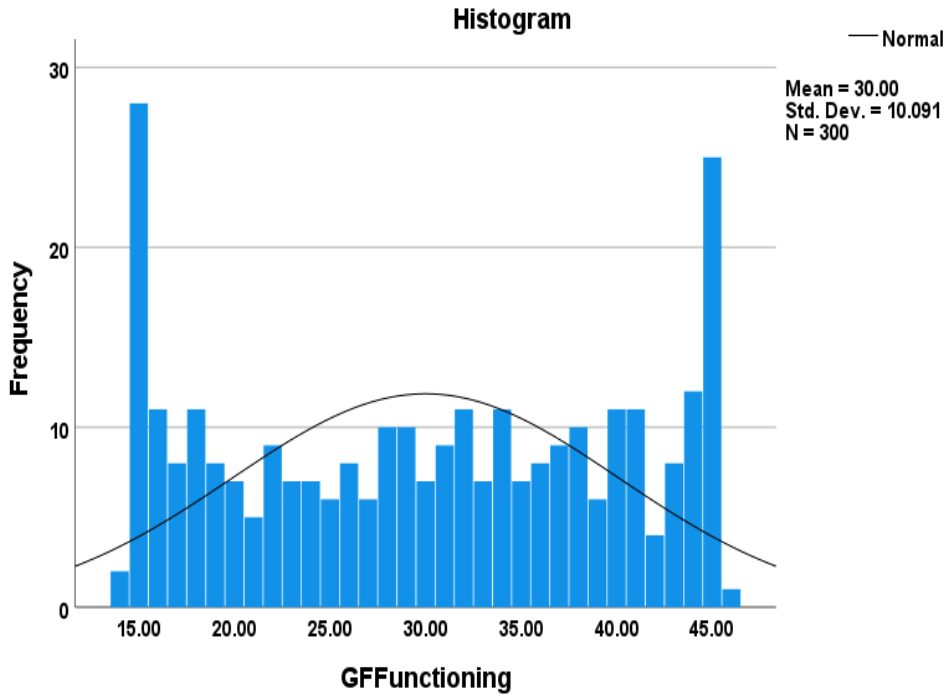

FIGURE 4.13: Histogram with normality curve for affective responses (FAD) (N=300)

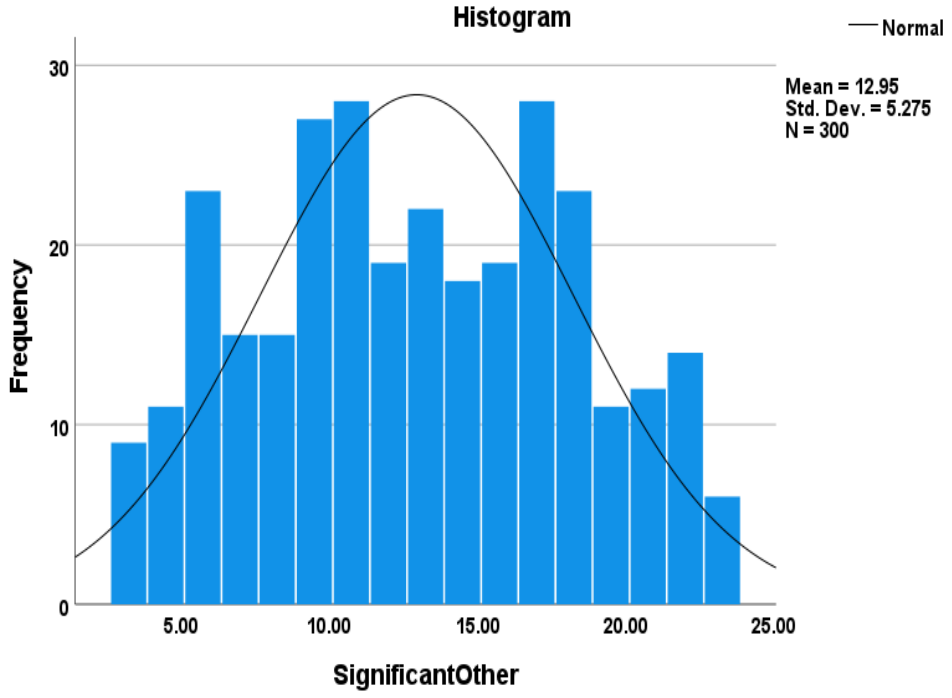

FIGURE 4.14: Histogram with normality curve for affective involvement (FAD) (N=300)

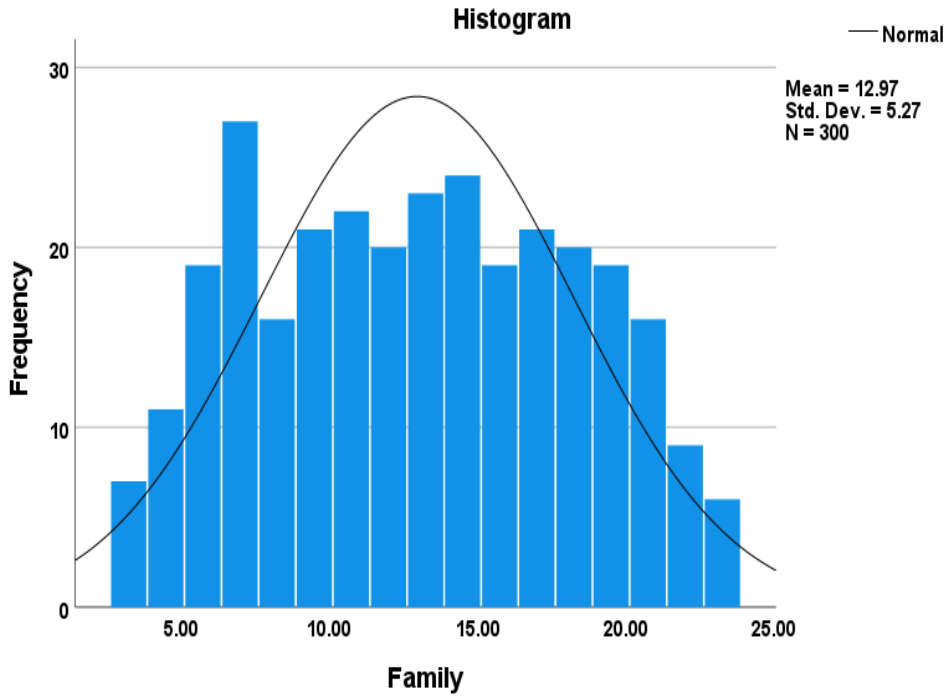

FIGURE 4.15: Histogram with normality urve for behaviour control (FAD) (N=300)

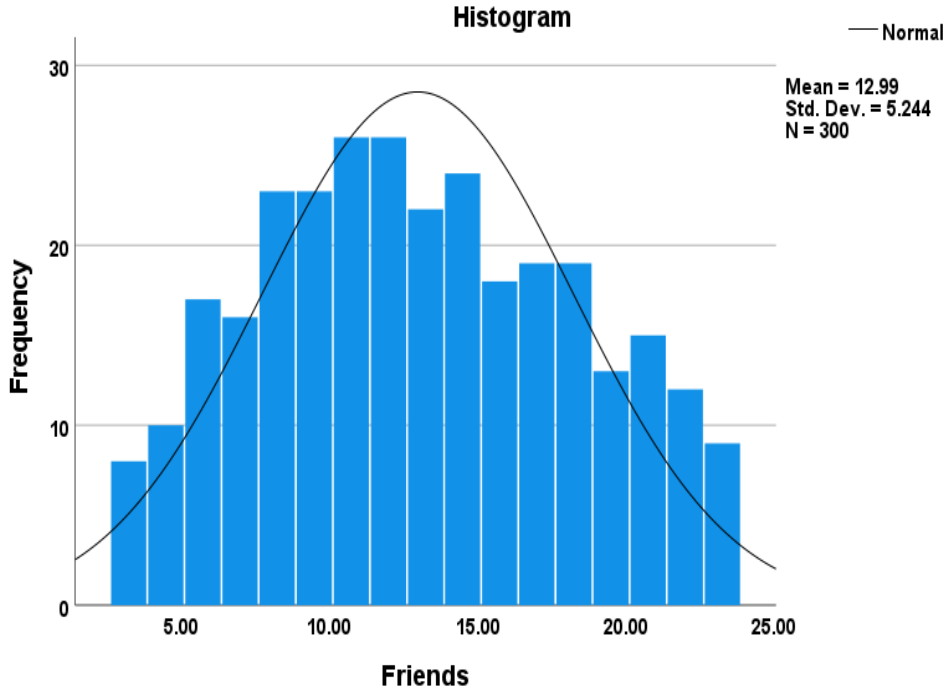

FIGURE 4.16: Histogram with normality curve for general family functioning (FAD)

TABLE 4.4: Spearman's Rho Correlations between Family Functioning (FAD) Subscales and Quality of Life Domains (N = 300).

Variables	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**
Family Assessment	—										
Problem Solving	.017	—									
Communication	.060	−.095*	—								
Roles	.010	−.062	.093	—							
Affective Responsiveness	.058	.117*	−.060	−.068	—						
Affective Involvement	.090	−.092	.149**	.020	.031	—					
Family Functioning	−.078	−.086	−.012	.079	−.024	.002	—				
Physical Quality of Life	.111*	−.008	−.063	−.017	.041	.021	−.020	—			
Psychological Quality of Life	.049	−.112*	−.028	−.050	.043	−.036	−.007	.708**	—		
Social Quality of Life	.075	−.138**	−.046	−.078	.076	−.006	−.011	.700**	.755**	—	
Environmental Quality of Life	.056	−.090	−.041	−.020	.041	−.004	.021	.757**	.815**	.830**	—

Note. *=<.005, **=<.001, ***=<.000

Hypothesis 1 was that increased family functioning is associated with increased quality of life among males with substance use disorder. Table 4 shows the Spearman rho correlations between the family functioning dimensions, perceived social support and quality of life domains.

The findings show that the majority of the correlations between the variables of family functioning were low, with only a few being statistically significant. Communication showed a small but significant negative relationship with roles ($r = .095$, $p < .05$), Domain 2 ($r = .112$, $p < .05$), and Domain 3 ($r = .138$, $p < .01$), while a weak positive association was observed with affective involvement ($r = .117$, $p < .05$).

Moreover, behavior control was positively correlated with roles ($r = .149$, $p < .01$). Problem-solving had a weak but significant positive correlation with Domain 1 ($r = .111$, $p < .05$), and no other significant relationships were found with this variable. There were no significant associations of overall family functioning (GFF) with other variables in the study, suggesting that they were not directly associated with other variables in this sample.

There were high positive relationships between quality of life domains (Domain 1-Domain 4) with coefficients of between .700 to.830 ($p < .01$), indicating high degree of interrelationships between these dimensions. On the whole, the data indicates that the family functioning variables do not have strong relationships but the domains of quality of life are closely connected, which indicates that they are well-organized in the given research.

Hypothesis 2 was that males with substance use disorder who reported better self-efficacy will report increased quality of life.Hypothesis 2 predicted that the trait general self-efficacy would have a positive correlation with quality of life in drug users. Since the assumption of normality was not met, the rho correlation analysis with Spearman was used to analyse the correlations between trait general self-efficacy and the domains of quality of life.

Table 4.5: Spearman's Rho Correlations between Self-Efficacy and Quality of Life Domain (N = 300).

Scales and Subscales	**1**	**2**	**3**	**4**	**5**
1. Self-Efficacy	—				
2. Domain 1 (Physical)	.269**	—			
3. Domain 2 (Psychological)	.333**	.708**	—		
4. Domain 3 (Social)	.337**	.700**	.755**	—	
5. Domain 4 (Environment)	.373**	.757**	.815**	.830**	—

Note. $^{**}p < .01$. Values represent Pearson product-moment correlation coefficients.

The outcomes showed statistically significant positive correlations of trait general self-efficacy with all quality of life domains, such as physical, psychological, social, and environmental domains (p <.01).These relationships were moderate to moderately strong, which implied that higher levels of self-efficacy were associated with persons indicating better levels of perceived quality of life in various life areas.

In particular, self-efficacy was positively related to physical quality of life in moderate terms, implying that those who consider themselves more successful and able to perform better could have better physical functioning and health-related well-being. Higher correlations were perceived between self-efficacy and psychological, social and environmental quality of life, and this demonstrates the pivotal role of self-efficacy in emotional well-being, interpersonal and environmental resources satisfaction.

These results also indicate that self-efficacy can serve as an important psychological resource of drug users, which helps drug users to be better prepared to deal with stressors, sustain social relationships, and have a more positive outlook on their current life situations despite the existing problems related to substance use.Overall, the consistent and significant positive associations across all quality of life domains provide strong empirical support for the proposed relationship between self-efficacy and quality of life.

Table 4.6: Spearman's Rho Correlations between Perceived Social Support and Quality of Life Domains (N = 300)

Scales and Subscales	1	2	3	4	5	6	7	8
1. TMSPSS	—							
2. Significant Others	.924**	—						
3. Family	.904**	.763**	—					
4. Friends	.907**	.784**	.743**	—				
5. Domain 1 (Physical)	.400**	.380**	.337**	.385**	—			
6. Domain 2 (Psychological)	.382**	.349**	.333**	.371**	.708**	—		
7. Domain 3 (Social)	.407**	.360**	.357**	.404**	.700**	.755**	—	
8. Domain 4 (Environment)	.442**	.407**	.393**	.403**	.757**	.815**	.830**	—

Note. TMSPSS = Total Multidimensional Scale of Perceived Social Support. $^{**}p < .01$. Values represent Pearson product-moment correlation coefficients.

Hypothesis 3 was that males with substance use disorder who perceived more social support are more likely to perceive better quality of life.Hypothesis 3 was that there would exist significant and positive correlations in perceived social support of family, friends and significant others, with quality of life among drug users. Since the data did not obey the normality assumption, the correlation analysis using rho of Spearman was used.

The outcomes showed statistically significant, positive relationships among perceived social support and domains of quality of life ($p < .01$).

There was a moderate positive correlation between overall perceived social support (TMSPSS) and physical, psychological, social, and environmental quality of life, which implies that the high overall perceived social support is always related to the high quality of life.

Family, friends, and significant others' support also played a vital and positive role at the subscale level and were significantly connected with all domains of quality of life.

These results indicate that social support that is achieved through various sources adds value to the physical health of individuals, their psychological adaptation, relations with others, and their satisfaction with the state of the environment.

Perceived social support is an important protective psychosocial factor for drug users, as these associations may be strong and consistent.

The respondents who have a more positive perception of emotional and instrumental support might be more advantageous to endure the stress, diminish the sense of isolation, and keep positive assessment of their life situation despite stressful experiences related to substance use. In totality, the results have solid empirical evidence on the desired hypothesis of the relationship between perceived social support and quality of life.

Table 4.7: Multiple Regression Analysis Predicting Outcome Variable

Scales and Subscales	Unstandardized Coefficients		Standardized Coefficients	t	p	95% CI	
	B	SE	β			LL	UL
Constant	33.51	6.96	—	4.82	$< .001$	19.82	47.21
Significant Other	0.69	0.31	.20	2.25	.025	0.09	1.30
Friends	0.78	0.30	.22	2.62	.009	0.19	1.37
Self-Efficacy	0.74	0.11	.34	6.79	$< .001$	0.53	0.95
$R^2 = .33$							
$F(11, 288) = 13.00$							

Note. SE = Standard Error; β = Standardized beta coefficient; CI = Confidence Interval; LL = Lower Limit; UL = Upper Limit.

The predictors of quality of life among substance users were investigated using a multiple regression analysis.The overall model was statistically significant, F(11, 288) = 13.00, p < .001, explaining 33% of the variance in quality of life ($R^2 = .33$).

The final model included only statistically significant predictors.Among them, general self-efficacy became the most significant positive predictor of the quality of life (0.34, t = 6.79, p =.001), which means that the higher the self-efficacy, the better quality of life the person is going to report.Moreover, perceived social support of friends (= +.22, t = +2.62, p = +.009) and significant others (= +.20, t = +2.25, p = +.025) also were found significant and positive predictors.

On the whole, these findings suggest that individual psychological resources (self-efficacy) and selective interpersonal support (friends and significant others) are key factors in promoting the quality of life among substance users.

TABLE 4.8: Kruskal–Wallis H Tests Examining Differences in Quality of Life Domains Across Educational Level and Marital Status (N=300).

Grouping Variable	***Domain***	χ^2	**df**	***p***
Educational Level	D1 (Physical)	2.75	3	.432
	D2 (Psychological)	2.58	3	.461
	D3 (Social)	1.48	3	.686
	D4 (Environment)	2.87	3	.412
Marital Status	D1 (Physical)	2.57	3	.463
	D2 (Psychological)	2.45	3	.485
	D3 (Social)	0.89	3	.829
	D4 (Environment)	2.11	3	.550

Note. Kruskal–Wallis H test was used due to non-normal distribution of data. D1 = Physical Quality of Life; D2 = Psychological Quality of Life; D3 = Social Quality of Life; D4 = Environmental Quality of Life. $p < .05$ indicates statistical significance.

The Kruskal-Wallis H tests were applied to test the differences in the quality of life domains according to educational level and marital status, since there was a violation of the normality assumption.The outcome showed that physical, psychological, social, or environmental quality of life had no significant relationships with educational level ($p > .05$ in all of them). On the same note, no statistically significant difference was shown in any quality of life domain among groups of marital status ($p > .05$).

Although slight differences in means ranks were identified among groups, they were not statistically significant. Overall, it can be concluded that the level of education and the status of marriage did not play a major role in the quality of life of the drug users in the current sample.

Chapter 5

Discussion and Conclusion

The current research was aimed at analyzing the associations between family functioning, self-efficacy, the perception of social support, and the quality of life in males with substance use disorder and assessing the impact of the chosen demographic variables.

The sample size was 300 participants who were of various marital statuses and educational levels with a significant number of divorced, unmarried, or widowed and most of them having a primary to secondary education. This age profile represents a group of people who might be exposed to different levels of social instabilities and life stressors, which can be applicable in the context of substance use and psychosocial functioning.

Descriptive results revealed that overall, the participants reported moderate levels on major study variables, such as family functioning problems, perceived social support, self-efficacy, and quality of life areas. Notably, reliability analysis showed that the measures used had high internal consistency, with Cronbach alpha coefficients of acceptable to excellent reliability indicating that the measures used were appropriate in terms of precision and consistency in measuring the constructs.

Since the assumption of normality was not met in all the variables, non-parametric

statistics were used, such as Spearman rho correlations and KruskalWalls tests, thus making the results robust and valid. The general trend of the outcomes showed a differentiated and theoretically significant set of relations. In particular, the variables of family functioning revealed mostly weak and nonsignificant correlations with quality of life, which means that the structural and relational elements of family dynamics might not directly reflect perceived well-being in this population.

Self-efficacy, on the other hand, exhibited moderately significant and statistically significant positive relationships with all domains of quality of life, indicating its pivotal position as a psychological resource contributing to the ability of people to cope with stressors, regulate their emotions, and continue to adaptively perform despite substance-related obstacles.

Likewise, perceived social support, such as family, friends, and significant other support, was significantly and positively correlated with quality of life, which indicates that perceived more emotionally and instrumentally supported people are more likely to report improved physical, psychological, social, and environmental well-being.

Nevertheless, the regression analysis developed a more subtle picture, as the predictor of quality of life was only self-efficacy when the predictors were used at the same time, and the family functioning and perceived social support did not show any significant unique effects. This result indicates that social support is a significant factor at a correlational level but its predictive ability could be overwhelmed by other psychological factors like self-efficacy.

Moreover, the demographic variables analysis revealed that education level and marital status did not have a significant effect, which implies that the psychosocial and psychological factors are more likely to contribute to the well-being of males with substance use disorder than demographic factors. Combined, these results can offer a complete picture of the comparative role of interpersonal, psychological, and demographic determinants, with the most significant influence being the internal

psychological resources, which determine the quality of life among a specific clinical group.

5.1 Hypothesis 1: Family Functioning and Quality of Life

Hypothesis 1 was that increased family functioning is associated with increased quality of life among males with substance use disorder. Nevertheless, this hypothesis was not backed by the results of the current study. A majority of family functioning dimensions, such as problem solving, communication, roles, affective responsiveness, affective involvement, behaviour control, and general family functioning did not have weak and non-significant correlations with quality of life domains. A limited number of small associations were found, which point to the fact that the family functioning did not become a powerful direct predictor of the quality of life in this sample.

These results can be explained by the fact that substance use disorders are chronic and complicated. Persistent family conflict, emotional detachment, and broken relationships are commonly linked to long-term substance use and could diminish the immediate impact of family processes on the subjective well-being of individuals. Consequently, people might be more inclined to depend on personal coping skills or external support as opposed to the family dynamics and assess their quality of life.

These results are in line with the earlier studies that indicate that family influences might not directly determine the overall quality of life but might act via more specific or indirect mechanisms. Indicatively, Zeng and Tan (2021) found that family cohesion had stronger relationships with treatment-related and psychological outcomes as compared to global quality of life.
In a similar manner, Karow et al. (2008b) detected that conflict between individuals in family and partner relations was linked to worse quality of life in those with

opioid dependence, and that the effects of particular stressors in relationships, and not just family functioning, may be more significant. Birkeland et al. (2021b) also found out that people with substance use disorders can undergo a relative stable quality of life with psychological distress as a stronger predictor instead of low levels of family cohesion and social support.

Moreover, one can interpret these findings in the context of the theory of ecological systems (Bandura, 1977) according to which individuals are affected by a number of interacting systems. In this regard, the proximal factors that influence the quality of life might be peer relationships, occupational status, and individual psychological resilience more than family functioning in isolation.

In the same vein, recovery capital (Cloud & Granfield, 2008) is a concept that proposes a variety of personal, social, and environmental resources as having a role in recovery and well-being, which may outweigh the influence of family variables.

The other significant factor is that quality of life is a multidimensional construct that includes physical, psychological, social and environmental dimensions (World Health Organization, 2020). These domains may be indirectly impacted by family functioning, mediating variables like coping strategies, emotional regulation or perceived social support, but not directly.

This is exhibited by Afkari et al. (2013) who stressed that family processes tend to influence outcome in an indirect manner but not necessarily in a direct manner. In general, the results indicate that although family functioning is a significant contextual predictor in substance use disorders, it may have weaker links with quality of life especially when taking chronic substance dependence populations.
This is exhibited by Afkari et al. (2013) who stressed that family processes tend to influence outcome in an indirect manner but not necessarily in a direct manner.
As such, family-only interventions might not be effective enough to increase general quality of life. Rather, a more holistic strategy, which also accounts to the

personal psychological factors, coping and a larger social support network, might be more effective.

5.2 Hypothesis 2: Self-Efficacy and Quality of Life

Hypothesis 2 proposed that self-efficacy would be positively and significantly correlated with quality of life among drug users. The results of the current study fully supported this hypothesis, as trait general self-efficacy demonstrated significant positive associations across all quality-of-life domains, including physical, psychological, social, and environmental well-being. These findings position self-efficacy as a central psychological resource influencing subjective well-being among individuals with substance use disorders.The present findings are highly consistent with prior research highlighting the critical role of self-efficacy in recovery and quality-of-life outcomes.

Valencia and Peters (2025) reported that higher self-efficacy not only facilitated motivation to change but also directly improved quality of life and reduced relapse risk, particularly during early recovery phases. Similarly, Abdelmouttelb et al. (2026) demonstrated that life-skills training significantly enhanced self-efficacy related to emotional regulation, social pressure, and craving management, all of which are closely linked to improved quality-of-life perceptions.

The strong association between self-efficacy and quality of life may also help explain the weak relationship observed between family functioning and quality of life in Hypothesis 1. Birkeland et al. (2021a) found that individuals with substance use disorders reported relatively preserved quality of life despite low family cohesion, suggesting that internal psychological resources may compensate for relational deficits. Supporting this view,Karow et al. (2008a) observed that personality pathology and interpersonal conflicts were more strongly associated with

quality of life than social or substance-related factors, emphasising the protective role of psychological strengths such as self-efficacy.

Evidence from trauma-exposed and vulnerable populations further underscores the importance of self-efficacy. Weber and Lynch (2026) showed that trauma-coping self-efficacy mediated the relationship between interpersonal violence, substance use, and PTSD in incarcerated women. Equally, Muñoz (2023) established that the negative impact of home disruption on substance use outcomes was buffered by internal coping resources.

These results are relevant to those of the present study, as self-efficacy is a fundamental process that helps individuals to have a better quality of life despite adversity. To conclude, the existing findings suggest that self-efficacy is a strong and stable predictor of quality of life in drug users. Interventions which aim at strengthening self-efficacy, e.g., life-skills training, coping strategies development, empowerment-based interventions, are thus likely to result in significant quality-of-life changes and should be highlighted in treatment and rehabilitation programs.

5.3 Hypothesis 3: Perceived Social Support and Quality of Life

Hypothesis 3 was that males with substance use disorder who perceived more social support are more likely to perceive better quality of life.

The results of the present research provided strong support to this hypothesis because perceived social support showed moderate and statistically significant positive links amongst all areas of quality of life. This puts social support as an important protective strategy in promoting overall well-being in people with substance use disorders. The findings are in line with other past empirical studies on the relevance of social support in recovery and quality-of-life measures.

In a study by Shaarif et al. (2025), the study found that the perception of social support correlated with increased success in recovery and reduced relapse rates in people in rehabilitation centres in Pakistan, which can be attributed to the fact that perceived social support was considered relevant in resource-constrained environments. This implies that social networks that support abstinence not only support abstinence but also increase subjective well-being. Experiments investigating the mental processes of this relationship also confirm the current results.

The study by Imtiaz et al. (2025) displayed that the perceived social support had a positive impact on quality of life as it mediated between defence mechanisms and well-being. Likewise, Khazaee-Pool et al. (2025) demonstrated that social support minimised the substance use cravings by lowering the loneliness and increasing self-control, which consequently increased the level of emotional stability and quality of life. These findings are also in line with family-based research.

According to Birkeland et al. (2021a), participants with substance use disorders had less family cohesion and social support than those with physical illnesses, but social support was positively correlated with the quality of life. Jagoe and Maina (2025) additionally pointed out that family dysfunction and co-dependency involving addiction play a major role in decreasing the quality of life, which supports the idea that supportive relationships are systemic.

All these findings point to the fact that perceived social support is the key factor contributing to the quality of life among drug users. The family, peer and community support systems interventions are therefore desirable not only to maintain recovery but also to improve overall life satisfaction and well-being.

5.4 Hypothesis 4: Predictors of quality of life

Hypothesis 4 hypothesized that quality of life in male substance use disorder patients would be significantly predicted by the family functioning, self-efficacy, and perceived social support.This hypothesis was partially justified by the results of

the current study.The multiple regression analysis results showed that the overall model was statistically significant, with the ability to explain about 33 percent of variance in quality of life (R 2 =.33, F(11, 288) = 13.00, p ¡.001).

General self-efficacy (GSE) was the most significant and strong positive predictor of quality of life.Furthermore, the perceived social support of significant others and friends also significantly contributed to the model, but family support and all dimensions of family functioning (problem solving, communication, roles, affective responsiveness, affective involvement, behaviour control and general family functioning) did not make statistically significant unique contribution to the model.These results indicate that psychological resources at the individual level especially self-efficacy are the major determinants of quality of life in individuals with substance use disorders.

Self-efficacy is the feeling that a person has about their power in effectively handling challenges and exerting control over the life situations, a concept which is widely explained by Albert Bandura.Self-efficacy is one of the most important determinants of behavior, motivation and emotional regulation, particularly in high-risk and stressful situations like substance use recovery.The positive relationship between self-efficacy and quality of life of the current study is in agreement with previous studies.As an example, Ali et al. (2018) found that the quality of life among people in recovery had a direct relationship with the improvement in psychological resources, such as self-efficacy and coping capacity.Likewise, Rassool et al. (2020) established that the extent of self-efficacy was positively linked with enhanced psychosocial functioning and life satisfaction, ultimately contributing to the better control of substance use behaviors.These results support an idea that those who see themselves as competent and capable tend to enjoy improvement in well-being in various life spheres.Self-efficacy can also impact quality of life in its coping and resilience.

Those who have greater self efficacy will be more apt to adaptive coping strategies, manage negative emotions in a more effective way, and continue to face adversity

(Bandura, 1977).Self-efficacy can be used as a buffer psychological resource that can improve overall functioning and life satisfaction in the context of substance use disorders, wherein individuals are often exposed to relapse triggers, stigma, and social instability.To support this view, Jia et al. (2024) have proved that the higher self-efficacy, the greater engagement in the treatment process and more sustained outcomes of recovery.
Conversely, quality of life in the current study did not significantly depend on family functioning, despite its theoretical significance in addiction studies.This observation can possibly be accounted by the chronic and complex nature of substance use disorders and the fact that family relationships are often typified by long-standing conflict, mistrust and emotional disengagement.

These patterns of relations can be comparatively fixed in time, and may not have a direct impact on the current perceptions of quality of life in people.Previous studies support this interpretation.Indicatively, Karow et al. (2008a) discovered that particular interpersonal conflicts, but not general family functioning, were more closely related with poorer quality of life among individuals with opioid dependence.

Likewise, Birkeland et al. (2021b) found that people with substance use disorder might lack good family cohesion but still have relatively stable levels of quality of life, indicating that the constructs might be somewhat independent of each other.As far as perceived social support is concerned, the results showed an intricate trend.

Quality of life was highly predicted by support of significant others and friends whereas family support did not.This implies that not every source of social support will have the same effect on well-being among this population.A possible reason is that the quality and functional value of support and not its origin alone may be more important in determining outcomes.In other instances, individuals who use substances may be integrated into social networks whereby peers are involved in maladaptive behaviors and may limit the protective value of social support.

As Dobkin et al. (2002) pointed out, although social support has the potential to improve psychological functioning, its effectiveness is affected by the type, context, and quality of the support given.The findings can also be interpreted within the context of the recovery capital model by William L. Cloud and Robert Granfield (2008) that assumes the combined role of personal, social and environmental resources in recovery.

Personal capital (e.g., self-efficacy) seems to have a more immediate and direct impact on the quality of life than social and family capital in the present study.It is especially applicable in chronic conditions of substance use where internal psychological strengths might be more critical to sustaining well-being.

Moreover, the results can be interpreted in terms of the ecological systems theory by Urie Bronfenbrenner (1979), according to which individuals are influenced by a set of interacting systems.

Family and social environment, though they may also have a significant impact on risk factors, are not as critical a contextual system as individual psychological factors among people with substance use disorders.In general, the results of the current research demonstrate that self-efficacy, as well as selective elements of social support, play the central role in predicting the quality of life among male substance users.

These results have important clinical implications.The interventions that should be applied in a bid to improve the quality of life of this population should focus on improving self-efficacy by applying strategies like skills training and cognitive behavioral techniques and relapse prevention programs.Although interventions based on family support and social support are still relevant, they may work better when combined with the ones that empower individual psychological resources.

Finally, the findings partially support Hypothesis 4, indicating that self-efficacy and some types of perceived social support (i.e., those of significant other and

friends) are important predictors of quality of life, and family functioning and family support do not seem to play a significant role in this respect.These findings highlight the need to consider the psychological elements of well-being at the individual level when addressing and improving the well-being of individuals diagnosed with substance use disorders.

5.5 Hypothesis 5:Demographics and Quality of Life

Hypothesis 5 was that demographic factors, education level, and marital status would have a significant effect on quality of life among drug users. This hypothesis was not confirmed by the findings of the present investigation because no statistically relevant differences in the quality of life were found among educational or marital status groups. It implies that the quality of life of people with substance use disorders can be associated with the basic demographic features to a relatively low extent.

These results correlate with the literature, indicating that psychosocial and psychological factors prevail over demographic factors in determining the quality of life. In both Birkeland et al. (2021a)and Karow et al. (2008a), mental distress, interpersonal conflict, and psychological comorbidities were found to be stronger predictors of the quality of life than sociodemographic variables.

This indicates that the over-reaching impact of substance use can obstruct demographic disparities. This interpretation is supported by additional evidence from research on recovery.

The results of Shaarif et al. (2025) and Yanuarti et al. (2025) have shown that perceived social support and self-efficacy had a stronger impact on the quality of life and recovery outcomes compared to education or marital status. On the same

note, Valencia and Peters (2025) emphasized the mediating effect of self-efficacy on the outcomes of quality of life, and the contribution of demographic variables was insignificant. Qualitative research gives more background. Iqbal and Ijaz (2025) exemplified that the chronic psychosocial hardship was realized by the long-term effects of a substance-related stigma and family disruption, irrespective of the demographic background.

Jagoe and Maina (2025)also highlighted that family stresses linked to addiction have a detrimental impact on the quality of life in various socio-cultural communities. Overall, the results show no significant direct impact of demographic factors on the quality of life among the users of drugs, including education and marital status. Alternatively, it turns out that the quality of life is more likely to be influenced by adjustable psychosocial factors, such as self-efficacy, social support, and mental health. Altogether, the results of the present research point to the fact that the most influential correlates of the quality of life among drug users are self-efficacy and perceived social support, and family functioning and demographic factors have weaker direct impacts.

The findings elucidate the significance of focusing on psychological empowerment and social support promotion in the treatment and rehabilitation efforts. Both interventions that enhance internal coping strategies and programs that facilitate positive social conditions will most probably bring in the most significant and long-lasting change in the quality of life of the people with substance use problems.

5.6 Implications

5.6.1 Theoretical Implications

Theoretically the results substantiate psychological theories that highlight the importance of self-efficacy as a factor of well-being. The findings indicate that the direct impact of individual-level factors can be more significant than that of the

role of family functioning and it is necessary to combine psychological and social frameworks in comprehending substance use recovery.

5.6.2 Practical Implications

Clinically, it is important to focus on self-efficacy by using cognitive-behavioral interventions, skills programs, and relapse prevention programs.

Even though the perceived social support has a significant relationship with the quality of life, it might be more effective when interventions are added, which focus on addressing individual psychological strengths. The rehabilitation programs are thus advised to take a holistic approach that incorporates psychological and social elements.

5.7 Limitations

The following are the limitations of the study:

i. Cross-sectional design limits causal interpretation of relationships among variables.

ii. Use of self-report measures may have introduced response and social desirability biases.

iii. Non-normal data distribution required non-parametric analyses, limiting comparability with parametric studies.

iv. A sample drawn from a specific population restricts generalizability to other groups and settings.

5.8 Future Recommendations

i. Employ longitudinal research designs to clarify the causal relationships between self-efficacy, perceived social support, and quality of life among individuals with substance use disorders.

ii. Incorporate qualitative methodologies to gain deeper insight into how drug users perceive family functioning and social support within the context of substance use and recovery.

iii. Examine intervention-based approaches to determine whether enhancing self-efficacy and social support results in sustained improvements in quality of life.

iv. Extend future research to more diverse populations and cultural contexts to improve the generalizability and applicability of findings.

5.9 Conclusion

The current research investigated the connection between family functioning, self-efficacy, and perceived social support and quality of life in males with substance use disorder. The results present valuable information on the psychosocial factors of well-being in this group. The findings showed that family functioning was weakly related to quality of life and was mostly not found to be significant, which implies the lack of a powerful direct effect of family functioning on the overall well-being of people with substance use disorders.

Conversely, self-efficacy and perceived social support were significantly related to quality of life in various domains, indicating their significance as protective psychosocial variables. Regression analysis however showed that, self-efficacy was the only significant predictor of quality of life, whereas family functioning and perceived social support did not show any significant predictive effect when used together. This indicates that even though social support is linked to quality of life,

when one considers individual psychological variables like self-efficacy, the special contribution of social support might be diminished. These results highlight the pivotal importance of internal psychological resources in determining the quality of life in males with substance use disorder.

Those who have a greater self-efficacy have a better chance of effectively coping with challenges, being emotionally stable, and having a more positive view of their situation in life. Although social support is still a significant contextual determinant, its effect seems to be less direct and more indirect in nature. In general, the paper concludes that to enhance the quality of life among this population, a dual approach to psychological empowerment and social support systems should be taken, and, in particular, the self-efficacy needs to be reinforced.

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Appendix A:Consent Form

شرکاء کے لیے معلوماتی پرچہ

تحقیق کا عنوان:

مرد منشیات استعمال کرنے والوں میں خاندانی نظام، خود موثریت (Self-Efficacy)، محسوس شدہ سماجی تعاون اور معیارِ زندگی کے درمیان تعلق

تحقیق کا مقصد:

اس تحقیق کا مقصد یہ جانچنا ہے کہ خاندانی نظام، خود موثریت اور سماجی تعاون کس طرح منشیات استعمال کرنے والے افراد کے معیارِ زندگی پر اثر انداز ہوتے ہیں۔ اس تحقیق سے حاصل ہونے والی معلومات محققین اور ذہنی صحت کے ماہرین کو بحالی اور فلاح و بہبود کو متاثر کرنے والے عوامل کو بہتر طور پر سمجھنے میں مدد دیں گی اور مستقبل میں مؤثر مداخلتی پروگرامز کی تیاری میں معاون ثابت ہو سکتی ہیں۔

رضاکارانہ شرکت:

اس تحقیق میں شرکت مکمل طور پر رضاکارانہ ہے۔ آپ کو یہ حق حاصل ہے کہ آپ تحقیق میں شرکت سے انکار کریں یا ڈیٹا کے تجزیے سے پہلے کسی بھی وقت بغیر کوئی وجہ بتائے تحقیق سے دستبردار ہو جائیں۔ آپ کے اس فیصلے سے آپ کو حاصل ہونے والی کسی بھی موجودہ سہولت یا علاج پر کوئی منفی اثر نہیں پڑے گا۔

طریقۂ کار:

اگر آپ اس تحقیق میں شرکت پر رضامند ہوں، تو آپ سے آبادیاتی معلومات (Demographic Information Sheet) اور خاندانی نظام، خود موثریت اور سماجی تعاون سے متعلق سوالنامہ پُر کرنے کے لیے کہا جائے گا۔ اس عمل میں تقریباً 40 تا 45 منٹ لگیں گے۔

رازداری:

آپ کی فراہم کردہ تمام معلومات کو مکمل طور پر رازدارانہ رکھا جائے گا۔ کسی بھی رپورٹ، پریزنٹیشن یا اشاعت میں

آپ کا نام یا ذاتی شناخت ظاہر نہیں کی جائے گی. جمع شدہ ڈیٹا کو محفوظ طریقے سے رکھا جائے گا اور اسے صرف تحقیقی مقاصد کے لیے استعمال کیا جائے گا.

فوائد:

اگرچہ اس تحقیق میں شرکت کا کوئی براہِ راست ذاتی فائدہ نہیں ہو سکتا، تاہم آپ کی شرکت منشیات استعمال کرنے والے افراد کے معیارِ زندگی کو متاثر کرنے والے عوامل کو بہتر طور پر سمجھنے میں مدد دے گی، جس سے مستقبل میں نفسیاتی معاونت اور بحالی کے پروگرامز کو بہتر بنایا جا سکے گا.

ممکنہ خطرات:

اس تحقیق میں شامل ہونے سے خطرات نہایت کم ہیں. بعض سوالات آپ کو ذاتی تجربات پر غور کرنے پر مجبور کر سکتے ہیں. اگر کوئی سوال آپ کو غیر آرام دہ محسوس ہو، تو آپ کو یہ حق حاصل ہے کہ آپ اس سوال کو چھوڑ دیں.

شرکاء کی رضامندی کا فارم

میں اس بات کی تصدیق کرتا/کرتی ہوں کہ میں نے شرکاء کے لیے معلوماتی پرچہ بغور پڑھ لیا ہے اور اسے بخوبی سمجھ لیا ہے۔ مجھے سوالات پوچھنے کا مکمل موقع فراہم کیا گیا ہے۔

میں اس بات سے آگاہ ہوں کہ اس تحقیق میں میری شرکت مکمل طور پر رضاکارانہ ہے، اور میں ڈیٹا کے تجزیے سے پہلے کسی بھی وقت بغیر کوئی وجہ بتائے تحقیق سے دستبردار ہو سکتا ہوں۔

میں یہ بھی سمجھتا ہوں کہ میری فراہم کردہ تمام معلومات کو مکمل طور پر رازدارانہ رکھا جائے گا اور انہیں صرف تحقیقی مقاصد کے لیے استعمال کیا جائے گا۔

ذیل میں دستخط کر کے میں اس تحقیق میں شرکت پر اپنی رضامندی کا اظہار کرتا ہوں۔

شرکاء کے دستخط: _____

تاریخ: _____

شرکاء کی آبادیاتی معلومات

شمار	سوال	جوابی اختیارات
1	عمر	____ سال
2	جنس	مرد / عورت
3	تعلیمی سطح	پرائمری / سیکنڈری / کالج / یونیورسٹی / دیگر: _____
4	ازدواجی حیثیت	شادی شدہ / غیر شادی شدہ / طلاق یافتہ / بیوہ
5	سماجی و معاشی حیثیت	کم / متوسط / بلند
6	منشیات کے استعمال کی مدت	____ سال
7	استعمال شدہ منشیات کی قسم	چرس / ہیروئن / کوکین / الکحل / دیگر: _____

Appendix B:Scales

Gernal Self-Efficacy Scale (GSES)

ہدایات:
نیچے دیے گئے ہر بیان کے سامنے چار ممکنہ جوابات دیے گئے ہیں۔ ہر بیان کو غور سے پڑھیں اور یہ فیصلہ کریں کہ وہ آپ کی ذات کے بارے میں کس حد تک درست یا غلط ہے۔ اب ان چار ممکنہ جوابات میں سے کسی ایک منتخب جواب کے ہندسے کے گرد دائرہ لگا دیں۔

1. میں مشکل مسائل کو حل کرنے میں کامیاب ہو سکتا/سکتی ہوں اگر میں کوشش کروں۔

1. بالکل غلط 2. کچھ حد تک درست 3. کافی حد تک درست 4. بالکل درست

2. اگر کوئی میری مخالفت کرے تو میں جو چاہتا/چاہتی ہوں وہ حاصل کرنے کے لیے راستے اور ذرائع تلاش کر سکتا/سکتی ہوں۔

1. بالکل غلط 2. کچھ حد تک درست 3. کافی حد تک درست 4. بالکل درست

3. مجھے یقین ہے کہ میں اپنے مقاصد حاصل کر سکتا/سکتی ہوں۔

1. بالکل غلط 2. کچھ حد تک درست 3. کافی حد تک درست 4. بالکل درست

4. مجھے اعتماد ہے کہ میں غیر متوقع واقعات کا مستعدی سے مقابلہ کر سکتا/سکتی ہوں۔

1. بالکل غلط 2. کچھ حد تک درست 3. کافی حد تک درست 4. بالکل درست

5. میرے با تدبیر ہونے کی بدولت میں غیر متوقع حالات کا مقابلہ کر سکتا/سکتی ہوں۔

1. بالکل غلط 2. کچھ حد تک درست 3. کافی حد تک درست 4. بالکل درست

6. میں اکثر مسائل کو حل کر سکتا/سکتی ہوں اگر میں ضروری کوشش کروں۔

1. بالکل غلط 2. کچھ حد تک درست 3. کافی حد تک درست 4. بالکل درست

7. میں مشکلات کے سامنے پُرسکون رہ سکتا/سکتی ہوں کیونکہ میں اپنی مقابلے کی صلاحیتوں پر بھروسہ سکتا/سکتی ہوں۔

1. بالکل غلط 2. کچھ حد تک درست 3. کافی حد تک درست 4. بالکل درست

8. جب میں کسی مسئلے سے دو چار ہوتا/ہوتی ہوں تو میں اس کے کئی حل تلاش کر سکتا/سکتی ہوں۔

1. بالکل غلط 2. کچھ حد تک درست 3. کافی حد تک درست 4. بالکل درست

9. اگر میں کسی مشکل میں پڑ جاؤں تو میں اس کا ایک اچھا حل سوچ سکتا/سکتی ہوں۔

1. بالکل غلط 2. کچھ حد تک درست 3. کافی حد تک درست 4. بالکل درست

10- میں ہر قسم کے حالات کا مقابلہ کر سکتا/سکتی ہوں۔

1. بالکل غلط 2. کچھ حد تک درست 3. کافی حد تک درست 4. بالکل درست

Family Assessment Device (FAD) – Urdu Version

ہر بیان کے بارے میں اپنی رائے درج ذیل آپشنز میں سے منتخب کریں:

1 = بالکل متفق نہیں

2 = متفق نہیں

3 = متفق

4 = بالکل متفق

1. خاندانی سرگرمیوں کی منصوبہ بندی مشکل ہو جاتی ہے کیونکہ ہم ایک دوسرے کو غلط سمجھتے ہیں ۔

1 = بالکل متفق نہیں 2 = متفق نہیں 3 = متفق 4 = بالکل متفق

2. ہم گھر کے زیادہ تر روزمرہ کے مسائل حل کر لیتے ہیں ۔

1 = بالکل متفق نہیں 2 = متفق نہیں 3 = متفق 4 = بالکل متفق

3. جب کوئی پریشان ہوتا ہے تو دوسرے جان لیتے ہیں کہ کیوں ہے۔

= بالکل متفق نہیں 2 = متفق نہیں 3 = متفق 4 = بالکل متفق

4. جب آپ کسی کو کچھ کرنے کے لیے کہتے ہیں تو آپ کو یہ دیکھنا پڑتا ہے کہ انہوں نے وہ کام کیا ہے ۔

1 = بالکل متفق نہیں 2 = متفق نہیں 3 = متفق 4 = بالکل متفق

5. اگر کوئی مشکل میں ہو تو دوسرے لوگ حد سے زیادہ ملوث ہونے لگتے ہیں ۔

1 = بالکل متفق نہیں 2 = متفق نہیں 3 = متفق 4 = بالکل متفق

6. مشکل وقت میں ہم ایک دوسرے سے مدد حاصل کر سکتے ہیں ۔

1 = بالکل متفق نہیں 2 = متفق نہیں 3 = متفق 4 = بالکل متفق

7. جب کوئی ہنگامی صورتحال پیش آتی ہے تو ہمیں نہیں پتا ہوتا کہ کیا کرنا ہے ۔

1 = بالکل متفق نہیں 2 = متفق نہیں 3 = متفق 4 = بالکل متفق

8. ہماری کبھی کبھی وہ چیزیں ختم ہو جاتی ہیں جن کی ہمیں ضرورت ہوتی ہے۔

1 = بالکل متفق نہیں 2 = متفق نہیں 3 = متفق 4 = بالکل متفق

9. ہم ایک دوسرے سے اپنی محبت کا اظہار کرنے میں ہچکچاہٹ محسوس کرتے ہیں ۔

1 = بالکل متفق نہیں 2 = متفق نہیں 3 = متفق 4 = بالکل متفق

10. ہم اس بات کو یقینی بناتے ہیں کہ افراد اپنی خاندانی ذمہ داریاں پوری کریں۔

1 = بالکل متفق نہیں 2 = متفق نہیں 3 = متفق 4 = بالکل متفق

11. ہم ایک دوسرے سے اس اداسی کے بارے میں بات نہیں کر سکتے جو ہم محسوس کرتے ہیں۔

1 = بالکل متفق نہیں 2 = متفق نہیں 3 = متفق 4 = بالکل متفق

12. ہم عموماً مسائل کے بارے میں اپنے فیصلوں پر عمل کرتے ہیں۔

1 = بالکل متفق نہیں 2 = متفق نہیں 3 = متفق 4 = بالکل متفق

13. آپ کو دوسروں کی دلچسپی صرف تب ملتی ہے جب کوئی چیز ان کے لیے
اہم ہو۔

1 = بالکل متفق نہیں 2 = متفق نہیں 3 = متفق 4 = بالکل متفق

14. کسی شخص کی باتوں سے یہ نہیں بتایا جا سکتا کہ وہ کیا محسوس کر رہا/رہی ہے۔

1 = بالکل متفق نہیں 2 = متفق نہیں 3 = متفق 4 = بالکل متفق

15. فیملی کے کام مناسب طور پر تقسیم نہیں ہوتے۔

1 = بالکل متفق نہیں 2 = متفق نہیں 3 = متفق 4 = بالکل متفق

16. ہر فرد کو اس کی اپنی شخصیت سمیت قبول کیا جاتا ہے۔

1 = بالکل متفق نہیں 2 = متفق نہیں 3 = متفق 4 = بالکل متفق

17. آپ قانون توڑنے پر آسانی سے بچ نکل سکتے ہیں۔

1 = بالکل متفق نہیں 2 = متفق نہیں 3 = متفق 4 = بالکل متفق

18. لوگ اشاروں کی بجائے سیدھی بات کہہ دیتے ہیں۔

1 = بالکل متفق نہیں 2 = متفق نہیں 3 = متفق 4 = بالکل متفق

19. ہم میں سے بعض لوگ جذباتی طور پر ردعمل ظاہر ہی نہیں کرتے۔

1 = بالکل متفق نہیں 2 = متفق نہیں 3 = متفق 4 = بالکل متفق

20. ہنگامی صورتحال میں ہمیں معلوم ہوتا ہے کہ کیا کرنا ہے۔

1 = بالکل متفق نہیں 2 = متفق نہیں 3 = متفق 4 = بالکل متفق

21. ہم اپنے خوف اور خدشات پر بات کرنے سے گریز کرتے ہیں۔

1 = بالکل متفق نہیں 2 = متفق نہیں 3 = متفق 4 = بالکل متفق

22. ایک دوسرے سے نازک جذبات کے بارے میں بات کرنا مشکل ہے .

1 = بالکل متفق نہیں 2 = متفق نہیں 3 = متفق 4 = بالکل متفق

23. ہمیں اپنے بل ادا کرنے میں مشکل پیش آتی ہے۔

1 = بالکل متفق نہیں 2 = متفق نہیں 3 = متفق 4 = بالکل متفق

24. ہمارے خاندان کی طرف سے کسی مسئلے کو حل کرنے کی کوشش کے بعد ہم اہم طور پر بات کرتے ہیں کہ حل مؤثر تھا یا نہیں۔

1 = بالکل متفق نہیں 2 = متفق نہیں 3 = متفق 4 = بالکل متفق

25. ہم بہت زیادہ خود غرض ہیں .

1 = بالکل متفق نہیں 2 = متفق نہیں 3 = متفق 4 = بالکل متفق

26. ہم ایک دوسرے کے ساتھ اپنے جذبات کا اظہار کر سکتے ہیں .

1 = بالکل متفق نہیں 2 = متفق نہیں 3 = متفق 4 = بالکل متفق

27. ہمارے پاس بیت الخلا کی عادات کے بارے میں واضح توقعات نہیں ہیں.

1 = بالکل متفق نہیں 2 = متفق نہیں 3 = متفق 4 = بالکل متفق

28. ہم ایک دوسرے سے اپنی محبت کا اظہار نہیں کرتے۔

1 = بالکل متفق نہیں 2 = متفق نہیں 3 = متفق 4 = بالکل متفق

29. ہم لوگوں سے براہِ راست بات کرتے ہیں، کسی کے ذریعے نہیں۔

1 = بالکل متفق نہیں 2 = متفق نہیں 3 = متفق 4 = بالکل متفق

30. ہم میں سے ہر شخص کے مخصوص فرائض اور ذمہ داریاں ہیں .

1 = بالکل متفق نہیں 2 = متفق نہیں 3 = متفق 4 = بالکل متفق

31. ہمارے خاندان میں بہت سے منفی جذبات پائے جاتے ہیں۔

1 = بالکل متفق نہیں 2 = متفق نہیں 3 = متفق 4 = بالکل متفق

32. ہمارے یہاں ایک دوسرے کو مارنے کے بارے میں واضح اصول موجود ہیں۔

1 = بالکل متفق نہیں 2 = متفق نہیں 3 = متفق 4 = بالکل متفق

33. ہم ایک دوسرے میں صرف اُس وقت دلچسپی لیتے ہیں جب کوئی بات ہمیں ذاتی طور پر دلچسپ لگے۔

1 = بالکل متفق نہیں 2 = متفق نہیں 3 = متفق 4 = بالکل متفق

34. ذاتی دلچسپیوں کو آگے بڑھانے کے لیے ہمارے پاس بہت کم وقت ہوتا ہے۔

1 = بالکل متفق نہیں 2 = متفق نہیں 3 = متفق 4 = بالکل متفق

35 . ہم اکثر وہ نہیں کہتے جو ہم اصل میں کہنا چاہتے ہیں۔

1 = بالکل متفق نہیں 2 = متفق نہیں 3 = متفق 4 = بالکل متفق

36. ہمیں محسوس ہوتا ہے کہ ہمیں ہماری اصل شخصیت سمیت قبول کیا جاتا ہے۔

1 = بالکل متفق نہیں 2 = متفق نہیں 3 = متفق 4 = بالکل متفق

37. ہم ایک دوسرے میں صرف اس وقت دلچسپی دکھاتے ہیں جب ہمیں اس سے کوئی ذاتی فائدہ ہو.

1 = بالکل متفق نہیں 2 = متفق نہیں 3 = متفق 4 = بالکل متفق

38. ہم زیادہ تر جذباتی مشکلات کو حل کر لیتے ہیں جو ہمارے سامنے آتے ہیں۔

1 = بالکل متفق نہیں 2 = متفق نہیں 3 = متفق 4 = بالکل متفق

39. ہمارے خاندان میں نرمی دوسری ترجیح پر ہوتی ہے۔

1 = بالکل متفق نہیں 2 = متفق نہیں 3 = متفق 4 = بالکل متفق

40. ہم اس بارے میں بات کرتے ہیں کہ گھر کے کام کون کرے گا۔

1 = بالکل متفق نہیں 2 = متفق نہیں 3 = متفق 4 = بالکل متفق

41. فیصلے کرنا ہمارے خاندان کے لیے ایک مسئلہ ہے.

1 = بالکل متفق نہیں 2 = متفق نہیں 3 = متفق 4 = بالکل متفق

42. ہمارا خاندان ایک دوسرے میں اسی وقت دلچسپی ظاہر کرتا ہے جب وہ اس سے کچھ حاصل کر سکیں۔

1 = بالکل متفق نہیں 2 = متفق نہیں 3 = متفق 4 = بالکل متفق

43. ہم ایک دوسرے کے ساتھ کھل کر بات کرتے ہیں۔

1 = بالکل متفق نہیں 2 = متفق نہیں 3 = متفق 4 = بالکل متفق

44. ہم کسی اصول یا معیار پر قائم نہیں رہتے ہیں۔

1 = بالکل متفق نہیں 2 = متفق نہیں 3 = متفق 4 = بالکل متفق

45. اگر لوگوں سے کوئی کام کرنے کو کہا جائے، تو انہیں یاد کروانا پڑتا ہے۔

1 = بالکل متفق نہیں 2 = متفق نہیں 3 = متفق 4 = بالکل متفق

46. ہم یہ فیصلہ کرنے کی صلاحیت رکھتے ہیں کہ مسائل کو کیسے حل کیا جائے۔

1 = بالکل متفق نہیں 2 = متفق نہیں 3 = متفق 4 = بالکل متفق

47. اگر قواعد توڑ دیے جائیں تو ہمیں معلوم نہیں ہوتا کہ اس کے کیا نتائج ہوں گے۔

1 = بالکل متفق نہیں 2 = متفق نہیں 3 = متفق 4 = بالکل متفق

48. ہمارے خاندان میں کچھ بھی چلتا ہے۔

1 = بالکل متفق نہیں 2 = متفق نہیں 3 = متفق 4 = بالکل متفق

49. ہم نرمی کا اظہار کرتے ہیں۔

1 = بالکل متفق نہیں 2 = متفق نہیں 3 = متفق 4 = بالکل متفق

50. ہم جذبات سے متعلق مسائل کا سامنا کرتے ہیں۔

1 = بالکل متفق نہیں 2 = متفق نہیں 3 = متفق 4 = بالکل متفق

51. ہم ایک دوسرے کے ساتھ اچھی طرح نہیں چل سکتے۔

1 = بالکل متفق نہیں 2 = متفق نہیں 3 = متفق 4 = بالکل متفق

52. جب ہم غصے میں ہوتے ہیں، تو ہم ایک دوسرے سے بات نہیں کرتے۔

1 = بالکل متفق نہیں 2 = متفق نہیں 3 = متفق 4 = بالکل متفق

53. فیملی کی جو ذمہ داریاں ہمیں دی جاتی ہیں، ہم عام طور پر اُن سے مطمئن نہیں ہوتے۔

1 = بالکل متفق نہیں 2 = متفق نہیں 3 = متفق 4 = بالکل متفق

54. اگرچہ ہماری نیت اچھی ہوتی ہے، پھر بھی ہم ایک دوسرے کی زندگیوں میں حد سے زیادہ مداخلت کرتے ہیں۔

1 = بالکل متفق نہیں 2 = متفق نہیں 3 = متفق 4 = بالکل متفق

55. خطرناک حالات سے نمٹنے کے لیے(ہمارے یہاں) واضح اصول موجود ہیں۔

1 = بالکل متفق نہیں 2 = متفق نہیں 3 = متفق 4 = بالکل متفق

56 ہم ایک دوسرے پر بھروسہ کرتے ہیں۔

1 = بالکل متفق نہیں 2 = متفق نہیں 3 = متفق 4 = بالکل متفق

57. ہم کھل کر روتے ہیں ۔

1 = بالکل متفق نہیں 2 = متفق نہیں 3 = متفق 4 = بالکل متفق

58. ہمارے پاس مناسب سواری موجود نہیں ہے۔

1 = بالکل متفق نہیں 2 = متفق نہیں 3 = متفق 4 = بالکل متفق

59. جب ہمیں کسی کا کیا ہوا کام پسند نہیں آتا تو ہم اسے بتا دیتے ہیں۔

1 = بالکل متفق نہیں 2 = متفق نہیں 3 = متفق 4 =بالکل متفق

60. ہم مسائل کے حل کے لیے مختلف طریقے سوچنے کی کوشش کرتے ہیں۔

1 = بالکل متفق نہیں 2 = متفق نہیں 3 = متفق 4 = بالکل متفق

The Multidimensional Scale of Perceived Social Support (Urdu)

ہدایات: ہم یہ جاننا چاہتے ہیں کہ مندرجہ ذیل بیانات کے متعلق آپ کس طرح محسوس کرتے ہیں۔
ہر بیان کو غور سے پڑھیے۔ نشان دہی کیجئے کہ آپ ہر بیان کے متعلق کس طرح سے محسوس کرتے ہیں۔

"1" پر دائرہ لگائیے اگر آپ شدید غیر متفق ہیں۔
"2" پر دائرہ لگائیے اگر آپ شدید غیر متفق ہیں۔
"3" پر دائرہ لگائیے اگر آپ کچھ حد تک غیر متفق ہیں۔
"4" پر دائرہ لگائیے اگر آپ غیر جانبدار ہیں۔
"5" پر دائرہ لگائیے اگر آپ کچھ حد تک ہم آہنگی رکھتے ہیں۔
"6" پر دائرہ لگائیے اگر آپ بہت ہم آہنگی رکھتے ہیں۔
"7" پر دائرہ لگائیے اگر آپ بہت زیادہ اہم آہنگی رکھتے ہیں۔

1	ایک خاص شخص ہے۔ جو ہر ضرورت کے وقت میرے پاس ہوتا ہے۔	1	2	3	4	5	6	7
2	ایک خاص شخص ہے۔ جس کے ساتھ میں اپنے غم اور خوشیاں بانٹ سکتا ہوں/سکتی ہوں۔	1	2	3	4	5	6	7
3	میرے گھر والے میری مدد کرنے کی پوری کوشش کرتے ہیں۔	1	2	3	4	5	6	7
4	مجھے میرے گھر والوں سے جس جذباتی مدد اور سہارے کی ضرورت ہوتی ہے وہ مجھے ملتی ہے۔	1	2	3	4	5	6	7
5	میرے پاس ایک خاص شخص ہے۔ جو واقعی میرے لئے رابطے کا ذریعہ ہے۔	1	2	3	4	5	6	7
6	میرے دوست میری مدد کرنے کی واقعی کوشش کرتے ہیں۔	1	2	3	4	5	6	7
7	جب مشکل پڑے تو میں اپنے دوستوں پر بھروسہ کر سکتا ہوں/سکتی ہوں۔	1	2	3	4	5	6	7
8	میں اپنے گھر والوں کے ساتھ اپنے مسائل کے متعلق بات کر سکتا ہوں/کر سکتی ہوں۔	1	2	3	4	5	6	7
9	میرے ایسے دوست ہیں جن کے ساتھ میں اپنی خوشیاں اور غم بانٹ سکتا ہوں/سکتی ہوں۔	1	2	3	4	5	6	7
10	میری زندگی میں ایک خاص شخص ہے جو میرے احساسات کی پرواہ کرتا ہے/کرتی ہے۔	1	2	3	4	5	6	7
11	میرے گھر والے فیصلے کرنے میں میری مدد کرتے ہیں۔	1	2	3	4	5	6	7
12	میں اپنے مسائل کے متعلق اپنے دوستوں سے بات کر سکتا ہوں/کر سکتی ہوں۔	1	2	3	4	5	6	7

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 نمبر 1 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۔

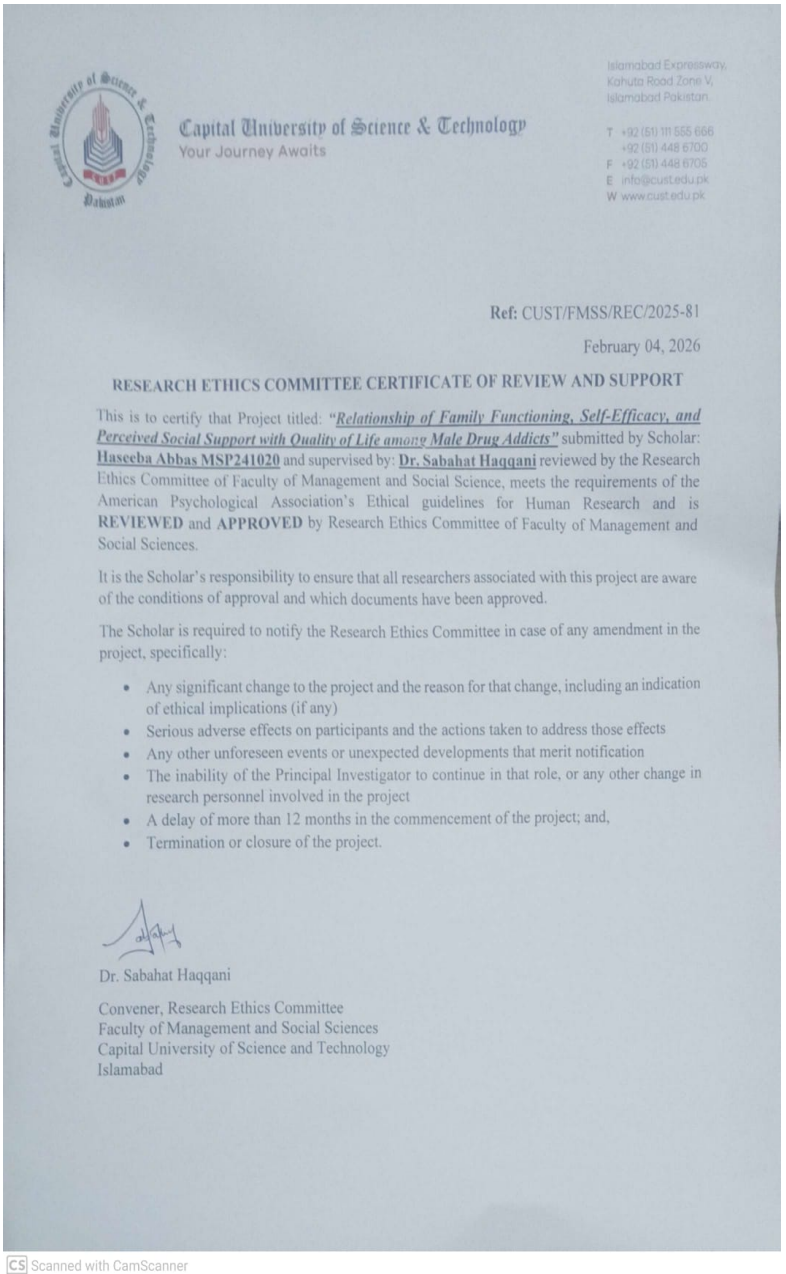
3.	آپ کس حد تک محسوس کرتے ہیں کہ جسمانی درد آپ کے لئے وہ کام کرنے میں رکاوٹ بنتی ہے جس کا کرنا آپ کے لئے ضروری ہوتا ہے۔	بالکل نہیں	کبھی کبھار	کچھ حد تک	بیشتر اوقات	بہت زیادہ
4.	روزمرہ کاموں کی ادائیگی کے لئے آپ کس حد تک طبی علاج کی ضرورت پڑتی ہے۔	بالکل نہیں	کبھی کبھار	کچھ حد تک	بیشتر اوقات	بہت زیادہ
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 اردگرد کا طبعی ماحول کس حد تک صحت مند 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 اردگرد جسمانی طور پر کس حد تک چلنے پھرنے کے قابل ہیں۔	بالکل نہیں	کبھی کبھار	کچھ حد تک	بیشتر اوقات	بہت زیادہ

مندرجہ ذیل سوالات 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 زندگی 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 صلاحیت 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 صلاحیت 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 حالات 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 آمد و رفت 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 مثلاً وغیرہ۔	مکمل طور پر غیر متفق	غیر متفق	نہ مطمئن نہ غیر مطمئن	مطمئن	مکمل طور پر متفق

Appendix C :Approval Letters



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Ref: CUST/FMSS/REC/2025-81

February 04, 2026

RESEARCH ETHICS COMMITTEE CERTIFICATE OF REVIEW AND SUPPORT

This is to certify that Project titled: ***"Relationship of Family Functioning, Self-Efficacy, and Perceived Social Support with Quality of Life among Male Drug Addicts"*** submitted by Scholar: **Haseeba Abbas MSP241020** and supervised by: **Dr. Sabahat Haqqani** 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
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Ref. CUST/IBD/PSY/Thesis-1846
February 04, 2026

SUBJECT: REQUEST FOR DATA COLLECTION

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. Haseeba Abbas, registration number **MSP241020** is a bona fide student in MS Psychology program at this University from Spring-2024 till date. In partial fulfillment of the degree, she is conducting research on "***Relationship of Family Functioning, Self-Efficacy, and Perceived Social Support with Quality of Life among Male Drug Addicts***". 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
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Ph No. 111-555-666 Ext: 178
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