

**CAPITAL UNIVERSITY OF SCIENCE AND
TECHNOLOGY, ISLAMABAD**



**Mediating Role of Emotional Dysregulation in
the Relationship Between Perceived Social
Support and Relapse Risk among Individuals
with Substance Use Disorder**

by

Zainab Arshad

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

in the

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Department of Psychology

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CERTIFICATE OF APPROVAL

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Abstract

Relapse risk remains a major challenge in the treatment of individuals with substance use disorder (SUD). Emotional dysregulation, characterized by difficulties in recognizing, and managing emotional experiences, has been identified as an important psychological factor that increases vulnerability to relapse risk. In contrast, perceived social support from family, friends, and significant others serves as an important protective factor by reducing emotional distress, promoting emotional stability during recovery. The study investigated the mediating role of emotional dysregulation in the relationship between perceived social support and relapse risk among individuals with substance use disorder. A sample of 250 males participants from various rehabilitation centers in Islamabad and Rawalpindi using correlational research design. Data was collected through standardized self-report instruments including, the Multidimensional Scale of Perceived Social Support (MSPSS), the Difficulties in Emotion Regulation (DERS), and the Advance Warning of Relapse (AWARE). Data will be analyzed using descriptive statistics, correlation, regression analysis, independent samples t-test, one-way Anova and mediation analysis through SPSS. The findings suggest that emotional dysregulation is an important psychological factor associated with relapse risk, while perceived social support contributes primarily to better emotional functioning rather than directly reducing relapse risk.

Keywords: *Mediating role of emotional dysregulation in the relationship between perceived social support and relapse risk among individual with substance use disorder*

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Abbreviations

Acronym	What (it) Stands For
AWARE	Advance Warning of Relapse Questionaries
DERS	Difficulties in Emotional Dysregulation
MSPSS	Multidimensional scale of Perceived Social Support
SUD	Substance Use Disorder

Chapter 1

Introduction

1.1 Substance Use Disorder

Substance use disorder (SUD) is recognized as a chronic, relapsing condition characterized by a persistent inability to control the use of psychoactive substances despite experiencing harmful physical, psychological, and social consequences ([Saleem and Masood, 2024](#)).

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), addiction should not be viewed as a consequence of poor self-discipline or inadequate willpower. Instead, it is recognized as a chronic medical condition that gradually alters both the structure and functioning of the brain. These neurobiological changes impair judgment, weaken decision-making abilities, intensify cravings, and promote compulsive substance-seeking behaviors. Because these alterations often persist even after treatment, relapse remains common, making continuous treatment, long-term monitoring, and sustained recovery support essential components of effective rehabilitation ([Kamarajan and Muehlhan, 2026](#)).

Substance use disorder has become one of the leading public health challenges worldwide. Evidence suggests that detoxification alone rarely provides lasting recovery, highlighting the need for comprehensive treatment approaches that address the psychological and behavioral aspects of addiction to minimize the likelihood of relapse ([Xia et al., 2022](#)).

A defining characteristic of SUD is impaired control over substance use. Individuals frequently consume substances in larger quantities or over longer periods than originally intended, repeatedly fail in attempts to reduce or discontinue use, and continue substance use despite recognizing its adverse consequences. These behavioral patterns represent core diagnostic features of the disorder and distinguish problematic substance use from controlled or occasional use ([Adam et al., 2019](#)).

Substance use exists along a continuum ranging from mild to severe. During the early stages, individuals may retain some degree of control over their substance use, a phase that has been described as "pre-addiction," where timely preventive interventions may reduce progression. However, as the disorder advances, the ability to resist cravings gradually weakens, resulting in persistent substance use despite its damaging effects on health, interpersonal relationships, occupational functioning, and overall quality of life. At this stage, structured psychological and medical interventions become increasingly necessary to support recovery ([Volkow and Blanco, 2023](#)).

Recovery from Substance Use Disorder is an ongoing process that continues well beyond the completion of formal treatment or rehabilitation. Although achieving abstinence is an important milestone, successful recovery also involves improvements in emotional well-being, interpersonal relationships, social functioning, and overall quality of life. Given the chronic and relapsing nature of addiction, many individuals require long-term follow-up care, continuous psychosocial support, and structured relapse-prevention strategies to maintain recovery and achieve sustainable positive outcomes ([National Institute on Drug Abuse \(NIDA\), 2020](#)).

Contemporary scientific evidence increasingly conceptualizes substance use disorder as a chronic disorder of brain functioning rather than solely a behavioral problem. Addiction results from the complex interaction of biological, psychological, and environmental influences, effective treatment requires a comprehensive biopsychosocial approach that addresses each of these contributing factors ([Semaan and Khan, 2023](#)).

This broader understanding of SUD highlights the importance of integrating biological, psychological, and social dimensions when examining the development and

persistence of substance-related problems. Consequently, prevention, treatment, and recovery efforts should be designed to address the complex and multifaceted nature of the disorder.

1.2 Emotional Dysregulation

Emotional dysregulation relates to constant complicated in understanding, controlling and reacting to emotional experiences in an appropriate manner. Individuals with emotional dysregulation often struggle to regulate intense emotions such as anger, sadness, fear, or frustration and may require a prolonged period to regain emotional balance after experiencing stressful situations ([Pedersen, 2022](#)).

[Gratz and Roemer \(2004\)](#) conceptualized emotional dysregulation as deficits in recognizing, understanding, accepting, and effectively managing emotional responses. Expanding upon this perspective, [Aldao and Tull \(2015\)](#) emphasized that emotional dysregulation also involves difficulties controlling behaviors triggered by intense emotional experiences. Contemporary research has consistently identified emotional dysregulation deficits as a transdiagnostic process underlying numerous forms of psychopathology, with particularly strong associations observed in individuals with substance use disorder ([Garke et al., 2021](#); [Stellern et al., 2023](#); [Weiss et al., 2022](#)).

Another important characteristic observed among individuals with substance use disorder is heightened impulsivity during periods of emotional distress. Difficulty controlling emotional reactions often reduces the ability to inhibit impulsive behaviors, increasing engagement in risky activities, including substance use. Consequently, emotional dysregulation and impulsivity interact to influence both the initiation and continuation of addictive behaviors, making them important psychological targets for prevention and treatment interventions ([Mansueto et al., 2024](#)).

Many individuals use substances as a way to cope with painful emotions, stress, or psychological discomfort. Although substance use may provide temporary relief, repeated reliance on this strategy can strengthen the association between negative emotions and substance use, gradually increasing psychological dependence. Over

time, individuals may become increasingly reliant on substances to manage everyday emotional experiences, which contributes to the persistence and progression of addiction ([Weiss et al., 2022](#)).

People with SUD often experience difficulty understanding and managing their emotional states. As a result, substances may be used to escape feelings such as sadness, anxiety, anger, shame, or stress. While this coping strategy may reduce distress in the short term, it ultimately interferes with the development of healthier emotional dysregulation skills and may hinder long-term recovery ([Christiansen et al., 2026](#)).

Emotional dysregulation has also been closely linked to relapse vulnerability. Individuals who struggle to regulate emotions effectively are often more likely to return to substance use when faced with stressful situations, interpersonal conflicts, or intense negative emotions. In contrast, those who possess stronger emotional dysregulation skills generally demonstrate better coping abilities and greater resilience during recovery. For this reason, contemporary relapse-prevention approaches increasingly emphasize the development of adaptive emotional dysregulation strategies as an essential component of treatment ([Sancho et al., 2018](#)).

Another important perspective is provided by emotional dysregulation Theory, which proposes that people differ in their ability to identify, tolerate, and modify emotional experiences. Individuals with deficits in these abilities may be more vulnerable to impulsive or avoidant behaviors, including substance use. From this viewpoint, emotional dysregulation is not merely a consequence of addiction; it may also act as a predisposing factor that increases the likelihood of developing and maintaining substance-related problems ([Koob and Volkow, 2016](#)). Furthermore, emotional dysregulation has been identified as a transdiagnostic mechanism associated with a wide range of psychological disorders. Evidence indicates that difficulties regulating emotions are relevant to anxiety disorders, mood disorders, borderline personality disorder, and other forms of psychopathology ([Garke et al., 2021](#)).

This broader association highlights the importance of emotional dysregulation as a central psychological process that influences multiple mental health outcomes,

including addiction. Gender-related research also suggests that males and females may differ in how emotional difficulties are expressed and managed. Some studies indicate that males may be more likely to engage in risky substance-related behaviors and less likely to seek emotional support when distressed. However, emotional dysregulation among males with substance use disorder remains relatively understudied, indicating the need for further investigation within this population ([Singh and Shrotriya, 2025](#)).

Emotional dysregulation is increasingly recognized as a multidimensional psychological construct that involves both cognitive and neurobiological processes. Effective emotional dysregulation depends on the coordinated functioning of several brain regions, including the prefrontal cortex, amygdala, anterior cingulate cortex, and insula, which collectively regulate emotional processing, impulse control, and decision-making ([McHugh and Kneeland, 2019](#)).

Emotional dysregulation plays a significant role in determining treatment engagement, rehabilitation success, and long-term recovery among individuals with substance use disorder (SUD). Individuals who experience persistent difficulties in managing their emotions are often less motivated to participate in treatment, encounter greater challenges in adhering to rehabilitation programmes, and are more likely to discontinue treatment prematurely. Conversely, improvements in emotional dysregulation have been associated with enhanced psychological well-being, stronger abstinence self-efficacy, more effective coping strategies, and healthier interpersonal relationships throughout the recovery process ([Peri et al., 2024](#)).

Individuals raised in emotionally invalidating, unpredictable, or unsupportive environments often have fewer opportunities to develop healthy ways of recognizing, expressing, and managing their emotions. As a result, they may become more likely to rely on maladaptive coping strategies, including the use of psychoactive substances, to alleviate emotional pain and psychological distress during adolescence and adulthood. From a developmental perspective, these early adverse experiences increase vulnerability to substance use disorder (SUD) by contributing to persistent deficits in emotional dysregulation, suggesting that emotional dysregulation serves not only as a consequence of prolonged substance use but also

as an important predisposing factor in the onset and maintenance of addiction (Stocchero et al., 2024).

Emotions play a vital role in shaping thoughts, decision-making, interpersonal relationships, and adaptive behaviour. Emotional regulation refers to the capacity to monitor, evaluate, and modify emotional responses in accordance with situational demands and personal goals. When this capacity is impaired, individuals encounter difficulties in understanding, accepting, and managing their emotions a condition known as emotional dysregulation. Among individuals with substance use disorder (SUD), these difficulties often result in the use of psychoactive substances as a maladaptive coping strategy for managing emotional distress, thereby contributing to the development, maintenance, and recurrence of addictive behaviours (McRae and Gross, 2020).

1.3 Perceived Social Support

Perceived social support has gained increasing attention because of its positive contribution to treatment engagement and recovery. Individuals who believe that they receive adequate support from family members, friends, and significant others generally demonstrate better psychological adjustment, enhanced quality of life, and a lower likelihood of relapse during the recovery process (Shaarif et al., 2025).

The confidence that supportive relationships are available often encourages individuals to remain committed to treatment and maintain abstinence. Among all sources of support, the family plays the most influential role throughout addiction recovery. A supportive family environment can facilitate adjustment to treatment, improve adherence to rehabilitation programs, and promote sustained recovery (Rushton et al., 2023).

In contrast, poor family cohesion, frequent interpersonal conflict, and limited emotional support have consistently been associated with greater substance use and poorer treatment outcomes. Beyond family relationships, support from peers, self-help organizations, and recovery groups provides additional emotional encouragement and practical guidance that assist individuals in coping with the challenges of recovery and maintaining long-term remission. Evidence suggests that individuals

who remain socially connected experience lower levels of substance use alongside improved psychological well-being ([Birkeland et al., 2021](#)).

Individuals living with substance use disorder frequently experience multiple interconnected difficulties that extend beyond addiction itself. These challenges commonly include physical health complications, co-occurring psychiatric disorders, family dysfunction, unemployment, educational disruption, reduced productivity, legal problems, and financial instability. Because these difficulties often reinforce one another, recovery requires more than individual determination alone ([Bahji, 2024](#)).

Perceived social support serves as an essential protective resource by helping individuals manage stress, cope with adversity, and restore meaningful social functioning. In its absence, feelings of isolation, hopelessness, and social exclusion may intensify, increasing vulnerability to continued substance use. Consequently, perceived social support is generally acknowledged as a significant shield against the negative effects of life stressors ([Shahzad et al., 2014](#)).

Successful recovery from substance use disorder depends not only on personal motivation but also on the availability of supportive interpersonal relationships and accessible treatment resources. Several barriers, including social stigma, financial hardship, discrimination, and inadequate family or community support, can interfere with treatment engagement and negatively affect recovery outcomes. Conversely, positive family relationships, supportive friendships, and healthy social networks create an environment that encourages abstinence, strengthens coping abilities, and promotes long-term recovery ([Farhoudian et al., 2022](#)).

Individuals who perceive strong support from family members, friends, and significant others generally feel more confident in managing stressful situations and overcoming recovery-related challenges. This belief that dependable assistance is available contributes to greater emotional security and psychological resilience. Conversely, individuals who perceive limited social support are more likely to experience loneliness, social isolation, and emotional distress, all of which may interfere with successful recovery ([Islam et al., 2023](#)).

Perceived social support contributes to improved psychosocial functioning and decreases the probability of relapse among individuals with substance use disorder. Supportive interpersonal relationships provide emotional encouragement, reinforce healthy behavioral changes, and facilitate long-term abstinence. Recovery communities further strengthen this process by offering practical guidance, shared experiences, accountability, and continuous motivation throughout treatment and rehabilitation. These supportive environments enhance abstinence self-efficacy, reduce substance cravings, and improve psychological adjustment, thereby promoting more favorable recovery outcomes ([Abdelaal et al., 2025](#); [Patterson et al., 2025](#)).

Family involvement also represents an important protective factor against substance use and relapse. Increasing family awareness regarding effective parenting practices and healthy family interactions during childhood and adolescence may reduce the likelihood of substance use initiation and strengthen long-term recovery among individuals receiving treatment ([Arabshahi et al., 2023](#)). Accordingly, perceived social support has been identified as a valuable psychosocial resource that promotes emotional stability, facilitates treatment participation, and supports positive psychological adjustment among individuals recovering from substance use disorder ([Rathinam and Ezhumalai, 2021](#)).

Perceived social support has consistently been associated with improved psychological well-being. Individuals who believe that emotional support is available from family members, friends, and significant others often demonstrate greater resilience when coping with the emotional challenges encountered during rehabilitation. Acceptance, empathy, encouragement, and emotional reassurance provided by supportive relationships enable individuals to manage treatment-related stress more effectively. In contrast, conflictual or unsupportive relationships may increase psychological distress and complicate the recovery process ([Noor and Alyana, 2025](#); [Brooks et al., 2017](#)).

Peer support constitutes another essential component of successful addiction recovery. Individuals who interact with peers who share similar recovery experiences often develop stronger feelings of understanding, acceptance, and mutual trust.

Participation in self-help groups, peer-led interventions, and recovery communities encourages accountability, reinforces abstinence, and promotes the development of adaptive coping strategies. Such relationships provide practical advice and emotional encouragement that strengthen long-term recovery efforts ([Eddie et al., 2025](#)).

Within Pakistan, perceived social support assumes even greater importance because of the country's collectivistic social structure, where family relationships, kinship networks, and community ties strongly influence individual behavior and psychological well-being. Nevertheless, individuals with substance use disorder frequently encounter stigma, discrimination, family conflict, and social rejection, which may weaken available support systems and create additional barriers to recovery. These sociocultural challenges can reduce treatment engagement and increase vulnerability to relapse despite the presence of potentially supportive family structures ([Alyana et al., 2024](#)).

Beyond family and peers, support from the broader community also contributes substantially to successful recovery. Community acceptance, opportunities for meaningful social participation, access to social resources, and involvement in productive activities foster a sense of belonging, purpose, and social reintegration. Recovery-supportive environments not only reduce feelings of isolation but also encourage personal growth, improve overall well-being, and enhance the sustainability of long-term recovery from substance use disorder ([Vigdal et al., 2022](#)).

Perceived social support refers to an individual's belief that emotional, practical, and interpersonal assistance will be available whenever it is needed. Within the context of substance use disorder (SUD), this perception plays a vital role because successful recovery depends not only on professional treatment but also on the extent to which individuals feel supported by the people around them. Such perceptions can enhance coping abilities, promote active participation in treatment, and contribute to sustained recovery by reducing feelings of loneliness and social disconnection often experienced by individuals with addiction ([Lakey and Orehek, 2011](#)).

Thus, perceived social support remains an important factor in sustaining recovery.

Within rehabilitation settings, perceived social support can be enhanced through comprehensive, person-centered treatment approaches. Interventions such as psychological counseling, relapse prevention programs, psychoeducation, and peer support help individuals build effective coping strategies and remain engaged in the recovery process. Moreover, positive therapeutic relationships with mental health professionals encourage trust, respect, and active participation in treatment, particularly for individuals who have experienced stigma or previous treatment setbacks. Together, these supportive rehabilitation practices contribute to stronger recovery resources, improved treatment engagement, and sustained abstinence among individuals with substance use disorder (Esteban et al., 2023).

In Pakistan, perceived social support holds particular importance because the country's collectivistic culture places strong emphasis on family bonds, extended kinship, and community relationships. For individuals with substance use disorder (SUD), family members often serve as the primary source of emotional, practical, and financial support throughout the recovery process. Strong family involvement can encourage treatment participation, improve adherence to rehabilitation programs, and support long-term recovery (Jibeen, 2016).

Individuals who perceive stronger social support are more likely to remain engaged in treatment, adopt adaptive coping strategies, and achieve positive recovery outcomes. In contrast, inadequate perceived support may increase feelings of loneliness, psychological distress, and social isolation, thereby compromising recovery efforts. Consequently, integrating family participation, peer support, and community-based rehabilitation services into addiction treatment is considered essential for promoting sustained recovery and reducing the likelihood of relapse (McCrady and Flanagan, 2021).

1.4 Relapse Risk

Relapse risk is generally defined as the resumption of substance use following a period of abstinence or after the successful completion of treatment. It represents a complex and gradual process in which biological predispositions interact with psychological functioning and social circumstances to influence recovery outcomes.

Identifying these determinants is essential for designing effective prevention strategies that promote long-term abstinence and reduce the burden of substance use disorder on individuals, families, and society ([Mathebula et al., 2026](#)).

Modern addiction theories suggest that relapse risk should not be interpreted as a simple failure of willpower or personal weakness. Instead, relapse results from a complex interaction of biological predisposition, psychological functioning, and environmental influences. Among these determinants, emotional dysregulation has emerged as a particularly important psychological factor. Individuals who experience difficulty regulating negative emotions frequently use substances as a maladaptive coping strategy, thereby increasing craving intensity and the likelihood of returning to substance use during emotionally challenging situations ([Hand et al., 2024](#)).

The factors associated with relapse risk may differ according to the stage of recovery. During the early stages following treatment, relapse is commonly linked to depression, co-occurring mental health conditions, unemployment, financial stress, and insufficient social support. Conversely, relapse risk occurring after prolonged abstinence is more often associated with avoidant coping styles, reduced confidence in maintaining recovery, and underestimation of the long-term risks associated with substance use. These findings suggest that relapse prevention strategies should be tailored according to an individual's stage of recovery and specific psychosocial needs ([Moe et al., 2022](#)).

Relapse risk as a multidimensional phenomenon influenced by the interaction of biological, psychological, social, and environmental factors. A comprehensive scoping review identified several common contributors to relapse, including persistent cravings, negative emotional states, psychological vulnerabilities, family-related difficulties, peer influence, and inadequate social support. These findings indicate that relapse is rarely the result of a single cause; rather, it develops through the combined effect of multiple risk factors that compromise an individual's ability to maintain recovery ([Husiny, 2025](#)).

Given the high prevalence of relapse risk among individuals with substance use disorder, researchers have increasingly focused on identifying psychological and

social factors that contribute to relapse vulnerability. In particular, emotional dysregulation and perceived social support have received considerable attention because of their potential influence on coping abilities and recovery maintenance. A better understanding of these variables may assist in developing evidence-based interventions that strengthen long-term recovery and reduce the likelihood of relapse ([Al-Ziadat, 2024](#)).

Relapse risk is especially common among individuals with substance use disorder who also experience co-occurring affective or emotional disorders. Previous detoxification attempts, repeated hospitalization, persistent emotional difficulties, and substance-related clinical characteristics have all been associated with an elevated risk of returning to substance use. These findings emphasize the importance of addressing both psychological and clinical factors throughout addiction treatment ([Wang et al., 2021](#)).

From a behavioral perspective, relapse represents a breakdown in an individual's efforts to modify substance use behaviors, resulting in a return to previous patterns of use after a period of sobriety. This challenge remains widespread across the world and is particularly pronounced in low- and middle-income countries, where relapse rates tend to exceed those reported in high-income nations because of limited treatment resources, inadequate follow-up services, and restricted access to continuing care ([Kabisa et al., 2021](#)).

Family functioning has also been recognized as a significant determinant of recovery success. Dysfunctional family environments, poor communication, and inadequate emotional support may increase vulnerability to relapse risk, particularly among adolescents and young adults with substance use disorder. Since family relationships influence treatment engagement and recovery maintenance, strengthening family functioning has become an important component of relapse-prevention interventions ([Sonbol et al., 2024](#)).

Recovery from substance use disorder is influenced by numerous personal, interpersonal, and environmental factors that may either protect against or contribute to relapse risk. Individuals in recovery frequently encounter emotional distress, social pressure, stressful life events, and difficulties adapting to a substance-free

lifestyle. These ongoing challenges highlight the importance of continuous psychosocial support throughout the recovery process ([Ramsewak et al., 2020](#)). The period immediately following discharge from rehabilitation is considered particularly vulnerable because individuals must independently manage cravings, emotional stress, and everyday recovery-related challenges. Continuous follow-up services, relapse-prevention programs, and targeted psychosocial interventions during this transition period are therefore essential for sustaining abstinence and improving long-term treatment outcomes ([Betancourt et al., 2022](#)).

Recovery capital has become an important concept for explaining why some individuals achieve sustained recovery while others remain vulnerable to relapse risk. It refers to the personal, social, family, community, and cultural resources that facilitate recovery from substance use disorder (SUD). Individuals with higher levels of recovery capital generally possess stronger coping skills, supportive social relationships, stable employment, secure housing, and better access to treatment and community services. These resources strengthen resilience, promote long-term abstinence, and reduce the likelihood of relapse by providing continuous emotional and practical support ([Cloud and Granfield, 2008](#)).

Relapse risk is now widely understood as a dynamic aspect of the recovery process rather than merely an indicator of treatment failure. Recovery from Substance Use Disorder (SUD) involves ongoing psychological, behavioural, and social adaptation, during which individuals may experience both progress and temporary setbacks. From this perspective, relapse reflects changes in the recovery process that occur when an individual's coping abilities and recovery resources are no longer sufficient to manage internal distress or external challenges ([Zemore et al., 2023](#)).

Relapse prevention is enhanced through psychosocial interventions such as Cognitive Behavioral Therapy (CBT), Motivational Interviewing (MI), and Mindfulness-Based Relapse Prevention (MBRP), which help individuals recognize high-risk situations, regulate emotions, manage cravings, and develop effective coping strategies. Combined with ongoing follow-up and individualized aftercare, these interventions strengthen treatment engagement, reduce relapse risk, and support long-term recovery among individuals with substance use disorder (SUD) ([Ramadas](#)

et al., 2021).

1.5 Problem Statement

Substance Use Disorder (SUD) is a chronic, progressive, and relapsing condition that continues to pose a major challenge to public health worldwide. Despite considerable advances in treatment and rehabilitation services, maintaining long-term recovery remains difficult for many individuals, with relapse continuing to be one of the most common obstacles following treatment (Anam and Asmat, 2023). This persistent pattern highlights the need to identify the psychological and social factors that contribute to relapse vulnerability and influence recovery outcomes.

Among the psychological variables associated with SUD, emotional dysregulation has received growing attention because of its significant role in addiction and relapse. Emotional dysregulation refers to difficulties in recognizing, understanding, accepting, and effectively managing emotional experiences. Individuals with Substance Use Disorder frequently experience deficits in emotional dysregulation, making them more likely to use psychoactive substances as a maladaptive strategy for coping with emotional distress. Consequently, poor emotional dysregulation may intensify psychological distress, increase craving, and elevate the likelihood of relapse during the recovery process (Iqbal et al., 2026).

Contemporary empirical evidence consistently identifies emotional dysregulation as an important predictor of poor treatment outcomes among individuals with substance use disorder. Deficits in emotional dysregulation reduce an individual's capacity to tolerate stress and negative emotional experiences, thereby increasing dependence on substances as a coping mechanism. Emotional dysregulation has therefore emerged as a central psychological construct involved in the development, maintenance, and recurrence of addictive behaviors. Compared with healthy individuals, those diagnosed with SUD consistently demonstrate greater impairment in their ability to regulate emotions effectively (Muñoz and Santoso, 2025).

Substance Use Disorders remain among the leading contributors to global morbidity and mortality, emphasizing the importance of identifying factors associated

with addiction severity and relapse. Although emotional dysregulation and impulsivity have been widely recognized as significant risk factors, protective psychosocial variables such as perceived social support have also received increasing attention. Individuals who perceive stronger emotional and practical support from family, friends, and significant others generally demonstrate better psychological adjustment and more favorable recovery outcomes. Nevertheless, the persistently high relapse rates observed among individuals with SUD suggest that existing interventions may not sufficiently address deficits in emotional dysregulation, particularly among individuals experiencing inadequate social support ([Mansueto et al., 2026](#)).

Recent theoretical perspectives propose that emotional dysregulation may represent an important psychological mechanism through which perceived social support influences relapse risk. Individuals who perceive limited social support may experience greater emotional distress and poorer emotional dysregulation, which in turn may increase vulnerability to relapse by weakening adaptive coping abilities. Although this mediating relationship is theoretically supported, empirical investigations examining emotional dysregulation as a mediator between perceived social support and relapse risk remain limited, particularly among individuals receiving treatment for substance use disorder ([Huang et al., 2025](#)).

Recovery from Substance Use Disorder is influenced by multiple psychosocial factors, among which perceived social support plays an essential role. Individuals who perceive greater support from family members, friends, and significant others generally demonstrate improved psychological well-being, stronger treatment engagement, and greater resilience during recovery. Conversely, inadequate social support may reduce coping capacity, increase emotional distress, and negatively affect recovery outcomes ([Das et al., 2024](#)).

Within the Pakistani context, social support assumes particular importance because of the collectivistic nature of society, where family systems and close interpersonal relationships strongly influence psychological well-being. However, stigma associated with addiction, social rejection, family conflict, and limited awareness regarding substance use disorder may reduce the effectiveness of these support systems. Consequently, many individuals experience emotional isolation, diminished

treatment motivation, and increased susceptibility to relapse despite living within extended family structures ([Batool and Masood, 2024](#)).

Considering these gaps, understanding the psychological processes that connect perceived social support with relapse risk is essential for improving addiction treatment. Investigating the mediating role of emotional dysregulation may provide valuable evidence for developing culturally appropriate interventions that simultaneously strengthen emotional dysregulation skills and supportive social relationships. Therefore, the present study aims to examine the mediating role of emotional dysregulation in the relationship between perceived social support and relapse risk among individuals with substance use disorder in Pakistan ([Liu et al., 2020](#)).

Despite these findings, empirical research investigating this mediating relationship remains scarce, particularly within Pakistan, where sociocultural characteristics, family structures, and mental health services differ considerably from Western settings. Addressing this gap may contribute to the development of more effective and culturally relevant interventions aimed at improving long-term recovery outcomes among individuals with substance use disorder ([Meyer and Segal, 2023](#)).

1.6 Research Gap

Despite the progress made in the treatment of SUD, it is still a chronic and relapsing disorder that continues to have a significant impact on individuals, families, health care systems and society globally. Despite significant advances in the knowledge of the psychological processes involved in addiction, relapse remains one of the most difficult obstacles to overcome in the process of successful long-term recovery ([Engeln and Ahmed, 2025](#)).

This ongoing challenge highlights the importance of ongoing research on factors affecting recovery outcomes. In line with this requirement, recent international studies have consistently found emotional dysregulation to be a significant psychological risk factor for severity of substance use, treatment outcomes, and relapse vulnerability. People with poor emotional regulation tend to be more sensitive to stress, have poor coping skills, and are more likely to use substances as a way to cope with emotional distress ([Chrétien et al., 2025](#)).

The results underscore the importance of emotion regulation in addiction pathways. In addition to these broad links, previous research has also shown that emotional dysregulation is strongly linked to substance abuse and behavioral addictions. People with poor emotion regulation skills tend to be more susceptible to starting, sustaining, and returning to addictive behaviors. The results indicate that emotional dysregulation is not just a result of chronic drug use, but also a significant psychological risk factor for maintaining addiction ([González-Roz et al., 2024](#)).

At the same time, perceived social support has been consistently identified as a protective psychosocial resource in addiction recovery. Family, friends, and significant others have been found to provide support that helps to decrease psychological distress, increase resilience, improve treatment engagement, and decrease risk of relapse. Social support also helps to mitigate the negative impact of stress by fostering adaptive coping mechanisms and enhancing psychological health in people recovering from substance use disorder ([Sun et al., 2024](#)).

There are limited studies that have explored emotional dysregulation as a mediator between perceived social support and relapse risk, and even fewer studies that have explored this relationship in non-Western settings like Pakistan where family structures are collectivistic and there are unique sociocultural stressors that may impact the relationship between perceived social support and emotional dysregulation. Previous studies have tended to examine the direct links between social support, emotional functioning, and relapse outcomes. Little research has been conducted to examine whether emotional dysregulation acts as a mediator between perceived social support and relapse risk ([Yucens et al., 2026](#)).

This is a gap that calls for research beyond direct effects to investigate underlying mechanisms. This need is especially felt in the Pakistani context, as the gap is stark. Previous studies in Pakistan have focused mainly on treatment barriers, social stigma, family relationships, community support, and the psychosocial experiences of people with SUD. These studies have emphasized the role of family engagement and social acceptance in supporting recovery, but they have offered limited insights into the intricate psychological mechanisms by which perceived social support affects relapse risk ([Azad et al., 2024](#)).

In addition to these contextual factors, there are relatively few studies in Pakistan that have investigated emotional dysregulation, perceived social support, and relapse risk in people undergoing treatment for substance use disorder (SUD). Previous research on rehabilitation has largely focused on male participants, but there is limited empirical research on the mediating role of emotional dysregulation in this group. Thus, there is a significant gap in the literature regarding the association between perceived social support and relapse risk among people with SUD in Pakistan, which can be attributed to emotional dysregulation deficits ([Ghazal, 2019](#)).

His research gap could be a step toward advancing both theory and practice by elucidating the psychological mechanisms that underlie relapse after treatment. The study of emotional dysregulation as a mediator could offer important evidence for the development of comprehensive intervention programs that would improve emotional dysregulation skills and supportive interpersonal relationships. These findings could help clinicians, rehabilitation professionals, and policy makers design culturally relevant relapse prevention programs to enhance long-term recovery for people with substance use disorder in Pakistan. This line of research could help to fill some of the gaps between theory and practice and help to further develop context-sensitive approaches to addiction treatment. Such efforts may ultimately contribute to more effective and sustainable recovery outcomes for individuals with SUD.

1.7 Research Objectives

- i. To explore the relationship between emotional dysregulation, perceived social support and relapse risk among individuals with SUD.
- ii. To investigate whether emotional dysregulation mediates the relationship between perceived social support and relapse risk among individuals with SUD.
- iii. To examine the difference in perceived social support, emotional dysregulation and relapse risk across demographics factors (e.g., socioeconomic status marital status and family system).

1.8 Research Hypotheses

- i. Perceived social support will be negatively associated with emotional dysregulation among individuals with SUD.
- ii. Emotional dysregulation will be positively associated with relapse risk among individuals with SUD.
- iii. Perceived social support will be negatively associated with relapse risk among individuals with SUD.
- iv. Emotional dysregulation will mediate the relationship between perceived social support and relapse risk.
- v. There will be difference in perceived social support, emotional dysregulation and relapse risk based on family system among individuals with SUD.
- vi. There will be difference in perceived social support, emotional dysregulation and relapse risk based on socioeconomic status among individuals with SUD.
- vii. There will be difference in perceived social support, emotional dysregulation and relapse risk based on marital status among individuals with SUD.

Chapter 2

Literature Review

2.1 Substance Use Disorder

Substance use disorder continues to rank among the most prevalent psychiatric disorders and remains a significant public health concern worldwide ([Liu et al., 2025](#)). Current estimates indicate that more than one-tenth of the global population is affected by addiction, contributing substantially to disease burden, premature mortality, and rising healthcare and socioeconomic costs ([McLellan, 2017](#)).

Substance Use Disorder has emerged as a major public health concern worldwide. The World Drug Report 2024 estimates that approximately 292 million people used illicit drugs globally in 2022, representing a substantial increase over the past decade. The report further highlights that the burden of substance use is disproportionately greater in low- and middle-income countries, where limited access to prevention, treatment, and rehabilitation services often compromises recovery outcomes ([United Nations Office on Drugs and Crime, 2024](#)).

Recent research has also demonstrated that persistent substance use is associated with an increased likelihood of developing serious psychiatric complications, such as substance-induced psychosis, suicidal thoughts, and cognitive deficits. Continuous exposure to addictive substances impairs executive functions, weakens judgment, and limits problem-solving abilities, reducing an individual's capacity to manage stress effectively and sustain long-term recovery. Moreover, psychological distress and substance dependence frequently reinforce one another, creating

a cycle in which each condition contributes to the persistence and severity of the other ([Kelly et al., 2023](#); [World Health Organization, 2023](#)).

In Pakistan, growing evidence indicates that psychological comorbidities are highly prevalent among individuals undergoing treatment for SUD. Investigations conducted in rehabilitation facilities across cities such as Rawalpindi, Islamabad, Lahore, and Karachi have reported elevated levels of depression, anxiety, emotional dysregulation, and poor psychological well-being among people receiving treatment for substance dependence. These psychological challenges are associated with reduced treatment adherence, premature discontinuation of rehabilitation programmes, and higher relapse rates, highlighting the importance of integrating mental health interventions into addiction treatment services ([Majeed et al., 2022](#)).

2.2 Emotional Dysregulation

Recent evidence indicates that individuals diagnosed with substance use disorder experience significant impairments across multiple dimensions of emotional dysregulation. These impairments include reduced emotional awareness, difficulty accepting emotional experiences, limited impulse control during emotional distress, and an inability to utilize effective strategies for managing negative emotions. Consequently, psychoactive substances may become a maladaptive means of escaping or temporarily reducing psychological distress, reinforcing addictive behaviors over time ([Stellern et al., 2022](#)).

Recent empirical evidence has highlighted the central role of emotional dysregulation in addiction and recovery. Studies have demonstrated that individuals with substance use disorder who experience greater difficulties in emotional dysregulation report more severe substance use, stronger cravings, poorer treatment engagement, and a higher likelihood of relapse than those with better emotional dysregulation skills ([Sloan et al., 2023](#)).

Beyond international evidence previous research conducted in Pakistan included a sample of 104 individuals with SUD at Sheikh Zayed Medical College and Hospital, Rahim Yar Khan. These findings indicate that individuals with SUD may face challenges in managing and controlling their emotional responses effectively. The

study also reported a significant positive association between emotional dysregulation and aggression among individuals who use substances. Therefore, emotional dysregulation represents an important psychological factor for understanding substance use and recovery within the Pakistani context ([Mustafa et al., 2019](#)).

A systematic review reported that impairments in emotional dysregulation are consistently evident across various forms of substance use disorders and play a significant role in the development, persistence, and recurrence of substance use ([Sloan et al., 2017](#)). Individuals undergoing treatment for substance dependence exhibited significantly higher levels of emotional dysregulation than non-clinical populations, highlighting the widespread presence of these difficulties among treatment-seeking individuals ([Estévez et al., 2017](#)).

Emotional dysregulation is considered a common psychological feature among individuals with substance use disorder (SUD) and may increase vulnerability to relapse. Investigated the association between emotional dysregulation problems and relapse outcomes in a sample of 179 individuals undergoing treatment for SUD. Their findings revealed that greater difficulties in managing emotional experiences were linked with increased relapse vulnerability during treatment, indicating that individuals with limited emotional dysregulation abilities may face greater challenges in maintaining recovery ([Clarke et al., 2020](#)).

Recent research highlights the significance of strengthening emotional dysregulation abilities as a key component of long-term recovery from substance use disorder. Developing skills related to emotional awareness, tolerance of distress, cognitive restructuring, and mindfulness can help individuals manage difficult emotions in healthier ways. Therefore, interventions focused on improving emotional dysregulation may enhance psychological resilience and promote sustained recovery by reducing dependence on substances as a means of coping ([Droutman et al., 2022](#)).

Recent clinical perspectives emphasize the importance of assessing emotional dysregulation difficulties when developing treatment plans for individuals with substance use disorder. Since individuals vary in their ability to respond to conventional addiction interventions, those experiencing greater difficulties in managing emotions. Incorporating emotional dysregulation training into substance use

treatment programs may improve treatment engagement, enhance responsiveness to interventions, and contribute to more stable and long-term recovery outcomes (Cavicchioli et al., 2019).

Longitudinal research has also demonstrated that emotional dysregulation is associated with poorer recovery outcomes over time. Individuals who experience greater difficulties in regulating their emotions are more likely to return to substance use following treatment than those with better emotional dysregulation abilities. These findings suggest that strengthening emotional dysregulation skills may improve long-term recovery and reduce the likelihood of relapse (Zengin İspir et al., 2023). Emotional dysregulation contributes to an increased risk of relapse by exacerbating psychological distress and substance craving, both of which are recognized as significant predictors of recurrent substance use. These findings further highlight the importance of targeting emotional dysregulation difficulties in relapse prevention and addiction treatment (Darharaj et al., 2023).

Recent empirical investigations have consistently reported that deficits in emotional dysregulation are closely associated with unfavorable recovery outcomes among individuals with substance use disorder (SUD). Evidence indicates that individuals who experience greater difficulties regulating their emotions are more likely to report intensified substance cravings, diminished self-control, poor adherence to treatment programs, and an elevated risk of relapse after completing rehabilitation (Price et al., 2023).

Investigation continually shows that impairments in emotional consciousness, cognitive understanding, impulse control, along with flexible handling feelings approaches correlate with less favourable results for recuperation across drug classes involving substances like opioids, narcotics along with cannabis (Coyne et al., 2023). These results indicate that controlling your emotions is an important mental aspect for achieving long-term rehabilitation (Youngstrom, 2023).

Furthermore, experimental research has proven that targeted treatments in managing emotions can lead to substantial advances in preventing relapse. Medical techniques including CBT, DBT, mindful based addiction avoidance along with acceptance and commitment therapy, also called ACT have proven successful in

enhancing emotional control abilities and decreasing impulses along with relapse incidents ([Saunders et al., 2023](#)).

2.3 Perceived Social Support

Perceived social support received from family members, friends, and significant others can provide encouragement, guidance, and assistance in managing the challenges associated with recovery ([Lookatch et al., 2019](#)).

Consistent with this conceptualization, investigators have consistently demonstrated that people who believe they have higher amounts of support from society are more likely to exhibit better mental health along with resilient characteristics ([Gross and Ford, 2023](#)). Recent research has further highlighted the importance of perceived social support as a protective factor in the recovery process of individuals with substance use disorder (SUD). Evidence suggests that individuals who perceive consistent emotional and practical support from family, friends, and significant others are more likely to remain engaged in treatment, demonstrate improved psychological functioning, and sustain long-term recovery while experiencing a lower risk of relapse ([Arabshahi et al., 2023](#)).

Beyond international evidence, one study examined the association between perceived social support and relapse vulnerability among 188 individuals with substance use disorder (SUD) receiving treatment in rehabilitation centres located in Islamabad and Rawalpindi. Their findings demonstrated a significant inverse association between perceived social support and relapse vulnerability. This suggests that individuals who perceived greater levels of support from their social networks tended to report lower vulnerability to relapse ([Noor and Iqbal, 2023](#)).

Recent literature suggests that perceived social support is associated with greater resilience, improved psychological adjustment, and more favorable recovery outcomes among individuals with substance use disorder. Adequate support from family, friends, and significant others may enhance treatment engagement, strengthen coping abilities, and reduce vulnerability to relapse during the recovery process ([Kelly et al., 2023](#)).

Research has consistently demonstrated that individuals with substance use disorder (SUD) frequently report low levels of perceived support from family members, friends, and other significant people, particularly when prolonged substance use has resulted in interpersonal conflict, social stigma, and isolation. Evidence from treatment settings indicates that inadequate functional social support is associated with poorer treatment retention and less favorable recovery outcomes, suggesting that supportive relationships play a vital role in sustaining engagement in treatment ([Dobkin et al., 2002](#)).

Furthermore, findings from systematic reviews have shown that recovery-oriented support provided by peers, mutual-help groups, and recovery networks contributes to higher abstinence rates, greater participation in treatment, and improved long-term recovery among individuals with substance use disorder ([Bassuk et al., 2016](#)).

More recent review studies have further highlighted the value of recovery-oriented interventions in strengthening supportive interpersonal relationships and enhancing social functioning among individuals with substance use disorder (SUD). These interventions facilitate long-term recovery by improving access to emotional encouragement, practical assistance, and informational resources that help individuals cope more effectively with recovery-related challenges. By fostering supportive social networks and strengthening recovery resources, such interventions contribute to sustained abstinence and improved long-term recovery outcomes ([Sinclair et al., 2024](#)).

Recent evidence suggests that advances in technology and community-based recovery services have broadened opportunities for maintaining perceived social support beyond conventional face-to-face interactions. Online peer support groups, telehealth counselling, and digital recovery platforms provide individuals with continuous emotional support, practical guidance, and recovery-related information regardless of geographical or social barriers. These technology-assisted services improve access to supportive resources, reduce social isolation, and strengthen long-term recovery ([Ashford et al., 2019](#)).

Recent empirical studies indicate that perceived social support plays an important role in promoting positive mental health among individuals undergoing treatment

for substance use disorder (SUD). Individuals who perceive greater support from family members, friends, and peers generally report lower levels of depression, anxiety, loneliness, and perceived stress during recovery. Supportive social relationships foster emotional security, encourage adaptive coping strategies, and alleviate psychological distress, thereby improving overall well-being and supporting the recovery process. These findings suggest that perceived social support contributes to both better psychological functioning and more favorable substance use outcomes throughout recovery ([Choi et al., 2025](#)).

Recent evidence suggests that perceived social support promotes the use of adaptive coping strategies during recovery from substance use disorder (SUD). Individuals who perceive greater support from family, friends, and significant others are more likely to use problem-focused coping, effective emotional dysregulation, and appropriate help-seeking behaviours. ([Jarnecke et al., 2022](#)).

Several empirical studies have reported a significant inverse relationship between perceived social support and relapse risk among individuals with substance use disorder (SUD). Individuals who perceive greater support from family, friends, and significant others are generally more likely to maintain abstinence and less likely to return to substance use following treatment. Supportive social relationships enhance treatment engagement, strengthen motivation for recovery, reduce psychological distress, and reinforce commitment to abstinence, thereby contributing to more favorable long-term recovery outcomes ([Andrews et al., 2019](#)).

Evidence suggests that individuals who believe they have dependable emotional and practical support from family members, friends, and significant others are more likely to participate consistently in treatment, develop stronger confidence in their ability to sustain recovery, and achieve prolonged abstinence. These findings highlight the importance of supportive social relationships in promoting successful recovery and reducing relapse vulnerability ([Eddie et al., 2025](#)).

Research indicates that individuals who perceive stronger emotional, informational, and practical support from family members, friends, and significant others are better equipped to manage negative emotions and respond adaptively to stressful situations. Such supportive relationships foster effective coping, enhance

emotional stability, and reduce psychological distress during recovery. Conversely, individuals with lower levels of perceived social support are more likely to experience emotional dysregulation, making them increasingly vulnerable to maladaptive coping behaviours, including substance use ([Guo et al., 2024](#)).

Recent empirical findings have consistently demonstrated that perceived social support contributes significantly to positive emotional functioning and adaptive emotional dysregulation in both clinical and non-clinical populations. Individuals who perceive greater availability of emotional and practical support from their social networks tend to exhibit fewer difficulties in regulating their emotions, lower levels of anxiety and depressive symptoms, and enhanced psychological resilience. ([Taylor et al., 2023](#)).

A large empirical literature has shown a substantial negative association among perceived social assistance along with emotional instability across a variety of groups. Research has shown that participants with higher feelings of support from friends, relatives and influential relatives have higher emotional dysregulation, reduced reactivity to emotions along with higher mental adjustment ([Aldao and Tull, 2015](#)).

The empirical data further suggests that alleged social assistance is an implicit effect on emotional control through enhancement of resilient self-worth along with adaptable methods of coping. Retrospective along with cross-sectional analysis indicate that greater perceived assistance is associated with beneficial methods for controlling emotions, such as mental appraisal, expressive emotions along with coping with issues, in contrast to inadequate subjective assistance is associated with depression, avoiding, impulsiveness along with contemplation ([Gupta et al., 2024](#)).

Studies also shows that inadequate social assistance correlates with higher relapse susceptibility, higher levels of emotional disorder along with more mental health issues in substance misuse individuals. These scientific results highlight the importance of perceived support from others enhancement as an intervention plan to promote emotional control, increase mental wellness along with decrease negative behavioral consequences ([Kidorf et al., 2023](#)).

2.4 Relapse Risk

Relapse risk continues to represent one of the greatest obstacles to successful recovery among individuals with substance use disorder. Even after completing rehabilitation and maintaining abstinence for a considerable period, many individuals return to substance use due to the combined influence of biological vulnerability, emotional distress, ineffective coping strategies, stressful life events, and inadequate social support. Understanding these contributing factors is essential for developing comprehensive prevention programs and improving long-term treatment outcomes ([Yazıcı and Bardakçı, 2023](#)).

Research has consistently emphasized the protective role of family support throughout the recovery process. Individuals who experience limited emotional and practical support from family members often encounter greater difficulty maintaining abstinence and are more likely to relapse. In contrast, strong perceived social support enhances resilience, strengthens confidence in recovery, and promotes sustained abstinence. These findings highlight the significant contribution of supportive interpersonal relationships to successful addiction recovery ([Ibrahim et al., 2022](#)).

Beyond family support, previous research has explored the factors contributing to relapse among 119 male drug users who were receiving rehabilitation services in Lahore, Pakistan. Their findings indicated that negative family experiences and social stress were among the significant predictors linked with relapse risk. These findings suggest that individuals with substance use disorder may become more vulnerable to relapse when they experience difficulties in dealing with stressful circumstances and negative emotional states. Therefore, emotional dysregulation can be considered an important psychological factor that may contribute to relapse risk among individuals with SUD ([Batool et al., 2017](#)).

The consequences of substance use disorder extend beyond individual health and impose substantial economic and societal costs. In the United States alone, substance use disorders are estimated to generate annual costs exceeding 740 billion US dollars through healthcare expenditures, lost productivity, and crime-related expenses. Furthermore, existing treatments demonstrate only moderate long-term

effectiveness, with relapse rates ranging between 40% and 60%, a pattern comparable to other chronic medical conditions. These statistics underscore the need to identify reliable predictors of relapse that can improve assessment, treatment planning, and long-term recovery outcomes ([Vafaie and Kober, 2022](#)).

Existing evidence indicates that relapse remains highly prevalent across a wide range of treatment settings and patient populations. Recent studies have also demonstrated that relapse rates vary considerably according to factors such as the type of substance used, the duration of follow-up after treatment, and the nature of the intervention provided. For instance, a systematic review examining residential treatment outcomes among individuals with Opioid Use Disorder reported relapse rates ranging from 0% to 95% within one to six months following discharge, highlighting the substantial vulnerability to substance reuse during the early stages of recovery ([Ware et al., 2025](#)).

Likewise, recent reviews have continued to emphasize that relapse remains a persistent clinical challenge across stimulant, opioid, and other substance use disorders, highlighting the need for identifying psychological and social determinants that may improve long-term recovery outcomes ([Del Palacio-Gonzalez et al., 2024](#)). Recent evidence indicates that relapse risk is influenced not only by substance-related factors but also by impairments in executive functioning and decision-making. Chronic substance use can disrupt inhibitory control, cognitive flexibility, and reward processing, reducing an individual's ability to resist cravings and make adaptive decisions in high-risk situations. Consequently, neurocognitive deficits have been recognized as important contributors to relapse vulnerability during the recovery process ([Shahkarami et al., 2019](#)).

Research has consistently identified stress reactivity as an important predictor of relapse among individuals with substance use disorder (SUD). Prolonged exposure to stress may increase cravings, impair self-control, and heighten vulnerability to substance use by disrupting neurobiological systems involved in emotional dysregulation and reward processing. Consequently, individuals who experience greater psychological and physiological responses to stress are at an increased risk of relapse during recovery ([Fronk et al., 2020](#)).

Recent evidence indicates that the first six to twelve months after treatment completion represent the period of greatest relapse vulnerability. During this stage, individuals frequently encounter stressors such as interpersonal conflict, financial difficulties, occupational pressures, and exposure to substance-related environments. Therefore, individualized aftercare, regular follow-up, and family involvement are considered essential components of relapse prevention to support sustained recovery ([Day et al., 2025](#)).

Evidence further suggests that relapse risk is shaped by a range of clinical, psychological, and social factors. Research has shown that an earlier onset of substance use, greater addiction severity, sleep problems, psychiatric comorbidity, low self-efficacy, adverse life events, and socioeconomic disadvantage increase the likelihood of relapse. Conversely, supportive family relationships, strong treatment motivation, adherence to prescribed medication, and higher levels of perceived social support act as protective factors that promote sustained recovery and reduce relapse vulnerability ([Comiskey et al., 2019](#)).

Overall, current evidence indicates that relapse risk results from the interaction of multiple psychological, neurocognitive, social, and environmental factors rather than a single cause. Contemporary research supports comprehensive treatment approaches that integrate psychological interventions, strengthened social support, continuing care, and individualized relapse-prevention strategies to enhance long-term recovery and minimize the risk of relapse among individuals with substance use disorder (SUD) ([McKay, 2021](#)).

2.5 Demographic Influences

Demographic characteristics are widely recognized as important factors influencing the onset, course, treatment outcomes, and relapse risk of substance use disorder (SUD). Variables such as family system, educational level, marital status, and socioeconomic status can affect access to healthcare, availability of social support, coping abilities, and engagement in treatment, thereby shaping recovery outcomes. Previous studies have also shown that these demographic factors are associated with substance use behaviors, psychological well-being, treatment retention, and

relapse, emphasizing their significance in both addiction research and clinical practice ([Compton et al., 2024](#)).

Marital status has also been identified as an influential demographic characteristic affecting recovery from substance use disorder. Current evidence suggests that stable and supportive marital or family relationships provide valuable emotional, practical, and social resources that encourage treatment participation and facilitate long-term recovery. Such relationships strengthen adaptive coping, enhance accountability, and help individuals manage recovery-related stress more effectively. In contrast, individuals who are single, divorced, or separated often report lower levels of perceived social support, which may contribute to poorer treatment outcomes and a greater likelihood of relapse compared with those who have supportive partners or family networks ([Sadaqat et al., 2023](#)).

Socioeconomic status (SES), commonly determined by an individual's income, occupation, and educational level, has long been recognized as an important factor influencing both substance use and recovery outcomes. Empirical evidence indicates that individuals from socioeconomically disadvantaged backgrounds are more likely to encounter persistent financial difficulties, unemployment, unstable housing, and restricted access to healthcare and rehabilitation services. Conversely, individuals with higher socioeconomic resources generally have greater access to quality treatment, stronger social support networks, and more stable living environments, all of which facilitate sustained recovery and improve long-term treatment outcomes ([Fardone et al., 2023](#)).

Within Pakistan, demographic characteristics play a crucial role in influencing both the onset of substance use disorder and the recovery process. Recent Pakistani studies have therefore emphasized that demographic characteristics should be incorporated into the planning and implementation of prevention initiatives and rehabilitation programmes to improve treatment participation, strengthen recovery, and reduce relapse among individuals with substance use disorder ([Malik et al., 2023](#)). Therefore, understanding these demographic differences is important for identifying individuals who may face greater challenges during recovery. Such consideration can support the development of targeted and context-sensitive interventions to improve treatment outcomes and reduce relapse.

2.6 Theoretical Framework

Relapse Prevention Theory is a psychological behavioral theory founded in the 1980s by G. Alan Marlatt along with Judith R. Gordon. In the present study, Relapse Prevention Theory serves as the theoretical foundation for explaining the association between perceived social support, emotional dysregulation, and relapse risk. The theory proposes that individuals recovering from substance use disorder (SUD) regularly encounter high-risk situations that involve negative emotional experiences and environmental cues capable of triggering relapse ([Sharma et al., 2021](#)).

This framework thus provides a structured lens for understanding the interplay of the study variables. Consistent with this framework, Marlatt and Gordon's Relapse Prevention Theory (RPT) explains relapse through several important components: (1) high-risk situations, which may increase the likelihood of substance use; (2) coping responses, which refer to the ways individuals manage or respond to these situations; (3) self-efficacy, which reflects confidence in one's ability to resist substance use; (4) outcome expectancies, which involve beliefs about the anticipated effects or consequences of substance use; and (5) the abstinence violation effect, which refers to negative emotional reactions, such as guilt, disappointment, or a sense of failure, following a lapse. These interconnected components collectively account for the varied pathways through which relapse may occur.

Within this framework, perceived social support may provide emotional encouragement, guidance, and practical resources that can help individuals manage stressful or high-risk situations more effectively. However, when individuals experience difficulties in regulating their emotions, they may find it challenging to use adaptive coping responses when confronted with stress, negative emotions, cravings, or substance-related triggers. Thus, perceived social support may be associated with emotional regulation, while difficulties in emotional regulation may increase vulnerability to relapse. In this way, coping responses provide a relevant theoretical link for understanding how the study variables may be connected within the framework of Relapse Prevention Theory.

Within this framework, perceived social support acts as a protective factor by enhancing coping abilities. Conversely, emotional dysregulation is considered a significant psychological vulnerability that limits effective emotional coping and increases susceptibility to relapse. Accordingly, the present study suggests that greater perceived social support may reduce relapse risk both directly and indirectly through its positive influence on emotional dysregulation, making Relapse Prevention Theory an appropriate conceptual framework for explaining the proposed relationships among the study variables [Hendershot et al. \(2011\)](#).

Relapse Prevention Theory as a cognitive-behavioural framework designed to explain and reduce relapse among individuals recovering from substance use disorder (SUD). In contrast to earlier treatment models that interpreted relapse as an indication of treatment failure, the theory proposes that relapse is a common and expected part of the recovery journey, providing opportunities for learning and personal growth. The model shifts attention away from blame and instead focuses on recognizing relapse-related risk factors, enhancing adaptive coping skills, and equipping individuals with practical strategies to maintain long-term recovery ([Witkiewitz and Tucker, 2020](#)).

In the context of the present study, negative emotional states are particularly relevant because they are closely associated with emotional dysregulation. Individuals who have difficulty recognizing, accepting, and managing their emotional experiences are more likely to experience heightened emotional distress when exposed to high-risk situations. Such difficulties can reduce their capacity to cope effectively with stress, making them more susceptible to substance use as a maladaptive coping response. Consequently, emotional dysregulation can be considered an important psychological vulnerability that may contribute to an increased risk of relapse among individuals with substance use disorder ([Kaufman et al., 2016](#)).

Relapse Prevention Theory further emphasizes the protective role of social support throughout the recovery process. Assistance received from family, friends, significant others, counsellors, and peer support groups can provide emotional comfort, practical help, motivation, and guidance during challenging situations. In the present study, this protective factor is represented by perceived social support, which refers to an individual's belief that reliable emotional and practical support

is available from important people within their social network ([Brousseau et al., 2022](#)).

Relapse Prevention Theory offer a relevant theoretical foundation for the present study. According to the theory, individuals who perceive higher levels of social support are more likely to cope successfully with stressful and high-risk situations encountered during recovery. In contrast, those with greater difficulties in regulating their emotions may struggle to manage negative emotional experiences, increasing their vulnerability to relapse. Building on these assumptions, the present study proposes that emotional dysregulation may function as an intervening mechanism through which perceived social support is associated with relapse risk among individuals with substance use disorder. Accordingly, Relapse Prevention Theory provides a suitable conceptual framework for understanding the relationships among perceived social support, emotional dysregulation, and relapse risk ([Acri et al., 2012](#)).

2.7 Conceptual Framework

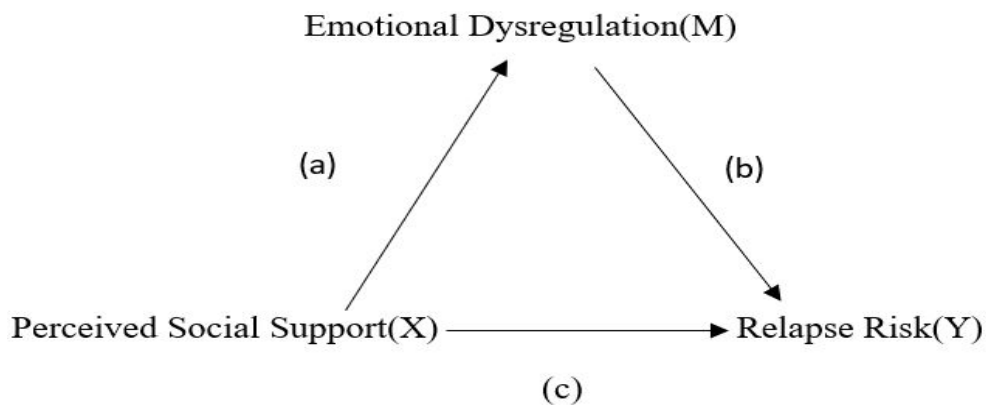


FIGURE 2.1: Conceptual Framework

In this framework the independent parameter was perceived social support, the dependent parameter was relapse risk along with the mediating parameter was emotional dysregulation. According to the model, people who view that they have more assistance from close companions and substantial people are more inclined to have lower relapse risk. Thus, high perceived social assistance is anticipated to have a protective effect on relapse risk ([Xiong and Jia, 2019](#)).

The direct path in the approach additionally indicates that sense of perceived social support might lower the likelihood of relapse, without consideration of the degree of emotional dysregulation. The structure also points to an indirect effect of perceptions of social support on the possibility of relapse through emotional dysregulation (Yang et al., 2021). Particularly deficits in perceptions of perceived social support may play a role in emotional dysregulation challenges, which can contribute to increased adverse consequences, impulsiveness, stressful tolerance along with dysfunctional coping behaviours (Pauw et al., 2022).

These challenges in emotional dysregulation make it more likely that the individual will turn to drug abuse as a way to cope, thus increasing the possibility of relapse risk. On the contrary sufficient perceived social support promotes emotional dysregulation along with effective coping strategies, which are associated with reduced emotional dysregulation resulting in a reduced possibility of relapse (Smart and Curran, 2025).

2.8 Rationale

Substance Use Disorder (SUD) continues to pose a significant public health challenge, with relapse remaining a common occurrence despite the completion of detoxification and rehabilitation programs. While advances in addiction treatment have improved recovery services, achieving and sustaining long-term abstinence remains difficult because recovery is influenced by a complex interplay of psychological, social, and environmental factors. Recent evidence indicates that successful recovery involves more than simply refraining from substance use; it also depends on the availability of adequate psychosocial resources that help individuals manage stress, resist cravings, and effectively cope with the ongoing challenges associated with recovery (Sadaqat et al., 2023).

The evidence examined in this section suggests that perceived support from society has been identified as an important protective factor during the process of recovery, offering psychological, knowledge-based, along with tangible assistance for maintaining a healthy lifestyle along with coping with recovery-associated difficulties. Research continually demonstrated that people who feel that they have

more assistance from close companions and important people are less inclined to relapse while achieving better rehabilitation experiences.

Social support is important in the Pakistani context as family and interpersonal relationships can play a role in rehabilitation and recovery. Social support, however, does not necessarily predict relapse in all people, so it is important to consider the psychological mechanisms by which social support might affect relapse-related outcomes.

Emotional dysregulation has been increasingly recognized as a key psychological determinant of relapse among individuals with substance use disorder (SUD). Deficits in identifying, understanding, and effectively managing emotional experiences may lead individuals to adopt maladaptive coping strategies, including substance use, particularly when confronted with stressful or emotionally challenging situations. Recent empirical findings further demonstrate that individuals with SUD exhibit significantly greater impairments in emotional dysregulation than non-clinical populations, highlighting emotional dysregulation as a critical factor contributing to increased relapse vulnerability ([Cyr et al., 2023](#); [Stellern et al., 2023](#)).

Concurrently emotional dysregulation has been recognized as a salient mental health issue that is related to substance abuse behaviours, addictions, inadequate coping skills along with higher susceptibility to relapse. Emotional dysregulation predicts relapse possibility, with those who find it difficult with managing adverse emotions potentially turning to illicit drug use as a dysfunctional coping method.

While there has been a lot for studies on social support, emotional dysregulation along with relapse vulnerability independently, there has not been much study on how perceptions of social support affect relapse vulnerability in people with SUD. Specifically, the mediation function of emotional dysregulation has not been given enough focus, particularly in emerging economies such as Pakistan, in which familial and social institutions may particularly affect rehabilitation results.

Specifically, in Pakistan, there is little empirical evidence on whether emotional dysregulation acts as a mediator in the relationship between perceived social support and relapse risk among people with SUD. This is particularly significant in

the context of Pakistani society and culture, where family and interpersonal relationships play a crucial role in the recovery journey. Considering these variables together in one framework might therefore help in understanding the psychological processes involved in the risk of relapse among people with SUD who are undergoing rehabilitation services in Pakistan (Hanif et al., 2019).

Furthermore, relatively few studies have explored how demographic characteristics are associated with perceived social support, emotional dysregulation, and relapse risk among individuals with substance use disorder.

Factors including age, marital status, educational attainment, family system, socioeconomic status, and employment may shape recovery processes and influence treatment outcomes; however, their contribution has not been adequately investigated, especially in the Pakistani context. ([Okonkwo et al., 2020](#)).

Chapter 3

Research Methodology

3.1 Research Design

The present study adopted a quantitative, cross-sectional, and correlational research design to investigate the mediating role of emotional dysregulation in the relationship between perceived social support and relapse risk among individuals with substance use disorder (SUD). A quantitative approach was selected because it allows the systematic measurement of psychological variables using standardized instruments and support statistical analysis of the relationships. The cross-sectional design included collecting data from participants at a particular time during their treatment in rehabilitation centres, making it suitable for assessing the current status of the study variables ([Setia, 2016](#)).

A correlational framework was adopted to investigate the direction and strength of the relationships among perceived social support, emotional dysregulation, and relapse risk without deception any variables. This method was considered appropriate because the study focused on naturally occurring psychological characteristics in a clinical population, where experimental manipulation would not be practical or ethically appropriate ([Mikszta et al., 2023](#)).

This design provided an appropriate basis for examining the proposed relationships among the study variables within a natural treatment setting. It also enabled the assessment of the mediating role of emotional dysregulation between perceived social support and relapse risk.

3.2 Sampling Method

The current study applied a purposive sampling technique to recruit participants from selected rehabilitation centers in Rawalpindi and Islamabad, Pakistan. Purposive sampling is a non-probability sampling method in which participants are intentionally selected based on characteristics relevant to the objectives of the study (Etikan et al., 2016). This approach was considered appropriate because the study specifically targeted individuals who had been diagnosed with substance use disorder (SUD) and were receiving treatment in rehabilitation settings.

Participants were recruited from rehabilitation centers that provide assessment, treatment, and recovery services for individuals with SUD. These centers were selected based on accessibility, availability of eligible participants, and administrative permission to conduct the study. Recruiting participants from multiple rehabilitation facilities also enhanced the diversity of the sample and improved the applicability of the findings to similar clinical settings.

3.3 Sample Size

The sample size for the present study was calculated through an a priori power analysis conducted through G*Power version 3.1. The analysis was conducted to ensure adequate statistical power for identifying significant associations among perceived social support, emotional dysregulation, and relapse risk. considering on a medium effect size (0.15), a significance level of $\alpha = .05$, and statistical power of 0.80, the minimum required sample size was estimated to be approximately 180 participants. To increase the reliability and accuracy of the results, the final sample size was increased to 250 participants (Yucens et al., 2026; Abdelaal et al., 2025).

The final sample comprised 250 male individuals diagnosed with substance use disorder (SUD) who were receiving treatment in selected rehabilitation centres in Rawalpindi and Islamabad, Pakistan. All participants met the predefined inclusion criteria and voluntarily participated after providing informed consent.

3.4 Access to Participants

Earlier to the initiation of data collection, formal permission was received from the administrations of the selected rehabilitation centres in Rawalpindi and Islamabad. The rehabilitation centres were initially contacted through telephone and online communication to introduce the study, explain its objectives and procedures, and request permission to conduct the research. Following institutional approval, each rehabilitation centre was visited to recruit eligible participants and carry out the data collection process.

Eligible participants were identified with the assistance of the administrative staff and mental health professionals working at the rehabilitation centres. Each eligible individual was personally approached, and the purpose of the study, the research procedures, and the approximate time required to complete the assessment were explained.

Participants were informed that their participation was entirely voluntary and that they could decline participation or withdraw from the study at any stage without any impact on their treatment or rehabilitation services. Written informed consent was collected from all respondents before the administration of the study measures. As some participants had limited literacy and were unable to read or complete the questionnaires independently, each questionnaire item was read aloud and simple, neutral explanations were provided whenever clarification was needed. Participants' responses were recorded accurately without influencing their answers. A number of eligible individuals chose not to participate or declined to complete the questionnaires due to personal reasons or a lack of interest in the study. Their decisions were fully respected, and no pressure was placed on them to participate.

3.5 Procedure

The present study was conducted in selected rehabilitation centre in Rawalpindi and Islamabad, Pakistan, including Hero Health Care, Pakistan Institute of Mental Health (PIMH), The New Life Rehab & Psychiatric Center, Ali Rehab Center, Golf

Addiction Treatment Center, Islamabad Rehab and Caring Center, and Islamabad Rehab Centre. Prior to data collection, ethical approval was obtained from the relevant university research committee, and formal permission was secured from the administrations of all participating rehabilitation centre. These approvals ensured that the study complied with institutional and ethical guidelines.

A purposive sampling technique was used to recruit participants who met the pre-determined inclusion criteria. With the assistance of clinical psychologists and rehabilitation staff, eligible individuals diagnosed with substance use disorder (SUD) were identified and invited to participate in the study. The researcher explained the purpose and procedures of the study, and written informed consent was obtained from all participants. Participation was entirely voluntary, and participants were assured of the confidentiality and anonymity of the information they provided. These measures helped foster trust and encouraged honest responding.

Data were collected individually in a quiet and comfortable setting within the rehabilitation centre. Each participant completed a Demographic Information Form, the Urdu version of the Multidimensional Scale of Perceived Social Support (MSPSS), the Urdu version of the Difficulties in Emotion Regulation Scale (DERS), and the Urdu version of the Advance Warning of Relapse (AWARE) Questionnaire–Revised. The assessment required approximately 25–35 minutes to complete. Participants were encouraged to answer honestly and were provided with clarification whenever necessary without influencing their responses. The standardized administration of these instruments ensured consistency across all data collection sessions.

Following data collection, all questionnaires were examined for completeness and assigned unique identification codes to ensure anonymity. The data were entered into IBM SPSS Statistics for analysis after checking for missing values, data entry errors, and outliers. Appropriate descriptive and inferential statistical analyses were then conducted to address the research objectives and test the proposed hypotheses. This systematic approach to data management ensured the accuracy and integrity of the analyses that followed.

3.6 Inclusion Criteria

- i. Individuals who had received a formal diagnosis of substance use disorder (SUD) in accordance with the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) criteria.
- ii. Participants who were actively undergoing treatment in a recognized rehabilitation center located in Rawalpindi or Islamabad at the time of data collection.
- iii. Male participants who were 18 years of age or older.
- iv. Individuals who possessed sufficient proficiency in Urdu to read, understand, and complete the study questionnaires independently.

3.7 Exclusion Criteria

- i. Individuals with severe cognitive impairments, such as dementia or intellectual disability, that limited their ability to comprehend or complete the research instruments accurately.
- ii. Participants experiencing significant psychological or cognitive difficulties that could interfere with their active participation in the study, as determined by the clinical or treatment staff at the rehabilitation centers.

3.8 Instruments

The present study employed a set of standardized psychological instruments to assess the major study variables, including perceived social support, emotional dysregulation, and relapse risk among individuals diagnosed with substance use disorder (SUD). To facilitate accurate comprehension and obtain reliable responses, the Urdu-translated versions of all standardized scales were administered. The use of culturally and linguistically adapted instruments ensured that participants clearly understood each item, thereby enhancing the validity and reliability of the collected data. In addition to these standardized measures, a researcher-developed demographic information sheet was used to obtain participants' background characteristics.

3.8.1 Demographic Information Sheet

Demographic information sheet was designed to obtain background information relevant to the objectives of the present study. The questionnaire gathered essential demographic and clinical characteristics of the participants, including age, educational qualification, marital status, employment status, and the primary substance used. The information collected through this form was used to describe the sample and provide a comprehensive overview of participants' characteristics. The demographic data were analyzed using descriptive statistical techniques, including frequencies, percentages, means, and standard deviations, to summarize the profile of the study participants. This information also facilitated a clearer interpretation of the findings by providing contextual details about the individuals receiving treatment for substance use disorder.

3.8.2 Multidimensional Scale of Perceived Social Support

Perceived social support was assessed using the Multidimensional Scale of Perceived Social Support (MSPSS), originally developed by [Zimet et al. \(1988\)](#). The MSPSS is a widely recognized self-report instrument designed to measure an individual's perception of support received from three important sources: family, friends, and significant others. The instrument consists of 12 items, with four items representing each of the three support domains: Family, Friends, and Significant Others. Responses are recorded on a 7-point Likert-type scale, ranging from 1 (Very Strongly Disagree) to 7 (Very Strongly Agree). Higher scores indicate greater perceived availability and adequacy of social support, whereas lower scores reflect a perception of limited interpersonal support.

For the present study, the Urdu-translation version by ([Jibeen and Khalid, 2010](#)) of the MSPSS was administered to ensure that participants could easily comprehend the questionnaire and respond accurately. The MSPSS has consistently shown excellent psychometric characteristics. Previous studies have reported high levels of internal consistency, with Cronbach's alpha coefficients typically ranging from .85 to .95 for the total scale and its respective subscales.

3.8.3 Difficulties in Emotion Regulation Scale

Emotional dysregulation was assessed using the Difficulties in Emotion Regulation Scale (DERS), originally developed by [Gratz and Roemer \(2004\)](#). The DERS is a comprehensive self-report measure designed to evaluate multiple dimensions of emotion regulation and to identify difficulties individuals experience in understanding, accepting, and managing their emotional responses. The original DERS consists of 36 items that assess six key dimensions of emotion regulation. Each item is rated on a 5-point Likert scale, ranging from 1 (Almost Never) to 5 (Almost Always). Participants indicate how frequently each statement reflects their typical emotional experiences. Several items are reverse scored before calculating the final scores. Higher total and subscale scores indicate greater difficulties in emotion regulation, whereas lower scores reflect more adaptive emotional functioning.

For the present study, the Urdu-translation version by Maham Irfan (2018) of the DERS was administered to ensure that participants could easily understand the questionnaire and provide accurate responses. Previous investigations have reported Cronbach's alpha coefficients ranging from .80 to .93 across the total scale and its subscales, indicating strong internal consistency. Within the present study, the DERS served as the mediating variable, allowing the researcher to examine whether emotional dysregulation explains the relationship between perceived social support and relapse risk among individuals diagnosed with substance use disorder.

3.8.4 Advance Warning of Relapse Questionnaire

Relapse risk was assessed using the Advance Warning of Relapse Questionnaire Revised (AWARE-R), originally developed by [Miller and Harris \(2000\)](#). The AWARE-R is a standardized self-report instrument specifically designed to identify the early cognitive, emotional, and behavioral warning signs that may indicate an increased likelihood of relapse among individuals recovering from substance use disorder (SUD). The questionnaire is widely recognized as a valuable clinical and research tool for monitoring recovery progress and identifying individuals who may require additional therapeutic support. The revised version of the AWARE questionnaire comprises 28 items, each representing experiences and

behaviors commonly associated with relapse vulnerability. Participants respond to each statement using a 7-point Likert-type scale, ranging from 1 (Never) to 7 (Always), indicating the frequency with which they have experienced each warning sign during recent weeks.

For the present study, the Urdu-translated version of AWARE-R translated by [Sahar and Naqvi \(2021\)](#) was administered to ensure linguistic clarity and cultural appropriateness for Urdu-speaking participants. The instrument has consistently shown good internal consistency, with Cronbach's alpha coefficients reported within the acceptable to excellent range across different clinical populations.

3.9 Ethical Consideration

Ethical clearance for the present study was obtained from the appropriate university research ethics committee before the commencement of data collection. In addition, official approval was secured from the management of the selected rehabilitation centre in Rawalpindi and Islamabad to conduct the research. Prior to participation, all individuals received a clear explanation of the study objectives and procedures, after which written informed consent was obtained. Participation was completely voluntary, and participants were informed of their right to decline participation or withdraw from the study at any time without affecting the treatment or rehabilitation services they were receiving. Special care was taken to ensure that participants were able to understand the information provided and voluntarily consent to participation. These measures ensured that informed consent was both meaningful and ethically sound.

Given the sensitive nature of information concerning substance use and relapse, particular attention was given to maintaining participants' privacy and confidentiality throughout the research process. Participants were not identified by their names; instead, unique codes were used to protect their identities. All collected data were stored securely and were accessible only to the researcher. Such safeguards were essential given the stigmatized nature of substance use within the Pakistani context. The privacy and confidentiality of all participants were carefully protected throughout the study. The collected data were stored securely

and used solely for research and academic purposes. Participants were also informed that they were free to omit any question they preferred not to answer. Throughout the data collection process, every effort was made to safeguard participants' privacy, respect their dignity, and ensure their comfort while complying with established ethical principles for psychological research. Collectively, these procedures reflect the study's commitment to upholding the rights and well-being of a vulnerable clinical population.

Chapter 4

Results

The present study was conducted to investigate the relationship between emotional dysregulation, perceived social support and relapse risk among individuals with SUD. In addition, the study examined mediating role of emotional dysregulation. This chapter presents the findings of the study. The results are organized into descriptive statistics, normality, reliability analyses, correlation analyses and mediation analysis

4.1 Demographic Characteristics of Study Participants

In the present study, data were collected from 250 participants. The demographic characteristics of the sample were examined in terms of marital status, socioeconomic status, educational level, and family system. Table 4.1 presents the frequencies, percentages, and descriptive statistics of the demographic variables. Majority of participants were single ($n = 129$, 51.6%), followed closely by married participants ($n = 121$, 48.4%). This indicates that the sample comprised predominantly single and married individuals.

The relatively balanced representation of both marital status groups provides an appropriate basis for further analysis. It also ensures that both single and married participants are adequately represented in subsequent comparisons. These demographic characteristics provide important context for interpreting the findings of the study.

TABLE 4.1: Demographic Characteristics of the Participants ($N = 250$)

Variable	Category	f	%
Marital Status	Single	129	51.6
	Married	121	48.4
Family System	Joint	160	64.0
	Nuclear	90	36.0
Socioeconomic Status	Low	49	19.6
	Middle	170	68.0
	Upper	31	12.4

Note. f = frequency; % = percentage.

The participants belonged to the middle socioeconomic class ($n = 170$, 68.0%). Participants from low socioeconomic backgrounds constituted 19.6% ($n = 49$) of the sample, whereas those belonging to the upper socioeconomic class accounted for 12.4% ($n = 31$) suggesting that the majority of the sample represented middle-income households.

4.2 Cronbach's Alpha Reliability of Scales

TABLE 4.2: Mean, Standard Deviation, Ranges, Skewness, Kurtosis and Cronbach's Alpha Reliability Coefficients (α) of Study Scales ($N = 250$)

Scales	N	M	SD	α	Potential Range	Actual Range	Skewness	Kurtosis
MSPSS	12	46.72	14.53	.87	12–84	12–84	-.137	-.004
AWARE	28	99.99	24.42	.89	28–196	28–163	-.18	-.28
DERS	36	101.40	17.43	.82	36–180	44–133	-0.92	0.48

Note. M = Mean; SD = Standard Deviation; α = Cronbach's alpha reliability coefficient; DERS = Difficulties in Emotion Regulation Scale; MSPSS = Multidimensional Scale of Perceived Social Support; AWARE = Advance Warning of Relapse Scale.

To evaluate the reliabilities of scales administered, Cronbach's alpha reliability (α) was analysed. Table 4.2 presents the means, standard deviations, ranges, skewness, kurtosis, and Cronbach's alpha reliability coefficients for the study variable scales. The Difficulties in Emotion Regulation Scale (DERS) showed good internal consistency, with a Cronbach's alpha coefficient of .82. The Multidimensional Scale of Perceived Social Support (MSPSS) demonstrated good internal consistency, with a Cronbach's alpha coefficient of .87. Similarly, the Advance Warning of Relapse Scale (AWARE) exhibited excellent internal consistency, with a reliability coefficient of .89. Overall, the reliability coefficients ranged from .82 to .89, indicating that all instruments showed good to excellent internal consistency and were suitable for subsequent analyses. Furthermore, the skewness and kurtosis values fell within acceptable ranges, suggesting that the study variables were approximately normally distributed.

4.3 Descriptive Statistics

TABLE 4.3: Descriptive Statistics of Emotional Dysregulation, Perceived Social Support, and Relapse ($N = 250$)

Scales	<i>M</i>	<i>Md</i>	<i>Mdn</i>	<i>SD</i>	Skewness	Kurtosis	K-S	<i>p</i>
MSPSS	46.72	48.00	48.00	14.53	-.137	-.004	.080	.001
AWARE	99.99	102.00	102.00	24.42	-.18	-.28	.060	.029
DERS	101.40	115.00	105.00	17.43	-.92	.48	.123	.000

Note. *M* = Mean; *Md* = Mode; *Mdn* = Median; *SD* = Standard Deviation; *K-S* = Kolmogorov–Smirnov Statistic; MSPSS = Multidimensional Scale of Perceived Social Support; AWARE = Advance Warning of Relapse Scale; DERS = Difficulties in Emotion Regulation Scale.

Table 4.3 presents descriptive statistics of the study variables including emotional dysregulation, perceived social support, and relapse. On the basis of skewness, kurtosis, normality tests, and the shape of the distribution curves, the variables in the present study were treated as approximately normally distributed for the purposes of correlation and subsequent parametric analyses.

The values of the Multidimensional Scale of Perceived Social Support (MSPSS) indicate a slight negative skewness and an approximately mesokurtic distribution, both of which fall within the acceptable range for normality assumptions. The Kolmogorov–Smirnov test yielded a value of .080 ($p = .001$).

The values of the Advance Warning of Relapse Scale (AWARE) indicate a nearly symmetric and slightly platykurtic distribution, which falls within the acceptable limits of normality. The Kolmogorov–Smirnov statistic for AWARE was .060 ($p = .029$).

The values of the Difficulties in Emotion Regulation Scale (DERS) indicate moderate negative skewness and slight leptokurtosis; however, both statistics remained within the acceptable range for assuming approximate normality. The Kolmogorov–Smirnov statistic for DERS was .123 ($p < .001$).

Overall, the skewness and kurtosis values of all study variables were within acceptable limits between +1 and -1, indicating that the distributions did not substantially deviate from normality and were therefore considered suitable for subsequent parametric analyses. These findings provide support for proceeding with the planned correlation and inferential analyses. The descriptive results also provide an overview of the central tendency and variability of the study variables before examining their relationships in the subsequent analyses.

These findings indicate that the study variables demonstrated acceptable distributional characteristics for the intended statistical procedures. The overall pattern of skewness and kurtosis suggests that no variable showed substantial departure from approximate normality. Therefore, the data were considered suitable for examining the relationships among perceived social support, emotional dysregulation, and relapse. These results provide a sound basis for proceeding with the subsequent correlation and inferential analyses.

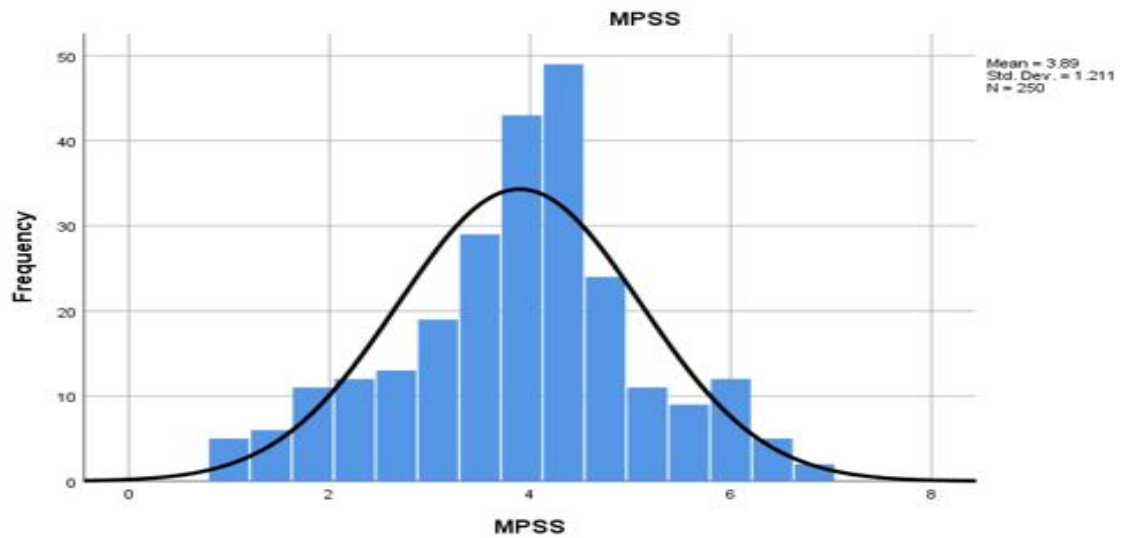


FIGURE 4.1: Distribution of Multidimensional Scale of Perceived Social Support

The histogram of perceived social support scores in figure 4.1 demonstrates an approximately normal distribution with a slight negative skew, indicating that the assumption of normality was reasonably satisfied.

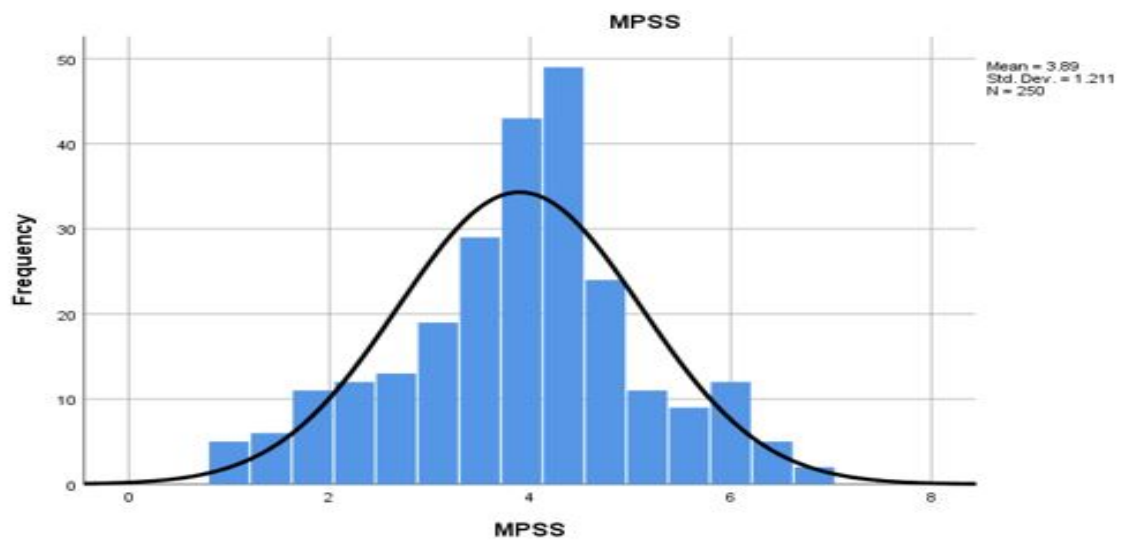


FIGURE 4.2: Distribution of Advance Warning of Relapse Scale

The histogram of relapse risk scores in figure 4.2 shows an approximately normal distribution with a slight negative skew and no substantial deviations from normality.

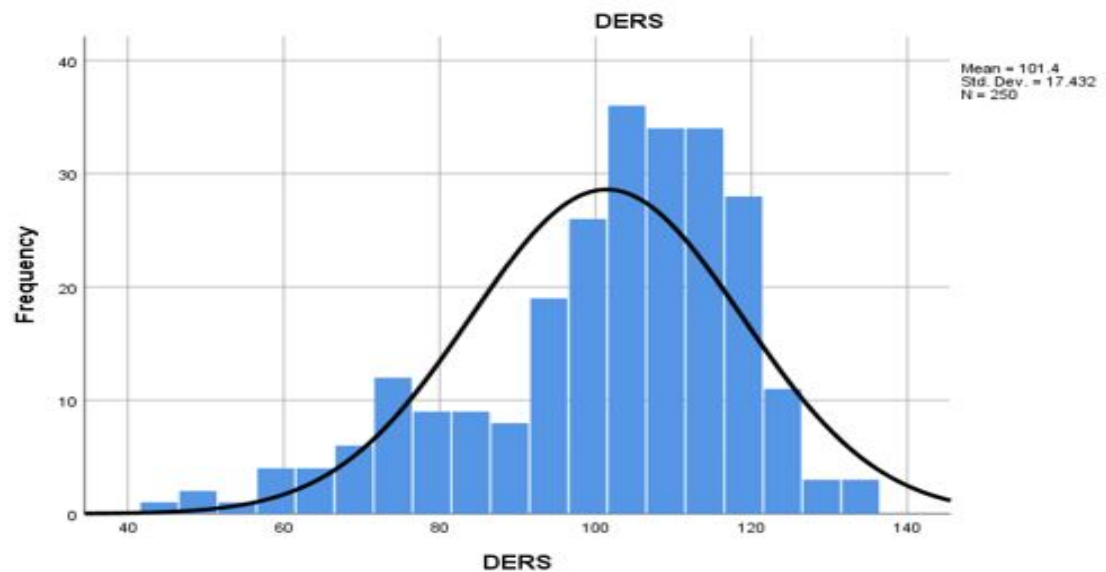


FIGURE 4.3: Distribution of Difficulties in Emotion Regulation Scale

The histogram of emotional dysregulation scores in figure 4.3 indicates a moderately negatively skewed but approximately normal distribution, supporting the use of parametric statistical analyses.

4.4 Correlations

TABLE 4.4: Pearson Correlations Among Study Variables ($N = 250$)

Variable	<i>N</i>	<i>M</i>	<i>SD</i>	1	2	3
1. MSPSS	250	3.89	1.21	—		
2. AWARE	250	99.99	24.42	.030	—	
3. DERS	250	101.40	17.43	-.130*	.502**	—

Note. *M* = Mean; *SD* = Standard Deviation; MSPSS = Multidimensional Scale of Perceived Social Support; AWARE = Advance Warning of Relapse Scale; DERS = Difficulties in Emotion Regulation Scale. * $p < .05$, ** $p < .01$.

The Pearson correlation analysis was conducted to examine the relationships among perceived social support, relapse, and emotional dysregulation. The analysis provides an understanding of the direction and strength of the associations between the major study variables. The results are presented in **Table 4.4**.

Table 4.4 presents the results of Pearson's correlation analysis among perceived social support, relapse, and emotional dysregulation. Perceived social support showed a non-significant positive relationship with relapse, indicating that perceived social support was not significantly associated with relapse among the participants. However, perceived social support was negatively and significantly associated with emotional dysregulation, suggesting that individuals reporting higher levels of perceived social support experienced lower levels of emotional dysregulation.

Furthermore, relapse demonstrated a moderate positive and statistically significant relationship with emotional dysregulation, indicating that higher levels of emotional dysregulation were associated with greater relapse warning signs. Overall, the findings suggest that emotional dysregulation is positively related to relapse and negatively related to perceived social support, whereas perceived social support was not significantly associated with relapse.

These findings provide an initial understanding of the associations among the study variables. The significant relationship between emotional dysregulation and relapse indicates that emotional dysregulation may be an important variable in understanding relapse-related outcomes. The negative association between perceived social support and emotional dysregulation also suggests that social support may be relevant to emotional regulation. However, the non-significant association between perceived social support and relapse indicates that this relationship may require consideration of other variables.

Taken together, the correlation findings provide a basis for further examining the relationships among the variables through subsequent inferential analyses. The pattern of correlations is also consistent with the proposed relationships among perceived social support, emotional dysregulation, and relapse.

4.5 Mediation Analysis

TABLE 4.5: Mediating Role of Emotional Dysregulation in the Relationship Between Perceived Social Support and Relapse Risk ($N = 250$)

Effect	Variable	Predictor	B	SE	t	p	F	$df1$	$df2$	LL	UL
a path (MSPSS $\rightarrow$ DERS)	DERS	MSPSS	-0.16	0.08	-2.06	.040	4.26	1	248	-0.30	-0.01
b path (DERS $\rightarrow$ AWARE)	AWARE	DERS	0.72	0.08	9.33	.001	—	—	—	0.57	0.87
c' path (PSS $\rightarrow$ AWARE)	AWARE	MSPSS	0.16	0.09	1.75	.081	43.65	2	247	-0.02	0.35
Total effect (c)	AWARE	MSPSS	0.60	1.28	0.47	.638	0.22	1	248	-1.92	3.12
Indirect effect ($a \times b$)	AWARE	DERS	-0.11	0.06 ^a	—	—	—	—	—	-0.23	0.04

Note. PSS = Perceived Social Support; ED = Emotional Dysregulation; RR = Relapse Risk; B = unstandardized regression coefficient; SE = standard error; LL = lower limit of the 95% confidence interval; UL = upper limit of the 95% confidence interval; a path = effect of perceived social support on emotional dysregulation; b path = effect of emotional dysregulation on relapse risk; c' path = direct effect of perceived social support on relapse risk controlling for emotional dysregulation; c path = total effect of perceived social support on relapse risk. ^a Bootstrapped standard error based on 5,000 bootstrap samples.

A simple mediation analysis was conducted using Hayes' PROCESS Macro to examine whether emotional dysregulation mediated the relationship between perceived social support and relapse risk among individuals with substance use disorder. Perceived social support (MSPSS) was entered as the independent variable (X), emotional dysregulation (DERS) as the mediator (M), and relapse risk (AWARE) as the dependent variable (Y).

The first regression model examined the effect of perceived social support on emotional dysregulation. The overall model was statistically significant. Perceived social support significantly and negatively predicted emotional dysregulation, indicating that higher levels of perceived social support were associated with lower levels of emotional dysregulation.

The second regression model examined the effects of perceived social support and emotional dysregulation on relapse risk. The overall model was statistically significant. Emotional dysregulation significantly and positively predicted relapse risk indicating that greater emotional dysregulation was associated with higher relapse risk. However, the direct effect of perceived social support on relapse risk was not statistically significant after controlling for emotional dysregulation.

The total effect model indicated that perceived social support did not significantly predict relapse risk. The total effect of perceived social support on relapse risk was not statistically significant.

The indirect effect of perceived social support on relapse risk through emotional dysregulation was not statistically significant, as the 95% bootstrap confidence interval included zero. Overall, although perceived social support significantly predicted lower emotional dysregulation, and emotional dysregulation significantly predicted higher relapse risk, neither the total effect nor the direct effect of perceived social support on relapse risk was statistically significant. Furthermore, the indirect pathway from perceived social support to relapse risk through emotional dysregulation was not statistically significant. Thus, the proposed mediation hypothesis was not supported. These findings suggest that emotional dysregulation did not significantly explain the relationship between perceived social support and relapse risk in the present study.

4.6 Differences in Study Variables Across Demographic Characteristics

4.6.1 Marital Status

TABLE 4.6: Means, Standard Deviations, and Independent Samples *t*-Test Comparing Perceived Social Support, Relapse Risk, and Emotional Dysregulation by Marital Status ($N = 250$)

Measure	Single		Married		t	p	95% CI		Cohen's d
	(n = 129)		(n = 121)						
	M	SD	M	SD			LL	UL	
MSPSS	46.69	14.19	46.66	14.96	.017	.973	-3.60	3.67	-0.00
AWARE	100.34	24.00	99.49	25.00	.273	.816	-5.26	6.96	0.03
DERS	101.22	18.16	101.89	16.43	-.304	.867	-4.98	3.65	-0.02

Note. *M* = Mean; *SD* = Standard Deviation; *d* = Cohen's *d*.

An independent-samples *t*-test was conducted to examine whether perceived social support, relapse risk, and emotional dysregulation differed significantly between single and married participants. **Table 4.6** presents the means, standard deviations, *t*-values, significance levels, and Cohen's *d* effect sizes for each study variable.

The findings indicated no statistically significant difference in perceived social support (MSPSS) between single and married participants. The 95% confidence interval for the mean difference included zero, and the negligible effect size further indicated that marital status was not meaningfully associated with perceived social support in the present sample.

Similarly, no statistically significant difference was observed in relapse risk (AWARE) between single and married participants. Although single participants obtained a slightly higher mean relapse risk score than married participants, the

difference was minimal and not statistically significant. The 95% confidence interval for the mean difference also included zero, indicating that relapse risk did not significantly differ according to marital status.

Likewise, no statistically significant difference was found in emotional dysregulation (DERS) between single and married participants. Married participants reported slightly higher emotional dysregulation than single participants; however, this difference was trivial and not statistically significant. Furthermore, the 95% confidence interval for the mean difference included zero, providing additional evidence that emotional dysregulation did not significantly differ according to marital status.

Overall, the results indicate that marital status was not significantly associated with perceived social support, relapse risk, or emotional dysregulation among individuals with substance use disorder.

4.6.2 Family System

TABLE 4.7: Means, Standard Deviations, and Independent Samples *t*-Test Comparing Perceived Social Support, Relapse Risk, and Emotional Dysregulation by Family System ($N = 250$)

	<u>Joint Family</u>		<u>Nuclear Family</u>		<i>t</i>	<i>p</i>	<u>95% CI</u>		Cohen's <i>d</i>
Measure	<i>(n = 160)</i>		<i>(n = 90)</i>						
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>			LL	UL	
MSPSS	46.87	16.16	46.46	11.12	.213	.814	-3.37	4.18	0.03
AWARE	96.14	25.76	106.83	20.20	-3.39	< .001	-16.50	-4.88	-0.46
DERS	99.49	18.28	104.80	15.33	-2.44	.015	-9.58	-1.03	-0.31

Note. *M* = Mean; *SD* = Standard Deviation; *d* = Cohen's *d*.

The findings indicated that perceived social support did not differ significantly between participants from joint families and those from nuclear families. The negligible effect size suggests that family system was not associated with differences in perceived social support.

However, a statistically significant difference was observed in relapse risk between the two-family systems. Participants belonging to nuclear families reported significantly higher relapse risk than participants from joint families. The effect size was moderate, indicating that family system was meaningfully associated with relapse risk, with individuals from nuclear families exhibiting greater vulnerability to relapse.

Similarly, emotional dysregulation differed significantly across family systems. Participants from nuclear families reported significantly higher levels of emotional dysregulation compared with those living in joint families. The effect size was small, suggesting that participants residing in nuclear family systems experienced modestly greater difficulties in emotion regulation than those living in joint family systems.

Overall, the findings indicate that family system was significantly associated with relapse risk and emotional dysregulation but not with perceived social support.

4.6.3 Socioeconomic Status

TABLE 4.8: Means, Standard Deviations, and One-Way Analysis of Variance of Perceived Social Support, Relapse Risk, and Emotional Dysregulation Across Socioeconomic Status ($N = 250$)

	Low		Middle		Upper		F	p	η^2
Measure	$(n = 49)$		$(n = 170)$		$(n = 31)$				
	M	SD	M	SD	M	SD			
MSPSS	42.67	14.76	47.00	14.54	50.62	12.62	3.79	.024	.03
AWARE	99.53	20.97	100.76	25.62	96.48	23.02	0.41	.663	.003
DERS	105.67	12.81	102.04	16.69	91.16	22.35	7.29**	.001	.06

Note. M = Mean; SD = Standard Deviation; η^2 = Eta squared effect size. Eta squared values of .01, .06, and .14 represent small, medium, and large effects, respectively (Cohen, 1988).

** $p < .001$.

The analysis revealed a statistically significant difference in perceived social support (MSPSS) across socioeconomic status groups. The effect size was small, indicating that socioeconomic status accounted for approximately 3% of the variance in perceived social support. Participants belonging to the upper socioeconomic group reported the highest level of perceived social support followed by participants from the middle socioeconomic group whereas those from the low socioeconomic group reported the lowest perceived social support.

For relapse risk (AWARE), the results indicated no statistically significant differences among the three socioeconomic status groups. The negligible effect size further indicates that socioeconomic status explained less than 1% of the variance in relapse risk. These findings suggest that relapse risk among individuals with substance use disorder did not differ significantly according to socioeconomic status within the present sample.

A statistically significant difference was also observed in emotional dysregulation (DERS) across socioeconomic status groups. The effect size was moderate, indicating that socioeconomic status explained approximately 6% of the variance in emotional dysregulation. Participants from the low socioeconomic group reported the highest levels of emotional dysregulation followed by those from the middle socioeconomic group whereas participants from the upper socioeconomic group demonstrated the lowest levels of emotional dysregulation.

Overall, the findings indicate that socioeconomic status was significantly associated with perceived social support and emotional dysregulation but not with relapse risk. Specifically, participants from higher socioeconomic backgrounds reported greater perceived social support and lower emotional dysregulation than those from lower socioeconomic backgrounds. In contrast, relapse risk remained relatively consistent across socioeconomic status groups, suggesting that factors other than socioeconomic status may play a more prominent role in influencing relapse risk among individuals with substance use disorder.

Chapter 5

Discussion and Conclusion

5.1 Discussion

The present study explored the associations between perceived social support, emotional dysregulation, and relapse risk among people with substance use disorder (SUD). It also examined the mediation of the relationship between perceived social support and relapse risk by emotional dysregulation. The results offer important insights into the psychological and social factors related to relapse among people in treatment for SUD. The reliability of the research instruments was measured to determine the trustworthiness of the results obtained.

All three measures showed good to high internal consistency, with Cronbach's alpha coefficients ranging from .82 to .89. The Multidimensional Scale of Perceived Social Support (MSPSS), Difficulties in Emotion Regulation Scale (DERS), and Advance Warning of Relapse Scale (AWARE) all demonstrated good reliability in the current sample, indicating that they measured the constructs they were designed to measure. Thus, the reliability achieved in the present study, combined with the proven validity of these measures, lends credibility and accuracy to the results of the study. The findings showed that there was a significant negative correlation between perceived social support and emotional dysregulation, indicating that those who felt more supported by family members, friends, and significant others had fewer emotional dysregulation difficulties. Furthermore, emotional dysregulation was significantly positively correlated with relapse risk, suggesting that

higher levels of emotional dysregulation were linked to higher levels of relapse risk factors. There was no significant direct association between perceived social support and relapse risk.

However, the mediation results also showed that emotional dysregulation did not significantly mediate the relationship between perceived social support and relapse risk. The indirect pathway to relapse risk was not significant, but higher levels of perceived social support were related to lower emotional dysregulation. These results indicate that emotional dysregulation is not the only factor that contributes to relapse, but rather that there are many other psychological, behavioral, and environmental factors that interact with emotional dysregulation. Regarding demographic factors, marital status was not significantly related to perceived social support, emotional dysregulation or relapse risk. On the other hand, the participants of nuclear family systems reported significantly higher emotional dysregulation and relapse risk than the participants of joint family systems. In addition, there were no differences in perceived social support or emotion regulation difficulties between higher and lower socioeconomic groups but the risk of relapse was similar across groups. The results of these studies collectively point to the complexity and multidimensionality of relapse risk and the need to take into account psychological and demographic factors in addiction treatment and recovery.

5.1.1 Discussion Hypothesis 1

The first hypothesis proposed that perceived social support would be negatively associated with emotional dysregulation among individuals with substance use disorder (SUD). The findings supported this hypothesis, revealing a significant negative relationship between perceived social support and emotional dysregulation ($r = -.130$, $p = .020$). This suggests that individuals who perceived greater support from family, friends, and significant others experienced fewer difficulties in understanding and regulating their emotions, highlighting the protective role of social support in emotional well-being. This result establishes perceived social support as a meaningful correlate of emotional functioning in this population.

These findings are consistent with previous research demonstrating that social support contributes to healthier emotional functioning ([Ozbay et al., 2007](#)) argued

that supportive social relationships strengthen emotional well-being by fostering resilience, reducing psychological distress, and promoting adaptive coping when individuals encounter stressful life. Similarly, (d'Arbeloff et al., 2018) found that individuals who perceived greater social support demonstrated better emotion regulation abilities and experienced lower levels of negative affect. Consistent with these findings, (Ferrari et al., 2010) reported that individuals with stronger social support networks exhibited better self-regulation, suggesting that supportive interpersonal relationships promote adaptive emotional and behavioral adjustment throughout the recovery process from substance use disorder (SUD).

These converging findings reinforce the robustness of the observed association. The relationship between perceived social support and emotional dysregulation emphasizes the importance of interpersonal resources in maintaining emotional stability during substance use recovery. Individuals who perceive stronger social support may have greater access to encouragement, emotional validation, practical assistance, and guidance, which can enhance their ability to cope with stressful situations and negative emotional states. In contrast, individuals with limited perceived support may experience greater emotional difficulties due to reduced access to resources that help them manage recovery-related challenges effectively (Woods-Jaeger et al., 2016).

Similar results have been reported by Kaufman et al. (2016) and Sloan et al. (2017), who observed that individuals receiving greater social support demonstrated better emotional functioning and fewer emotion regulation difficulties. In the Pakistani context, where family relationships represent a primary source of support, greater family involvement may contribute to improved emotion regulation and more successful rehabilitation outcomes. This cultural consideration further strengthens the relevance of the first hypothesis within the present study's context.

5.1.2 Discussion Hypothesis 2

The second hypothesis proposed that emotional dysregulation would be positively associated with relapse risk among individuals with substance use disorder (SUD). The findings supported this hypothesis, demonstrating a significant positive relationship between emotional dysregulation and relapse risk ($r = .502$, $p < .001$).

This indicates that individuals who experienced greater difficulties in regulating their emotions were more likely to report higher levels of relapse warning signs.

These findings suggest that emotional dysregulation is an important psychological factor contributing to relapse vulnerability among individuals undergoing treatment for SUD. The observed association indicates that emotional dysregulation may represent a significant psychological vulnerability contributing to relapse risk among individuals with substance use disorder (SUD) (McLeod, 2011). Difficulties in managing intense emotional experiences, tolerating psychological distress, and responding effectively to stressful situations may increase the likelihood of using substances as an ineffective coping mechanism. Individuals who experience greater challenges in regulating their emotions may also find it more difficult to manage cravings, cope with emotional triggers, and maintain recovery during challenging periods.

Similarly argued that poor emotion regulation contributes to maladaptive coping behaviors, whereas (Berking et al., 2011) reported that effective emotion regulation skills are associated with improved treatment outcomes and sustained abstinence. The findings of the present study are consistent with earlier research indicating that emotional dysregulation is positively associated with relapse risk among individuals with substance use disorder (SUD).

Within Pakistan, individuals recovering from substance use disorder often experience financial hardship, unemployment, family conflict, and social stigma. These ongoing stressors may intensify emotional distress, making relapse more likely when effective emotion regulation skills are lacking.

5.1.3 Discussion Hypothesis 3

The third hypothesis proposed that perceived social support would be negatively associated with relapse risk among individuals with substance use disorder (SUD). However, this hypothesis was not supported. The findings showed that perceived social support was not significantly related to relapse risk ($r = .030$, $p = .319$), indicating that higher levels of perceived social support did not directly reduce relapse risk in the present sample. The absence of a significant relationship indicates

that although perceived social support may offer emotional reassurance, encouragement, and motivation throughout the recovery process, it may not independently reduce relapse risk. Relapse is considered a multifaceted process influenced by various psychological, behavioral, and environmental factors, such as craving experiences, coping strategies, readiness for change, mental health difficulties, exposure to substance-related triggers, and commitment to treatment. Therefore, the beneficial role of social support in recovery may depend on the availability of additional protective resources and the individual's ability to effectively cope with recovery challenges.

These results suggest that although social support may promote recovery by improving emotional well-being, it alone may not be sufficient to directly influence relapse risk. The present study did not demonstrate a significant direct association between perceived social support and relapse risk. One possible explanation is that relapse represents a complex and dynamic phenomenon shaped by multiple psychological, behavioural, and environmental influences, including craving, coping abilities, motivation for treatment, psychiatric difficulties, exposure to substance-related triggers, and ongoing stressors ([Brorson et al., 2013](#)). Overall, the findings suggest that perceived social support may contribute to the recovery process indirectly by enhancing psychological well-being and encouraging greater engagement in treatment. However, it did not emerge as an independent predictor of relapse risk among individuals with substance use disorder in the present study. These results emphasize that relapse is influenced by multiple interacting psychological, behavioural, and social factors, highlighting the importance of comprehensive rehabilitation programmes that address diverse aspects of recovery ([Witkiewitz et al., 2014](#)).

Within the Pakistani context, social stigma, inadequate rehabilitation resources, and family-related difficulties may further reduce the effectiveness of available support systems. Therefore, relapse prevention interventions should incorporate psychological, behavioral, and environmental components alongside efforts to strengthen supportive social relationships. Such an integrated approach may strengthen coping abilities and support sustained recovery among individuals with substance use disorder.

5.1.4 Discussion Hypothesis 4

The fourth hypothesis proposed that emotional dysregulation would mediate the relationship between perceived social support and relapse risk among individuals with substance use disorder (SUD). However, the findings did not support this hypothesis. Although perceived social support significantly predicted lower emotional dysregulation ($B = -1.87$, $p = .040$), and emotional dysregulation significantly predicted higher relapse risk ($B = 0.72$, $p < .001$), the indirect effect was not statistically significant ($B = -1.35$, 95% CI $-2.77, 0.15$). Similarly, both the direct and total effects of perceived social support on relapse risk were non-significant. These findings indicate that emotional dysregulation did not function as a significant mediator between perceived social support and relapse risk.

Previous studies have indicated perceived social support has been recognized as an important factor that may facilitate emotional adjustment by improving individuals' ability to cope with stress and minimizing psychological difficulties. However, its role in reducing relapse vulnerability among individuals with substance use disorder may not be direct and can be influenced by various personal, psychological, and situational factors ([White, 2009](#)).

Within the Pakistani context, these findings may also reflect the impact of family conflict, stigma, financial difficulties, and limited mental health resources, which can weaken the protective effects of social support during recovery. Overall, the findings suggest that emotional dysregulation does not independently explain the relationship between perceived social support and relapse risk. Future research should examine other potential mediators and moderators, such as coping strategies, craving, recovery capital, self-efficacy, and family functioning, to better understand the mechanisms underlying relapse among individuals with substance use disorder ([Livingston et al., 2012](#)).

5.1.5 Discussion Hypothesis 5

Demographic factors demonstrated different patterns of association with perceived social support, emotional dysregulation, and relapse risk. Marital status was not found to be significantly related to any study variable, suggesting that single and

married participants did not differ meaningfully in terms of perceived support, emotion regulation difficulties, or relapse vulnerability. In contrast, socioeconomic status showed significant associations with perceived social support and emotional dysregulation, as individuals with higher socioeconomic backgrounds reported greater support and fewer difficulties in managing emotions. Additionally, family system was significantly linked with emotional dysregulation and relapse risk, with participants from nuclear families exhibiting greater emotional difficulties and relapse risk compared to those from joint family systems. These findings indicate that social and environmental factors may influence recovery-related outcomes among individuals with SUD, although their impact differs across various psychological domains. Therefore, the hypothesis was partially supported (McLaughlin et al., 2011).

Demographic characteristics revealed varying patterns in their relationship with perceived social support, emotional dysregulation, and relapse risk. Marital status did not show significant associations with any of the study variables, indicating that married and unmarried participants had comparable levels of perceived support, difficulties in emotional regulation, and susceptibility to relapse. Previous studies have highlighted that supportive social connections can facilitate recovery; however, their beneficial effects are influenced by factors such as relationship satisfaction, stability, and the overall social context in which individuals are situated (Tracy and Wallace, 2016).

Overall, the findings of the present study demonstrate the complex relationship among perceived social support, emotional dysregulation, relapse risk, and demographic characteristics in individuals with SUD. The results indicate that emotional dysregulation plays a significant role in relapse vulnerability, whereas perceived social support appears to influence emotional functioning rather than directly affecting relapse risk. Additionally, demographic factors showed selective associations, highlighting the contribution of socioeconomic and family-related characteristics to recovery experiences. These findings enhance the understanding of psychosocial factors involved in substance use recovery and emphasize the importance of improving emotion regulation skills and promoting supportive environments within rehabilitation settings (Kelly et al., 2017).

5.2 Conclusion

The present study explored the relationships among perceived social support, emotional dysregulation, and relapse risk in individuals diagnosed with substance use disorder (SUD) who were receiving treatment in rehabilitation centres in Rawalpindi and Islamabad, Pakistan. Drawing upon Relapse Prevention Theory (?) (Marlatt & Gordon, 1985), the study further examined whether emotional dysregulation served as a mediating mechanism linking perceived social support with relapse risk.

The results demonstrated that emotional dysregulation had a significant positive relationship with relapse risk, indicating that individuals who experience greater challenges in identifying, controlling, and managing emotional responses may have increased susceptibility to relapse. Additionally, perceived social support was negatively associated with emotional dysregulation, suggesting that supportive social connections may facilitate healthier emotional functioning. However, perceived social support alone did not significantly predict relapse risk.

Findings from the mediation analysis indicated that emotional dysregulation did not significantly explain the association between perceived social support and relapse risk. This suggests that relapse among individuals with SUD is a multifaceted phenomenon shaped by the interaction of various psychological, social, and contextual influences rather than being explained through a single underlying process.

The study also revealed that marital status was not significantly associated with the examined variables, while family system and socioeconomic status showed meaningful relationships with perceived social support and emotional dysregulation.

In conclusion, the findings underscore that effective treatment for substance use disorder requires a comprehensive approach that addresses both psychological and social dimensions of recovery. The study offers important implications for clinical psychologists, counsellors, rehabilitation practitioners, and policymakers by supporting the development of culturally appropriate and evidence-informed rehabilitation programmes. Furthermore, these findings provide a valuable foundation for

future research aimed at identifying additional psychological mechanisms underlying relapse and designing interventions that promote sustained recovery while reducing relapse among individuals with substance use disorder in Pakistan.

5.3 Limitations

- i. The cross-sectional research design restricted the ability to determine cause-and-effect relationships among perceived social support, emotional dysregulation, and relapse risk.
- ii. The use of purposive sampling from selected rehabilitation centres in Rawalpindi and Islamabad may limit the generalizability of findings to individuals with SUD from different regions and treatment settings.
- iii. The study included only male participants, which limits the applicability of findings to females with substance use disorder due to possible gender differences in recovery experiences and psychological functioning.
- iv. The study addressed sensitive topics related to substance use, emotional difficulties, and relapse experiences, some participants may have felt discomfort or hesitation in providing completely accurate responses.
- v. Reliance on self-report measures (MSPSS, DERS-SF, and AWARE Questionnaire) may have introduced response bias, social desirability effects, or subjectivity in participants' reporting.
- vi. The study primarily focused on perceived social support and emotional dysregulation; however, other important factors such as craving, coping mechanisms, psychiatric symptoms, and treatment-related variables were not assessed.
- vii. Since the research was conducted within the Pakistani cultural context, cultural values, family structures, and social relationship patterns may influence the extent to which findings can be generalized to other populations.

5.4 Research Implications

The findings of the current study provide meaningful implications for research, clinical practice, and addiction rehabilitation. The results highlight the importance of emotional dysregulation as a psychological factor associated with relapse risk among individuals with substance use disorder. These findings suggest that difficulties in understanding, managing, and responding to emotional experiences may increase vulnerability to relapse during the recovery process. In rehabilitation settings, the findings emphasize the need to integrate emotion regulation-focused interventions into existing rehabilitation programs. Therapeutic approaches including Cognitive Behavioral Therapy (CBT), Dialectical Behavior Therapy (DBT)-informed emotion regulation techniques, mindfulness-based approaches, and relapse prevention strategies may support individuals in developing effective coping skills and managing emotional distress more adaptively.

The study also highlights the supportive role of social relationships in addiction recovery. Although perceived social support did not show a direct predictive relationship with relapse risk, its significant association with reduced emotional dysregulation indicates that supportive relationships may contribute indirectly to better emotional functioning. Therefore, involving family members and significant others in treatment planning may enhance recovery outcomes, particularly in the Pakistani cultural context where family support often plays a central role in individuals' lives. Family psychoeducation and structured family interventions may help strengthen recovery-related resources.

From a rehabilitation perspective, clinical psychologists and mental health professionals should consider assessing emotional regulation difficulties and the availability of social support when developing individualized treatment plans. Early identification of individuals experiencing greater emotional difficulties may allow clinicians to provide targeted interventions aimed at reducing relapse vulnerability. The findings also provide directions for future research. Longitudinal investigations are needed to examine how social support, emotional dysregulation, and relapse risk interact across different phases of recovery.

Future studies should include larger and more representative samples involving females and individuals from diverse geographical areas of Pakistan. Overall, the present study contributes to existing knowledge regarding the psychological and interpersonal factors associated with relapse risk in individuals with substance use disorder. The findings support the importance of incorporating emotion regulation skills training and supportive social environments within comprehensive addiction treatment approaches to facilitate sustained recovery.

5.5 Recommendations

- i. Future research should adopt longitudinal methodologies to examine changes in perceived social support, emotional dysregulation, and relapse risk throughout different stages of recovery. Such designs may provide clearer insights into the developmental patterns and possible causal pathways among these variables.
- ii. Further studies should recruit larger and more diverse samples by including participants from different regions of Pakistan and involving both males and females with substance use disorder. Greater sample diversity would improve the generalizability of findings and provide a more inclusive understanding of relapse-related psychological and social factors.
- iii. Rehabilitation centres should consider incorporating structured interventions aimed at improving emotional regulation skills among individuals with SUD. Treatment approaches focusing on emotional awareness, distress tolerance, coping strategies, and management of negative emotional states may help individuals respond to challenges more effectively and decrease relapse vulnerability.
- iv. Addiction treatment programs should also encourage the involvement of family members and significant others through family counselling and psychoeducational programs. Enhancing supportive relationships may improve emotional adjustment and provide individuals with greater psychological resources during recovery.

- v. Future researchers should explore additional factors that may contribute to relapse risk, including craving intensity, coping mechanisms, readiness for change, treatment compliance, trauma-related factors, and co-occurring psychological difficulties. Investigating these factors may lead to a more comprehensive understanding of relapse development.
- vi. Researchers are also encouraged to use mixed-method research approaches that combine quantitative findings with individuals' personal recovery experiences. Such approaches may provide deeper insight into emotional challenges, social experiences, and recovery-related difficulties faced by individuals with substance use disorder.
- vii. Finally, future studies should focus on designing culturally sensitive interventions specifically suitable for individuals with SUD in Pakistan. Treatment strategies should consider cultural values, family structures, and social expectations to enhance intervention effectiveness and support long-term recovery.

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Appendix A

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Appendix A

اقرار نامہ

میں، زینب ارشد کپیٹل یونیورسٹی آف سائنس اینڈ ٹیکنالوجی میں ایم ایس سائنیکالوجی کی طالبہ ہوں، اور اپنی تعلیمی ضروریات کے تحت محترمہ ارم نورین (irum.noureen@cust.edu.pk) کی نگرانی میں ایک تحقیقی مطالعہ کر رہی ہوں۔ اس تحقیق میں آپ سے ایک سوالنامہ پُر کرنے کی درخواست کی جاتی ہے۔ جسے مکمل کرنے میں تقریباً 20 سے 30 منٹ درکار ہوں گے۔ اس تحقیق کے دوران حاصل کی گئی تمام معلومات مکمل طور پر خفیہ رکھی جائیں گی اور صرف تحقیقی مقاصد کے لیے استعمال ہوں گی۔ آپ کی شناخت ظاہر نہیں کی جائے گی۔ آپ تحقیق میں حصہ لینے سے انکار کر سکتے ہیں یا کسی بھی وقت بغیر کسی وجہ بتائے تحقیق چھوڑ سکتے ہیں۔ ذیل میں دستخط کر کے، اس مطالعہ میں حصہ لینے کے لیے رضامندی دیتے ہیں۔ اور اس بات سے اتفاق کرتے ہیں کہ آپ نے مذکورہ معلومات کو پڑھ اور سمجھ لیا ہے۔

شرکت کنندہ کے دستخط

تاریخ

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ڈیموگرافک شیٹ

عمر _____

جنس _____

ازدواجی حیثیت _____

سماجی و اقتصادی حیثیت (Socioeconomic Status) _____

تعلیم _____

پیشہ _____

خاندانی نظام (مشترکہ/علیحدہ) _____

استعمال شدہ نشہ _____

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ہدایات

اس سوالنامے میں دیئے گئے بیان کو غور سے پڑھیں اور اس کے سامنے دی گئی درجہ بندی پر (✓) ٹیک کا نشان لگائیں۔ اس سوالنامے میں ہماری دلچسپی یہ جاننے میں ہے کہ آپ کے جذبات آپ پر کس حد تک نبرد آزما ہو رہے ہیں

نمبر شمار	بیانات	(1) تقریباً کبھی نہیں 0-10%	(2) کبھی کبھی 11-35%	(3) تقریباً نصف وقت 36-65%	(4) زیادہ تر وقت 66-90%	(5) تقریباً بمیشہ 91-100%
1	میں اپنی احساسات کے بارے میں واضح ہوں					
2	میں اپنے احساسات کے بارے میں توجہ دیتا / دیتی ہوں۔					
3	میں اپنے احساسات کو اپنے اوپر غالب پاتا ہوں۔ اور انہیں اپنے کنٹرول سے باہر سمجھتا / سمجھتی ہوں					
4	مجھے کوئی اندازہ نہیں ہے کہ میں کیسا محسوس کر رہا / رہی ہوں					
5	مجھے احساسات سمجھنے میں مشکل پیش آتی ہے					
6	میں اپنے احساسات پر توجہ دیتا / دیتی ہوں					
7	میں یقینی طور پر جانتا / جانتی ہوں کہ میں کیسا محسوس کر رہا / رہی ہوں					
8	میں اپنے احساسات کا خیال رکھتا / رکھتی ہوں					
9	میں اپنے احساسات کے بارے میں الجھا / الجھی ہوں۔					

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					10	اپنی جذبات جب میں پریشان ہوتا/ ہوتی ہوں، تو میں کو تسلیم کرتا/ کرتی ہوں
					11	جب میں پریشان ہوتا/ ہوتی ہوں، تو اس طرح سے محسوس کرنے پر مجھے اپنے خود سے غصہ اٹا ہے
					12	جب میں پریشان ہوتا/ ہوتی ہوں، تو اس طرح سے محسوس کرنے پر مجھے شرمندگی ہوتی ہیں
					13	جب میں پریشان ہوتا/ ہوتی ہوں، تو مجھے اپنے کام مکمل کرنے میں دشواری ہوتی ہے
					14	جب میں پریشان ہوتا/ ہوتی ہوں تو میں اپنے کنٹرول سے باہر ہوجاتا/جاتی ہوں
					15	جب میں پریشان ہوتا/ ہوتی ہوں، مجھے یقین ہوتا ہیں کہ میں ایک لمبے عرصے کے لئے اسے ہی رہوں گا/گی
					16	جب میں پریشان ہوتا/ ہوتی ہوں، تو مجھے یقین ہوتا ہے کہ اب میں اداس ہو جاتا/ جاتی ہوں
					17	جب میں پریشان ہوتا/ ہوتی ہوں، تو مجھے لگتا ہے کہ میرے احساسات درست اور اہم ہے
					18	جب میں پریشان ہوتا/ ہوتی ہوں، تو دوسری چیزوں پر توجہ مرکوز کرے میں مشکل پیش آتا/ اتی ہے
					19	جب میں پریشان ہوتا/ ہوتی ہوں، تو خود کو بے قابو محسوس کرتا/ کرتی ہے
					20	جب میں پریشان ہوتا/ ہوتی ہوں، تو میں تب بھی سب کر سکتا/ کر سکتی ہوں
					21	جب میں پریشان ہوتا/ ہوتی ہوں، تو میں اپنے بارے میں شرمندگی محسوس کرتا ہوں ایسا محسوس کرنے پر
					22	جب میں پریشان ہوتا/ ہوتی ہوں، تو میں جانتا/جانتی ہوں کہ بلا آخر میں خود کو بہتر کرنے کا راستہ ڈونڈلوں گا/گی
					23	جب میں پریشان ہوتا/ ہوتی ہوں، تو خود کو کمتر محسوس کرتا/کرتی ہوں

				24	جب میں پریشان ہوتا/ ہوتی ہوں، تو مجھے اپنے احساسات پر پچھتاوا ہوتا ہے
				25	جب میں پریشان ہوتا/ ہوتی ہوں، تو مجھے ایسا محسوس کرنے پر شرمندگی محسوس ہوتی ہوں
				26	جب میں پریشان ہوتا/ ہوتی ہوں، تو مجھے توجہ دینے میں مشکل پیش آتی ہے
				27	جب میں پریشان ہوتا/ ہوتی ہوں، تو مجھے اپنے رویے کو کنٹرول کرنے میں مشکل پیش آتی ہے
				28	جب میں پریشان ہوتا/ ہوتی ہوں، تو میرا ماننا ہے کہ میں ایسا کچھ نہیں کر سکتا جس سے میں بہتر محسوس کرو
				29	جب میں پریشان ہوتا/ ہوتی ہوں، تو میں اپنے آپ سے چڑچڑا ہوجاتا/ ہوجاتی ہوں ایسے محسوس کرنے پر
				30	جب میں پریشان ہوتا/ ہوتی ہوں، تو میں اپنے بارے میں بہت برا محسوس کرتا/کرتی ہوں
				31	جب میں پریشان ہوتا/ ہوتی ہوں، تو مجھے لگتا ہے کہ اس میں الجھا رہنے کے علاوہ میں کچھ بھی نہیں کر سکتا/کر سکتی
				32	جب میں پریشان ہوتا/ ہوتی ہوں تو میں اپنے رویے پر کنٹرول کھوڑ دیتا/دیتی ہوں
				33	جب میں پریشان ہوتا/ ہوتی ہوں، تو مجھے کسی چیز کے بارے میں سمجھنے میں دقت محسوس کرتا ہوں
				34	جب میں پریشان ہوتا/ ہوتی ہوں، تو مجھے اپنے احساسات کو سمجھنے میں وقت لگتا/ لگتی ہے
				35	جب میں پریشان ہوتا/ ہوتی ہوں، تو مجھے بہت وقت لگتا ہے بہتر محسوس کرنے
				36	جب میں پریشان ہوتا/ ہوتی ہوں، تو میرے جذبات مجھ پر غالب محسوس ہوتے ہیں

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

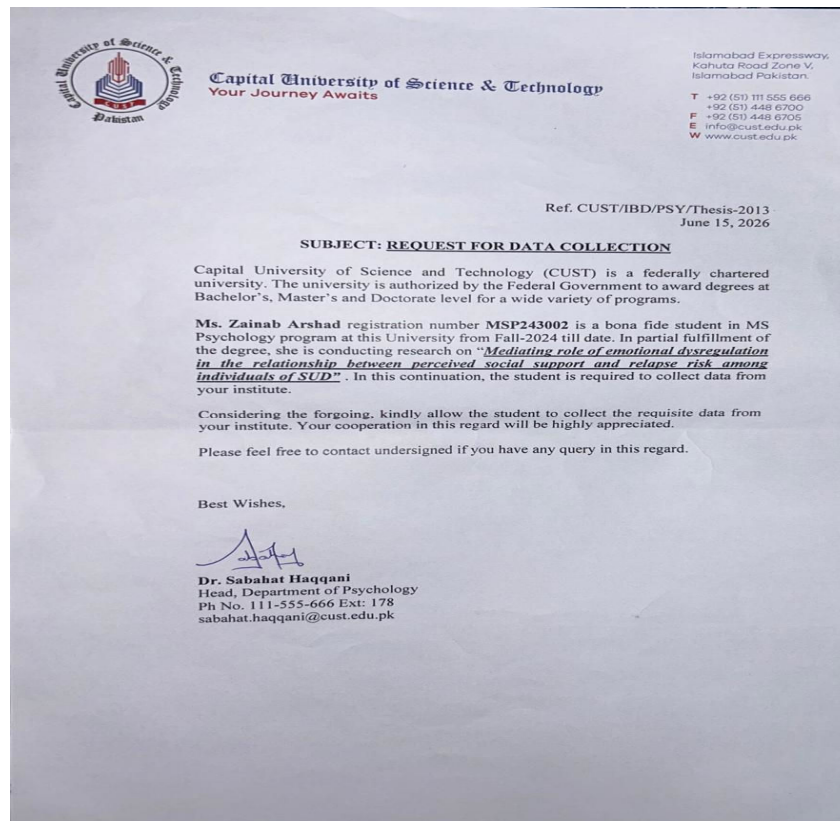
- “1” پردائرہ لگائیے اگر آپ شدید غیر متفق ہیں۔
 “2” پردائرہ لگائیے اگر آپ شدید غیر متفق ہیں۔
 “3” پردائرہ لگائیے اگر آپ کچھ حد تک غیر متفق ہیں۔
 “4” پردائرہ لگائیے اگر آپ غیر جانبدار ہیں۔
 “5” پردائرہ لگائیے اگر آپ کچھ حد تک ہم آہنگی رکھتے ہیں۔
 “6” پردائرہ لگائیے اگر آپ بہت ہم آہنگی رکھتے ہیں۔
 “7” پردائرہ لگائیے اگر آپ بہت زیادہ ہم آہنگی رکھتے ہیں۔

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

عبارات	کبھی نہیں	شاذ و نادر	کبھی کبھی	اکثر اوقات	بیشتر اوقات	تقریباً ہمیشہ	ہمیشہ
(۱)	(۲)	(۳)	(۴)	(۵)	(۶)	(۷)	(۸)
۱۵							مجھے محسوس ہوتا ہے کہ میں اس حد تک پھنسا ہوا ہوں کہ نکلنے کا کوئی رستہ نہیں ہے
۱۶							مجھے سونے میں مشکل ہوتی ہے
۱۷							مجھے لمبے عرصے تک شدید ذہنی دباؤ ڈپریشن رہتا ہے
۱۸							مجھے حقیقت میں فرق نہیں پڑتا کہ کیا ہوتا ہے
۱۹							مجھے محسوس ہوتا ہے کہ معاملات اتنے خراب ہیں کہ شاید مجھے نشہ کرنا پڑے
۲۰							میں واضح طور پر سوچنے کے قابل ہوں
۲۱							میں اپنے لئے کچھ محسوس کرتا/کرتی ہوں
۲۲							میں نشے کے بارے میں سوچتا/سوچتی ہوں
۲۳							میں دوسرے لوگوں سے جھوٹ بولتا/بولتی ہوں
۲۴							میں پُر امید اور پُر اعتماد محسوس کرتا/کرتی ہوں
۲۵							مجھے ویسے ہی دنیا پر غصہ آتا ہے
۲۶							میں ایسے کام کرتا/کرتی ہوں جن سے میں نشے سے دور رہ سکوں
۲۷							مجھے ڈر ہے کہ میں اپنے حواس کھو نا بیٹھوں
۲۸							میں حد سے زیادہ نشہ کرتا/کرتی ہوں

Appendix B

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Appendix C

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 **Capital University of Science & Technology**
Your Journey Awaits

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Ref: CUST/DERC/PSY/ERC/2026/134
June 15, 2026

RESEARCH ETHICS COMMITTEE CERTIFICATE OF REVIEW AND SUPPORT

This is to certify that Project titled: *"Mediating role of emotional dysregulation in the relationship between perceived social support and relapse risk among individuals of SUD"* submitted by Scholar: **Zainab Arshad MSP243002** and supervised by: **Ms. Irum Noreen** previewed by the Research Ethics Committee of Faculty of Management and Social Science, meets the requirements of the American Psychological Association's Ethical guidelines for Human Research and is **REVIEWED** and **APPROVED** by Research Ethics Committee of Faculty of Management and Social Sciences.

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

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

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


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

Appendix D

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Re: Permission to Use scale and send Urdu translation of DERS

Dear Zainab,

Yes, you have my permission to use the scale (DERS) for your research. Please do share your results with me once you have completed your study.

Wishing you the best of luck with your research.

Kind regards,

Maham Irfan

On Fri, May 8, 2026 at 7:28 AM zainab arshad <zainabarshad905@gmail.com> wrote:

I hope this email finds you well.

I am a student of MS psychology at CUST university. I currently working on a thesis topic mediating role of emotional dysregulation in the relationship of perceives social support and relapse risk among individual with SUD.

I would like to request your permission to use and send an Urdu translation version (DERS-Scale), I would be grateful if you could kindly share it. The translated version will be used strictly for research, and full credit will be given to you and the original authors .I would also appreciate any guidelines or conditions regarding its use.

Thank you very much for your time and consideration. I look forward to your response.

Regards.

Appendix E

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Namood-e- Sahar
To: zainab arshad >

02/05/2026 

Re: Permission Request for Use and send Urdu Translation of Relapse Risk Scale(AWARE)

Assalam o Alaikum...thanks for approaching. I hope you have already sought permission from the original author of the scale William Richard Miller: wrmillar@unm.edu. Find attached the AWARE-Urdu and article on AWARE translation and validation. Use its reference to cite in your research work

Sahar, N. & Naqvi, I. (2021). Assessing warning signs of relapse in drug addicts: Translation and validation of Advance Warning for Relapse (AWARE) Questionnaire. *Pakistan Journal of Medical and Health Sciences*, 15(9). 2198-2201. <https://doi.org/10.53350/pjmhs211592198>.

Full text can be viewed at:
https://www.researchgate.net/publication/355127481_Assessing_Warning_Signs_of_Relapse_in_Drug_Addicts_Translation_and_Validation_of_Advance_Warning_for_Relapse_AWARE_Questionnaire

Good luck

Best wishes,
Namood-e-Sahar
PhD Scholar
National Institute of Psychology, QAU
Islamabad-Pakistan

 **AWARE-Urdu.pdf**
127 KB 

Appendix F

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