INTEGRATED SELF, RELAPSE VULNERABILITY AND PSYCHOLOGICAL ADJUSTMENT OF RECOVERING DRUG ADDICTS: AN INTERVENTION BASED STUDY

GHAZALA FAZALDAD

50-FSS/PHDPSY/F18

DR. MUSSARAT JABEEN KHAN

Lecturer

Department of Psychology

Faculty of Social Sciences

International Islamic University Islamabad

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By

GHAZALA FAZALDAD
50-FSS/PHDPSY/F18

Department of Psychology

Faculty of Social Sciences

International Islamic University Islamabad

2024

Acceptance by the Viva Voce Committee

_____

Dean Faculty of Social Sciences

_____

Chairperson Department of Psychology

_____

Supervisor

_____

External Examiner

_____

Internal Examiner

DECLARATION

I, Ms. GHAZALA FAZALDAD, Registration No. 50-FSS/PHDPSY/F18 student of PhD in the subject of Psychology, session 2018-2023, hereby declare that the matter printed in the thesis titled: Integrated Self, Relapse Vulnerability and Psychological Adjustment of Recovering Drug Addicts: An Intervention Based Study, is my own work and has not been printed, published and submitted as research work, thesis or publication in any form in any University, Research Institution etc in Pakistan or abroad.

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RESEARCH COMPLETION CERTIFICATE

Certified that the research work contained in this thesis titled: Integrated Self, Relapse Vulnerability and Psychological Adjustment of Recovering Drug Addicts: An Intervention Based Study, has been carried out and completed by Ms. Ghazala Fazaldad, Registration No. 50-FSS/PHDPSY/F18 under my supervision.

_____

Supervisor
Dr. Mussarat Jabeen Khan
Lecturer
Department of Psychology
International Islamic University Islamabad

Date: _____

DEDICATED TO MY PARENTS, HUSBAND AND DAUGHTERS, TO WHOM I OWE EVERYTHING

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List of Abbreviations

APA	American Psychological Association
DSM	Diagnostic and Statistical Manual of Mental Disorders
SPSS	Statistical Package for Social Sciences
NIDA	National Institute on Drug Abuse
NIH	National Institute of Health
TIIP	Traditional Islamically Integrated Psychotherapy

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Abstract

The thesis comprised of 3 studies investigated the efficacy of Traditional Islamically Integrated Psychotherapy (TIIP) in recovering addicts improving their integrated sense of self, reduce relapse vulnerability and stronger psychological adjustment. In Study I, Integrated Self Scale (ISS) was developed in two phases. In Phase I, a pool of 157 items for ISS were established following standard steps and procedures. Judges (n = 20) screened the pool leaving 100 items; in Phase II, psychometric properties of ISS were determined by taking a purposive sample of 202 males and 202 females (N = 404) which consisted of normal people (n=384) and drug users (n=20). A structure of 4 factors was established by an Exploratory Factor Analysis (EFA), discarding an additional 30 items. Internal consistency of ISS and its subscales ranged from low to high, Physical Self (α = .66, 14 items), Cognitive Self (α = .87, n = 18), Emotional Self (α = .83, n = 18) and Spiritual Self (α = .92, n = 20). Overall internal consistency of ISS was very high (α = .94). Convergent validity (r = .83**) of ISS measured against Six Factors Self Concept Scale (Mir, 2015) was good and so was discriminant validity (r = -.32**) which was measured against one of its subscale that was vulnerability. In Study II, TIIP was translated (English to Urdu) by 5 Urdu language experts establishing a consensus on one translation. This version was back translated from Urdu to English to validated conceptual and linguistic equivalence; and in phase II the Urdu-translated TIIP was tested on 2 patients and 2 people from general population. In phase I of Study III, a purposive sample of recovering drug addicts (n = 200) from rehabilitation centers of Rawalpindi and Islamabad and non addicts (n = 200) completed ISS (Fazaldad et al., 2023), Advanced WArning of RElapse (AWARE) Questionnaire-Urdu or AWARE-U (Nashee et al., 2014) and Psychological Adjustment Scale (Sabir, 1999) to compare addicts and non-addicts on integration of self while relapse vulnerability and adjustment comparisons were made among drug

addicts only. Forty addicts with poor self-integration, greater relapse vulnerability and low psychological adjustment were screened and were randomly assigned to experimental (n = 20) and control (n = 20) groups in Phase II of the study. TIIP was administered to experimental group while the control group received general counselling provided by psychologists at rehabilitation centers keeping the number of sessions the same. After interventions, ISS, Aware Questionnaire-Urdu and Psychological Adjustment Scale were given again in a pretest-posttest design format. Results showed that experimental group showed improvement in integrated self, was less vulnerable to drug relapse and had better psychological adjustment compared to control group. One-month later, in Phase III, a follow up on experimental group addicts was carried out to determine the efficacy and reliability of TIIP. In this phase semi-structured interviews were conducted, and results indicated a large majority of addicts were satisfied with TIIP and avoided abusing drugs.

Key Words: Drug Addicts, Integrated Self, Relapse Vulnerability, Psychological Adjustment

Chapter 1

Introduction

People encounter a range of challenges, restrictions, and worries throughout their lives, which they must overcome in order to properly adapt to their daily lives. An individual's mental talents are restricted by physical and mental diseases. The use of drugs is one of these mental illnesses. Drug dependence has a substantial negative impact on a person's social and psychological well-being in addition to their physical health, which causes a great deal of stress in their lives. Drug abusers usually have a variety of challenges linked to physical symptoms and ongoing desires, which make their situation worse even while they are seeking treatment. Such issues alter human existence and have an impact on a person's entire life. There are many causes and reasons for drug addiction, such as peer pressure, environmental variables, and degree of stress but when we focus on the spiritual element of drug addiction, it becomes clear that the self plays a significant role in such mental health issues.

Drug Dependence

Drug addiction is a fundamental, chronic neurological disease whose manifestations are determined by hereditary, emotional, and environmental factors. Lack of control over substance misuse, obsession with drug use, continuing drug use despite negative effects, and yearning are its defining characteristics. Substance addiction is a compulsive urge to consume narcotics in order to function normally. Addicts go through withdrawal when they are unable to get addictive substances (American society of addiction Medicine, 2001).

Drug addiction is a medical disorder characterized by the compulsive need to keep using a drug to which one has become habituated via repeated use in order to experience its desired effect, which is often a change in mental state. According to Mosby's Medical Dictionary (2009), signs of addiction include a need for the substance urgently, a desire to

increase dosage, a psychological or physical reliance, and negative repercussions on the individual as well as the community.

Scenario of Drug Addiction in Pakistan

Drug addiction is a major problem in Pakistan. According to the United Nations Office on Drugs and Crime (UNODC, 2022), there are over 6.7 million people - had used a substance other than alcohol and tobacco. The most commonly abused drugs in Pakistan are Charas (or hashish, ganja, or marijuana) heroin, morphine, and opium. Charas is less pricy and easily available than other drugs. Drug addiction can have a devastating impact on individuals, families, and communities. It can lead to health problems, financial problems, and social problems. There are a number of factors that contribute to drug addiction in Pakistan. These include poverty, unemployment, lack of education, and social isolation. Drug addiction is also often linked to mental health problems such as depression and anxiety.

Drug Classification and Origin

Obsessions can be brought on by a wide range of substances, including opioids that are both legal and illegal, as well as prescription and over-the-counter medicines. Typically, casual or social drug use characterizes the early stages of the majority of drug addictions. For other people, this occasional use eventually develops into a well-established routine, with the incidence escalating. Over time, people may become tolerant to the drug and require increasing doses to feel the desired euphoric effects. Individuals could eventually become totally dependent on the chemical to feel happy. Abstinence from drugs may become more challenging as drug use increases. Taking steps to stop smoking could result in strong cravings and uncomfortable withdrawal symptoms. The particular indications and symptoms of drug addiction or dependence vary depending on the substance (Nutt, King, Saulsbury, & Blakemore, 2007).

Psychoactive substances. Psychoactive chemicals have an impact on the central nervous system, causing changes in mood, cognition, and behavior. Four broad categories can be used to classify these substances:

Depressants. Heroin, alcohol, and analgesics are a few examples of drugs that lower alertness by reducing the activity of the central nervous system.

Heroin. The neural system of the brain is affected by psychoactive drugs, which lowers the activity of several compounds in the brain's cortex. Numerous physiological processes, including respiration and heart rate, are impacted by this general slowness. Heroin is categorized as a narcotic, more particularly as an opioid or narcotic analgesic. These drugs have strong analgesic effects. Opioids are made from opium, a chemical found in the opium poppy plant that has been dried out. Heroin is made from morphine or codeine, two naturally occurring chemicals that are present in the fluid of the opium poppy seed capsule. Compared to morphine and codeine, heroin is thought to be a more potent and addictive drug (Johnston & Holt, 2014).

Opium has been used by many cultures for thousands of years. In order to address morphine addiction, a hospital in London created heroin in 1898. Around the world, there are many places where the opium vine thrives. In Pakistan, only three officially separate regions—settled districts, consolidated areas, also known as Provincially Administered Tribal Areas (PATA), and Federally Administered Tribal Areas (FATA)—are permitted to grow poppies. Khyber Pakhtoon Khawa (KPK) is strategically crucial and politically delicate due to its near proximity to the Afghan and Soviet borders. In the past, poppy growing was widespread in the PATA or combined regions, which produced about 20% of Pakistan's illicit drug supply. However, the combined PATA territories are currently the only places in Pakistan where opium is produced (Malik & Sarfraz, 2011).

Stimulants. Examples of stimulants that raise cerebral activity and, consequently, the body's alertness level include caffeine, nicotine, and amphetamines.

Amphetamines. Amphetamine Sulphate, Dexamphetamine, and Methamphetamine (commonly known as crystal meth or rock) are all types of amphetamines, also referred to as Speed, Whizz, Ice, or Uppers. These drugs are categorized as stimulant medicines since they have the capacity to quicken specific chemical reactions occurring within the brain. For the treatment of Attention Deficit Hyperactivity Disorder (ADHD), dexamphetamine is administered. There are several ways to use amphetamines, including oral consumption, injection, smoking, and inhalation (snorting). Amphetamines typically have a four to eight hour half-life.

Amphetamines were originally produced in Germany in 1887, which is where they got their start. They were first made available in the 1930s to treat ailments like low blood pressure and asthma. Amphetamines were employed to treat weariness and keep soldiers alert during the Second World War (Bagchi, 2005).

Clubs drugs. Teenagers and young adults frequently take club drugs at clubs, concerts, and parties. Examples include ketamine, GHB, Rohypnol ("roofies"), Ecstasy (MDMA), and Ecstasy. Despite not all belonging to the same category, these medications have certain common effects and risks.

Ecstasy. MDMA, sometimes known as ecstasy, is a kind of methamphetamine. A member of the amphetamine family, ecstasy has stimulant and hallucinogenic effects. It is also known as a psychedelic amphetamine. MDMA is not necessarily the only ingredient in ecstasy. Aspirin, caffeine, and ketamine, a veterinary anesthetic medication, are among the many other compounds that are frequently incorporated into ecstasy tablets (Greer & Tolbert 1986).

Merck Pharmaceuticals created methylenedioxymethamphetamine for the first time in 1912. Though never used for this purpose, it was first created as an appetite suppressant. In American therapy seminars in the 1970s, MDMA was used to improve communication.

Midway through the 1980s, ecstasy became a legal drug in Australia; it was made illegal in 1987 (Milhazes, et al., 2006).

Hallucinogens. A family of medications known as hallucinogens causes hallucinations and can affect perception. An illusion of seeing or hearing something that isn't actually there is referred to as a hallucination (Huxley, 2006).

You can make hallucinogens either naturally or artificially. Synthetic lysergic acid diethylamide (LSD), which is marketed as a liquid, an absorbent tab, or a tiny square of paper, is the most well-known hallucinogen. Plants like the psilocybin-rich mushrooms and mescaline-containing peyote cactus contain naturally occurring hallucinogenic compounds (Nichols, 2004).

A Swiss chemist named Albert Hoffman created LSD for the first time in 1938. The medication is typically sold on tiny tabs made of absorbent paper that are adorned with cartoons and cheerful faces. Additionally, it can be offered for sale as sugar cubes, tiny gelatin squares, capsules, tablets, or liquids.

Typically, mescaline is refined into a powder that ranges in color from white to brown after being dried and refined. The chemical psilocybin is present in magic mushrooms and golden top mushrooms. Psilocybin can be purchased as whole, dried brown mushrooms or as rudimentary mushroom mixtures (Freedman,1969).

Others. Some medicines are classified as "other" because they may possess many characteristics of other classes (cannabis, for example, has depressive, hallucinogenic, and some stimulating qualities).

Cannabis. Cannabis has a multitude of effects, making it challenging to pharmacologically categorize. Although mostly a depressive, it can also have some stimulant and psychedelic effects. THC, also known as delta-9 tetrahydrocannabinol, is the psychoactive component of cannabis. This chemical influences a person's perception and emotions. The

cannabis plant yields marijuana, hashish, and hashish oil. The plant's dried leaves and blossoms are used to make cannabis. Greyish-green to greenish-brown are its color ranges. Cannabis can have a delicate texture like dried herbs or a gritty texture like tea. It is typically smoked in water pipes called bongs or hand-rolled cigarettes known as joints (Rubin, 1975).

The dried flower buds needed to make cannabis are extracted to make marijuana. Shorter, bushier plants known as cannabis indica are adapted to milder climes and highland situations (Van-Bakel et al., 2013).

The dried, compacted resin extract from the female cannabis plant's flowering tops is known as hashish (hash). The color of hashish varies from pale brown to almost black. More potent than marijuana, it is. Typically, people consume hashish by smoking it in a pipe or cooking it into food. Hashish prepared by hand in Jamaica, India, Pakistan, and Nepal and is known as charas. Along the stretch of the Himalayas in Northern Pakistan, plants grow wild (Merlin, 2003).

An oily, viscous liquid extract of the cannabis plant is known as hashish oil. Its color is a reddish brown. Due to the high concentration of THC, even a small dose will have noticeable effects. Hashish oil is typically fried into food or added to joints before consumption (Risling, 2013; King, 2003). Numerous tropical and humid regions of the world are home to Cannabis sativa in its native state. Its use as a psychoactive substance has been documented in prehistoric communities in Africa and Europe (Butrica, 2002).

Causes of Drug Addiction

There are numerous factors that contribute to drug addiction. There are countless, unique, nearly distinctive reasons why people abuse drugs. According to Galea, Nandi, and Vlahov (2004), the causes listed below appear to be significant in identifying the motivations for the use of illegal drugs.

Parental guidance. One study is that young people from unhappy households, whose parents don't care about them and punish them physically, are more likely to use drugs than kids from better homes. The most significant factor is how much parents' drug use is emulated by them; when parents freely use alcohol, tranquilizers, and other legal drugs, their kids are more likely to do the same (Waldron, Vaughen & Pamela, 2014).

Influence of peers. According to numerous studies, the more drugs a young person experiments with, the more likely it is that his buddies will also use. Friends who use drugs may persuade young people to use them (Brown, Eicher & Petrie, 1986; Allen et al., 2005).

Character traits. No specific personality type is connected to drug use. People experiment with drugs for a variety of reasons, including curiosity, the desire to enter a different level of consciousness, alleviation from pain or other discomfort, and boredom (Hopwood, Baker & Morey, 2008).

Pathophysiology. To define the neural mechanisms behind drug addiction, various studies have been carried out using human functional brain imaging and animal models. It is believed that various brain changes are at play in drug abusing behavior (Goldberg, 2012).

Drug addiction's biological causes. Drug addiction is also heavily influenced by biological causes.

Genetic Variables. It has already been widely recognized for a sizable amount of time that drug dependency is influenced by social, psychological, and genetic variables. The self-treatment notion is one well-known idea in this area. According to epidemiological and other studies, 40–60% of the risk factors for drug addiction are thought to be hereditary in nature. A gene or set of genes may have a role in a variety of ways in the tendency to addiction. For instance, throughout development, altering quantities of a normal protein brought on by environmental variables may alter the structure or functionality of particular brain neurons. The vulnerability of a person

to their first drug use experience may shift as a result of these changed brain neurons (Kendler et al., 1994).

Physical dependency and increased tolerance. Drug abuse can alter a person's body's capacity to adjust to the presence of these substances. One impact is that people lose sensitivity to the drug, requiring higher dosages to get the intended results. Tolerance is the term used to describe this reduction of sensitivity (Alexander, Sayla, Holmes & Sachs, 2006).

When drug use stops, the body may experience withdrawal symptoms as it adjusts to the substance's presence. Physical reliance is the term for this condition. Because the body has become so dependent on the drug, fast withdrawal can, in certain situations, be life-threatening because it interferes with the body's regular functions. It is still unclear what adaptive changes underlie physical dependency and tolerance. The activation of parallel biochemical systems, modifications to metabolic pathways, cellular adaptability, and adjustments to neurotransmitter release appear to be involved, though. These modifications account for why it can be so challenging for some drug users to cease using. Numerous pertinent structures and processes (such as drug-specific receptor sites in the brain and the impacts of particular substances and their metabolic effects on neurotransmitters) have been discovered as a result of research on the neurobiological aspects of drug use. A common set of physiological or biochemical processes in the brain may underlie all addictive behaviors, according to certain theories (Loganathan & Ho, 2021).

Neurotransmitters' function. Different kinds of medication work in different ways to provide immediate effects. Dopamine (DA) is understood to be a key player. DA binds to the postsynaptic D1 receptor (as opposed to the presynaptic D2sh receptor), which starts a signaling cascade inside the cell. A transcription factor called cAMP response element binding protein (CREB) is phosphorylated by the enzyme cAMP dependent protein kinase (PKA),

which in turn causes the transcription of other genes, including C-Fos (Kalivas & Volkow, 2005).

What dopamine does. The main neurotransmitter in the brain's reward system is dopamine. Movement, emotion, cognition, motivation, and pleasurable sensations are all regulated by it. Dopamine is released as a natural reward when you eat, as well as when you use drugs recreationally. This is related to the reinforcing nature of both stimuli. Almost all addictive substances affect the brain's reward system by increasing dopaminergic activity, either directly or indirectly. When drugs are abused, large levels of dopamine are repeatedly released, which has a variety of effects on the reward system. Dopamine levels in the synaptic cleft that are too high can lead to sustained, heightened postsynaptic receptor activation and receptor down regulation. The sensitivity to natural reinforcers may be reduced as a result of mesocorticolimbic dopamine receptor down regulation (Nora & Joanna, 2007).

Depressant's Role in release of Dopamine. As reported by National Institutes of Health in 2011, stimulants, and diazepam are examples of depressants that work by making the GABA receptor more responsive to its ligand, GABA. As a result, the brain's activity is suppressed. On the contrary, opioids like heroin and morphine mimic the actions of endorphins, which are bodily chemicals that occur naturally and have effects comparable to those of dopamine. Opioids, on the other hand, can block the neurons that prevent the release of dopamine in the reward circuit of the brain. Certain mechanisms help explain why certain substances are enjoyable and addictive. These drugs, also known as "downers," frequently promote relaxation and pain alleviation.

Stimulant's Role in release of Dopamine. Drugs that stimulate dopamine signaling in the reward system include amphetamines, nicotine, and cocaine. These stimulants either increase dopamine release directly or prevent its absorption. These drugs—sometimes referred to as "uppers"—usually result in increased energy and alertness. They produce a "high," or pleasurable physical feeling and exhilaration. The user can experience low energy levels and/or

depression once this high wears off. This may intensify the user's need to redo, thereby raising the danger of addiction (Sulzer, Sonders, Poulsen & Galli, 2005).

Personal Dynamics. Behavior and psychological drug tolerance may be personal aspects in drug addiction (Hyman, Malenka & Nestler, 2006).

Behavior. Understanding how the mesolimbic pathway affects behavior and learning can help explain how addictive substances work. Drug addiction is characterized by strong, substance-seeking behaviors, in which users deliberately seek out drugs despite knowledge of the risks. Drugs' addictive properties are caused by the euphoric feelings that result from prolonged dopamine levels in the synaptic cleft of brain neurons. This satisfying result encourages users to keep using drugs. Operant conditioning is the process of linking an action or behavior, such as the desire for a drug, with the benefit of the drug's effects. This phenomenon has been documented not only in drug users but also in lab animals like mice, rats, and primates. According to the evidence, this behavior is most likely the outcome of synaptic alterations brought on by repeated drug exposure. Glutamatergic connections from the prefrontal brain to the Nucleus Accumbens (NAc) cause drug-seeking behavior. Data from research that demonstrate how the suppression of AMPA glutamate receptors and glutamate release in the NAc might prevent drug seeking behavior support this theory (Jones & Bonci, 2005).

Psychological tolerance towards drugs. The psychological component of drug tolerance is partially caused by the reward system. The CREB protein, a transcription factor, is activated after a drug-induced high by the chemical cyclic adenosine monophosphate (CAMP). Which turns on genes that create proteins like dynorphin, which stops the production of dopamine and momentarily blocks the reward pathway. A persistent activation of CREB in chronic drug users makes it need to take a higher dose to achieve the same effect. The user also experiences a general sense of depression and dissatisfaction, as well as a loss of enjoyment in

formerly pleasurable activities, which frequently prompts a return to the drug for another "fix" (Giannini & Martin, 1998; Kovacs et al., 2006).

Environmental Components. Research on both humans and animals has been analyzed to refute the assertion that addictive substances are so potent reinforcers that they frequently lead to unlimited access organisms to self-administer the drug to the exclusion of all other activity and reward, frequently until death. Animals balance the opportunities for accessible rewards, of which addictive substances appear to be a potent but by no means singular example, according to behavioral economic studies and models. Drug use is said to produce a compelling physiologic condition that controls an addict's behavior. According to animal research (Prescott & Myers, 2003), stress and other environmental conditions can have an impact on an animal's genotype.

Stress reaction. It is believed that stress processes, in addition to the reward pathway, also play a part in addiction. It is believed that while using drugs, the hypothalamic-pituitary-adrenal axis (HPA) and other stress systems in the extended amygdala are activated by the corticotrophin-releasing factor (CRF). The dysregulated emotional state linked to drug addiction is influenced by this activation. They discovered that as drug usage increases, CRF levels in human cerebrospinal fluid (CSF) increase as well. Separate applications of CRF antagonists and CRF receptor antagonists both reduced the study drug's self-administration in rat models. Enkephalin, an endogenous opioid peptide that controls pain, and other hormones connected to the HPA axis were dysregulated, according to previous studies in this review. Additionally, it appears that the enkephalin-activated -opioid receptor system has an impact on the reward system and can control the expression of stress hormones (Koob & Kreek, 2007; Ambroggi & van, 2009).

Drug addiction is a complex and pervasive issue that affects millions of individuals worldwide, often leading to devastating physical, psychological, and social consequences.

While various factors contribute to the development and perpetuation of addiction, it is essential to recognize the profound influence of spiritual causes on this multifaceted phenomenon. These spiritual causes encompass a wide spectrum of beliefs, values, and existential questions that can significantly impact an individual's vulnerability to substance abuse and their journey towards recovery. In this discussion, we will delve into the profound spiritual dimensions that underlie drug addiction, shedding light on how matters of the soul, purpose, and inner turmoil can play a pivotal role in the onset and persistence of this affliction.

A Spiritual Disease: Addiction

Drug addiction is considered as a spiritual disease that is expressed through a total self-centeredness on the part of the individual. Moral causes of addiction presume there is a “correct” morality based on particular set of values. Deviation from those values results in addiction.

According to Islam, the spiritual heart is housed in the physical heart (Yusuf, 2004). The object of God's mercy and kindness is a pure and sound spiritual heart. According to the Qur'an, the only person who will be safe on the Day of Judgment is the one who returns to God with a pure heart Another verse from the Bible states that the heart can only become quiet when God is remembered. Muhammad PBUH is claimed to have said, "There is a lump of flesh in the breast of humanity; if sound, then the whole body is sound; if corrupt, then the whole body is corrupt. Not the heart, is it? In 2001 (Bukhari). The corrupting of the spiritual heart occurs when it is not working according to the will of God. Muhammad claims that sins are God's sanctuaries in the same report, and that grazing too close to these sanctuaries will surely result in one breaking them. The Qur'an describes hypocrites as having a spiritual sickness because they constantly commit sins as a result of their double standards. According to God, their ongoing sin causes him to worsen the condition of their hearts (Haleem, 2005).

The human in the Qur'an is a paradoxical creature. According to Haleem in 2005 (al-Hijr 15:29), it is stated in the Qur'an that God created Adam from clay made from muddy soil. All the assembled angels and people were then commanded to kneel before him as he breathed in his spirit. Everyone bowed down except Iblis, who said that since God made Adam from dirt and him from fire, he is superior to Adam. Iblis was banished from the skies by God as a result of his disobedience, and he later changed his name to Shaytan (Satan). Satan hasn't been able to understand how paradoxical human nature is, according to the Qur'an. Satan was able to assert his superiority by emphasizing the earthly nature of people. Iblis did not accept the human's divine heritage—God's spirit—as a component of human nature. In truth, humans frequently are unaware of this facet of their nature and succumb to the devil's temptation. In Islam, this is the conflicting essence of people. People combine the sacred and the profane in a holy union that enables them to walk on Earth and still be greeted by angels in the heavens.

A balanced and reasonable perspective on life and its challenges is one of the distinctive characteristics of the Islamic worldview. Islam acknowledges the existence of natural human desires and offers guidance on how to satiate them without letting them rule one's life. The Exalted Qur'an declares:

"Oh Adam's offspring! Wear your beautiful clothing to all prayer times and locations. Eat and drink, but do not overindulge because Allah detests wasteful people. [Al-Quran 7:31]

Moderation is a virtue that is encouraged in Islam on both an individual and a communal level. Islam sees God's trust in the world's natural resources and in human life itself. As a result, each person is responsible for how they use these resources. In Islam, profligacy is viewed as a grave sin.

The individual's self is yet another crucial personal component. The self is made up of various elements that, if given equal weight, may have a good effect, but if any element is disregarded, the self can become disjointed and can result in major mental health problems.

Self

An individual is the self when they are the subject of their own reflecting consciousness. As a reference made by a subject to another subject, the self is inescapably subjective. However, subjectivity itself should not be confused with the sensation of being a self, also known as self-hood (Zahavi, 2005). This sense is ostensibly directed away from the subject in order to relate back to its "self" (or itself) internally. Depersonalization, which can occur in schizophrenia occasionally, is one example of a psychiatric illness where such "sameness" may break down. In this situation, the self appears to be separate from the subject.

Self-hood and personal identity are separated by the first-person viewpoint. While "identity" is (literally) sameness (Shoemaker, 2015), self-hood implies a first-person perspective and offers potential distinctiveness (Cragun & Cragun, 2006), and may also involve categorization and labeling. On the other hand, we refer to "person" as a third-person noun. In late-stage Alzheimer's disease and other neurodegenerative disorders, personal identity can be hampered. The self can be distinguished from "others" at last. The self vs other, including the dichotomy between sameness and otherness, is a research issue in modern philosophy (Ferro, 2013) and modern phenomenology, psychology, psychiatry, neuroscience, and neurology.

One of the many difficulties that the philosophy of the self and the study of consciousness in science face is the idea of privacy within subjective experiences. Subjective experiences provide challenges in their research and understanding despite being essential to our sense of self.

The study of how one's identity is conceptualised and experienced is known as the psychology of self. It includes the investigation of one's self in both its dual roles as the subject of knowledge (referred to as "I") and the knowledge object (referred to as "Me"). William James first outlined this contrast between the self as the experiencing subject and the self as the object of experience in his 1891 early definition of the self in modern psychology (Pant,

2023). According to current theories of the self in psychology, human motivation, cognition, affect, and social identity are all influenced by the self (Sedikides & Spencer, 2011). According to John Locke, self is a result of episodic memory (Conway & Pleydell-Pearce, 2000). However, research on people with amnesia has found that these people have a cohesive sense of self based on preserved conceptual autobiographical knowledge (Rathbone, Moulin & Conway, 2009). Correlating one's own cognitive and affective experiences with brain processes is becoming more and more possible. Psychiatrists have also researched the 'Disorders of the Self' in great detail (Berrios & Marková, 2003).

Facets of oneself. The integrated self has historically been used by psychologists to describe the completion of significant behavioural achievements. However, those who are really living up to their full potential show a sense of coherence in their ideas, feelings, and behaviours, which leads to a coherent "sense of self" or an integrated self. What characteristics must someone have to achieve such integration? The basic elements of a person are usually self-evident. It is well recognised that each person is born with a physical body capable of performing essential bodily tasks, a cognitive mind capable of reasoning, memory, problem-solving, and language proficiency, as well as motivations and emotions that direct their energy towards particular behaviours and goals. True human development, however, extends beyond these essential components. Only when all of a person's traits are in perfect balance with one another and form a cohesive whole that is greater than the sum of its parts, can a person fully realise their potential as a human. An individual with self-critical tendencies, for instance, may find it very difficult to control and regulate their emotions, which can have a big impact on how they act and behave. The connectivity of the self's various facets emphasizes the value of integration in developing a fully formed human being (Baumann, Kaschel, & Kuhl, 2007). One could say that a person's integration of their various parts reflects their essence or true selves. Therefore, we refer to this essential component of who we are as the integrated self.

Four facets of self. Simply put, a person is made up of four fundamental but very dissimilar parts of themselves. In terms of the body, they are the tangible or physical aspects, the conscious and intellectual elements, the emotional and spiritual aspects. When all of these are given attention at once, the four facets of the self, function in perfect harmony (Aronson, 2002).

The physical side of oneself. The physical element of oneself is highly valued by many people. The body is palpable and apparent, and we can simply react to it. The physical component is improved more than the other two in terms of time and money spent. However, this does not imply that the body is robust or in good health. The spirit, which is frequently experienced as feelings, and the intellect, which is frequently experienced as thought, both have a home in the body (Fadiman & Frager, 2004).

Cognitive Self-Aspect. Our understanding of oneself, comprising different elements like our name, race, preferences, worldview, morality, and even particular personality traits, is collectively referred to as our self-concept. According to Bushman and Baumeister (1998), the capacity for self-awareness is a fundamental component of selfhood and a defining characteristic of the human organism (p. 683) (Krendl & Heatherton, 2009). Numerous studies (Bower & Gilligan, 1979; Klein & Kihlstrom, 1986; Klein & Loftus, 1988; Maki & McCaul, 1985; Markus, 1977; Rogers, Kuiper, & Kirker, 1977), have been conducted in order to determine that whether the brain gives self-relevant information a special significance or processes it similarly to other types of information. Whether the self is actually "special" in terms of how the brain interprets information about oneself is the central subject of this ongoing discussion (Gillihan & Farah, 2005).

The self, according to Rogers and Colleagues in 1970, is a distinct type of cognitive structure with unique mnemonic skills that enhance the memorability of information processed in relation to the self. Some people place considerable significance on having a sharp intellect

and a good education. Because it controls the other two parts of the self, the mind is important. The mind instructs the body and emotions, directing their actions and reactions. The body and emotions' behaviours and responses are influenced by the thoughts we have in our minds. People have both positive and negative beliefs, and they react to their surroundings appropriately. Prayer, forgiveness, acceptance, and passion are all processes that are made possible by the mind's access to creativity and serenity. Sedikides and Spencer (2007) provide credence to these ideas.

The emotional side of oneself. Emotion is a significant psychological process that is related to the self. One distinguishing feature of the sense of self is that it generates affect—evaluations of oneself invariably result in emotional responses that have an impact on subsequent thoughts and deeds. People actually endow their possessions with a sense of self, which causes them to treat them differently from the possessions of others (Beggan, 1992).

According to Niebuhr (2004), people fear managing their emotions the most because they are hesitant and ill-equipped to do it. Attempting to control your emotions is like attempting to hold water in your hand. They are evasive and misleading. A choice made under emotional duress and pressure typically has a negative emotional impact. Unmanaged negative emotions are repressed and kept. Repression harms a happy self because all emotions, not just negative ones, are suppressed. Now that feelings are harder to access when needed, the person feels helpless and numb.

According to Greenberg, emotions are one of the psyche's most essential components in the construction of the self and a key factor in self organization. Emotions are adaptive on a fundamental level and can be used to identify needs, principles, or objectives. Certain life events and the memories that follow can create emotional schemas that can change healthy primary emotions into unhealthy ones. For instance, anger can emerge in response to sadness.

Loneliness, inadequacy, and unhealthful shame are examples of maladaptive emotions (Greenberg, 2010,2017).

The spiritual side of oneself. The spirit, also known as Ruh, is frequently thought of as the most complex part of the human person. Religious writings claim that knowledge of the soul is only partially complete and belongs to the divine realm (Qur'an, 17:85). Although assessing someone's spirituality (ruhaniyyah) can be difficult, it is a skill that can be developed. Ibn 'Arab claimed that the spirit that exists within a person's body controls both the body and the soul and is analogous to the universal spirit (ruh kulli), which rules over the entire cosmos (Ebstein, 2014).

Beyond the confines of time and space, there is a spiritual part of ourselves that is frequently referred to as our inner essence or soul. As a reflection of the interconnection of all life, it links us to the almighty source. Our ability to feel a part of the cosmos, understand our existence's larger significance and purpose, and see the world from a perspective that goes beyond our personality alone is all made possible by developing an awareness of our spiritual dimension. The spiritual level affects how the other levels of our being grow and evolve (Kiesling, Sorell, Montgomery & Colwell, 2008).

Theoretical Background

Imam Ghazali's Theory of Self. The eleventh-century Islamic scholar Abu Hamid Al Ghazali played a significant role in clarifying how to conceptualize the self or soul within an Islamic framework. He laid the foundations for an Islamic model of the self/soul based on Quranic principles. Ghazali delineated four key aspects of the human soul: the nafs (lower self), the qalb (heart), the aql (cognition), and the ruh (spirit). Each of these aspects possesses unique attributes and functions that collectively constitute the inner workings of the human soul. It's essential to note that these distinctions are primarily for the purpose of facilitating our understanding of the structure and function of the human condition. In reality, these aspects are

all interconnected and form an integrated whole. Therefore, these terms are often used interchangeably when referring to the various facets of an individual. The primary practical significance of comprehending these distinct functions of the self lies in the practice of "tazkiyat an nafs," which translates to the purification of the self (Keshavarzi & Haque, 2013).

Islamic View Point About Self

According to traditional personality theories, the self has a wide range of domains. It can show where transpersonal knowledge first emerged (Jung, 1933), how personality interactions are regulated (Sullivan, 1953), what drives psychological growth (Maslow, 1954), and how good character is formed (Baumeister & Exline, 1999).

The following regions of the human psyche or self have been identified, according to Imam Ghazali: (1) 'aql (cognitive), (2) nafs (Physical Aspect)/ (behavioral proclivities), (3) ruh (spirit), (4) qalb (heart), and (5) ih'sas (fundamental emotions).

Nafs: Keshavarzi and Haque (2013) define the term "nafs" as behavioural inclinations. According to al-Ghazali, Mullana 'Al al-Qari, and al-Suhrwardi's conceptualization, the nafs ammarah bi-l-s, or the nafs inclined towards evil, is contained within the aspect of the human being as a social animal with survival/aggressive instincts (quwwat ghadabiyyah), as well as appetitive/carnal drives (quwwat shahawa). As a result, the nafs is hedonistic and capable of increasing its hunger in its untrained form. In this regard, the nafs can be compared to Freud's conception of the id. The nafs can evolve, be nurtured, and develop through several phases (such as lawwamah and mutma'innah) with refinement and training, though, and thus lifts it above its animalistic, meek goals and toward the divine precepts of the latifah rabbaniyyah or ruh' ulwi samawi. Mukhlafat al-nafs, or resisting its animalistic inclinations, is the main strategy for reaching this goal (Al-Suharwardi,1993., Al-Ghazali, 2011, Ali al-Qari, 2015).

The rational capacity known as "aql" enables people to reason and gather knowledge. Al-Taftazani claims that when one's internal and exterior senses are functioning regularly, the

aql is what allows one to realise precise and intuitive knowledge (al-Taftāzānī, 2000, al-Farhārī, 2012). According to al-Ghazali (1990) al-Bayjūrī (2002), the laṭīfah rabbāniyyah is the source of gifts such as the ability to think, gather knowledge, recognise consequences, and distinguish between the truth and lies. It helps people comprehend how their actions affect others and mediates and interferes with the nafs' destructive whims (Ibn ʿĀbidīn, al-Haskafi, & al-Nasafi, 2006; Keshavarzi, H., & Ali, B. (2020).In the absence of this ability to think critically, which is necessary for ethical accountability, Islamic law would provide for escape from liability and accountability.

Ruh - The term ruh is comprised of two distinct elements: (a) the human spirit and life force and (b) the spirit's propensity towards the holy and desire for reconnection and recollection of the divine (rūḥ ʿulwī samāwī). The former drive, which is its source, initiates the nafs ammarah's drives. In contrast, the latter refers to the component of a person's inner soul that yearns for greater importance, meaning, and transcendence to its fundamental state of seeking divine presence, which is represented by the nafs mutma'innah.

The word "qalb" alludes to the spiritual heart, which is the source of all illness and health. Any input from any of the other sections either illuminates or dims the heart.

The ihsas component of human inner experiencing is made up of a person's fundamental emotions. It might not be accurate to think of it as a distinctive and separate feature of the human psyche because it is a secondary aspect of the human experience.

All of the interior regions of the human being are inextricably linked. As a result, any change in one domain will also affect the other domains in the system. Consider a person with hedonistic behavioral addictions as an illustration. Such addictions may cause emotional dysregulation, such as despondency, or they may result in cognitive rationalizations that will cause distortions in a person's belief system. As a result, ritual religious practices may be

reduced, which can have an impact on an individual's spirituality and overall psychological wellbeing (Keshavarzi & Haque, 2013).

Additionally, according to Inayat (2005), Islam understands the self in terms of the heart (qalb), which is the most significant and denotes an individual's most profound spiritual insight. The heart is the conduit via which a person connects to God and realizes Divine oneness (Tawhid), the Islamic concept of devotion. According to Smither and Khorsandi (2009, p. 87), "the heart gives a Muslim a more profound level of understanding of the world than rational intelligence." The Qur'anic verse that defines the spirit (roh) as God's breath also describes how it shapes human nature and influences behavior (Haque & Masuan, 2002; Abu-Raiya, 2012). In addition, Islam holds that leading a bodily existence devoid of spirit is not something that should be done. In this meaning, spirit gives a person's physical and spiritual growth, which happens through the body (Smither & Khorsandi, 2009).

Islamic Perspective on the Function of the Self

The human body is susceptible to temptation and is easily persuaded to sin. The Qur'an talks of Adam and Eve's stay in paradise and how Satan's whispering caused both of them to disobey the one command God gave them. God banished them from the heavens for their transgression and proclaimed Satan to be the unbeatable enemy of Adam, Eve, and their offspring (Haleem, 2005, al-A'raf 7:20-24). The fight between good and evil that exists between Adam and Satan is reflected in the human being, who is perpetually torn between the sacred and the profane. The profane part of the human being, called in Arabic as the "nafs" (self), yearns for boundless pleasure, even at the risk of committing sins, in contrast to the sacred spirit, the "ruh," whose location is the physical heart. A black dot is said to emerge on a person's heart when they sin, according to Muhammad. If that dot isn't removed by making amends to God and asking for his forgiveness, it starts to spread until it eventually consumes the heart (Hanbal, 2001). According to Yusuf's article from 2004, when a person sins, their ruh (spirit)

splits from their nafs (selves). In order to commit a crime (which is also a sin), one must first commit a crime against the heart, which has an impact on the entire person. The individual experiences spiritual agitation, which is subsequently covered up (kufr, a word that also connotes denial) by substances like alcohol, narcotics, and other illegal drugs.

According to the idea that alcohol and other drugs are the "handiwork of Satan" as described in the Qur'an, addiction indicates that the addict's "self" has given in to their evil inclinations, severing it from the "spirit." A spiritless, dead heart has no memory of God and has no desire to go back to God. Is the person who was dead and then We raised him to life [through faith] and gave him a light by which to walk among the people like someone who is trapped in darkness from which he cannot escape? asks the Qur'an.(Al-An'am 6:122, Haleem, 2005). The phrase "Is the one who was dead" is said by exegetes to relate to having a dead heart (Yusuf, 2004). In his classic essay on cannabis, Zahr al-Arish, Al-Zarkashi states that the negative effects of drugs on the spirit include: a reduction in the soul's potential; the destruction of the intellect (fikr); forgetfulness (nisyan al-dhikr); the vulgarisation of secrets; the conduct of evil activities; the loss of modesty (haya'); strong stubbornness; a lack of male virtue; the suppression of jealousy; wastefulness; keeping company.

This is clearly seen in the Qur'anic passage that follows, where God declares that drinking breaks the tie with Him and destroys relationships with Family and Community. It views alcohol as a major contributor to disruptive social behaviour. In order to prosper in both their horizontal relationship with family and kin and their vertical relationship with God, it exhorts believers to avoid and reject the habit (Rosenthal, 1971).

Haque and Mohamed (2009) established the notion of fitrah (nature) as the "innate and natural disposition of man to believe in and worship God" in their attempt to construct an Islamic personality of psychology. They stated that "the key to knowledge of God is knowledge of one's self both inwardly and outwardly" as a further foundation for contact with God. A prior

claim made by Mohamed (1998) was that "fitrah, together with divine revelation, allows humans to attain all levels of perception, even the knowledge of Allah in a direct and immediate way" (p.97). The Qur'an (Yusuf: 53) states that "truly, the soul (nafs) is a persistent enjoiner of evil." The Prophet Muhammad narrated the hadith (Tirmidhi, Jihad, 2) on nafs that states, "Truly, the soul (nafs) is a persistent enjoiner of evil." A Muslim is constantly obliged to understand and control their ego. Thus, it could be interpreted that the speaker is striving to know himself in opposition to his understanding of God, suggesting that true self-knowledge would bring to a closer relationship with the Creator. In a sense, one should be conscious of one's capacity for self-awareness and the capacity for striving towards God, both of which can strengthen one's inner workings, essence, and personal strivings (Quinn, 2008).

Additionally, prosperity could refer to both spiritual and psychological prosperity, both of which are severely impacted by drug addiction. You who think that drinking and gambling, doing idolatry, and [divining with] arrows are unsavoury activities that Satan is responsible for; eschew them so that you may prosper, the Qur'an says. Satan's only goal in using drugs and gambling is to incite animosity and hostility among you and prevent you from thinking about God and praying. Will you not abandon them? Al-Ma'ida 5:90–91 (Haleem, 2005).

Opinions on the Integrated Self. Self-study has gained a lot of attention and growth in recent years (Baumeister, Dale & Sommer, 1998; Sedikides & Spencer, 2007, 2011; Morf & Koole, 2014). However, the idea of an integrated self has received little attention from psychologists. The lack of a clear theoretical framework that explains the cognitive and neurobiological mechanisms behind the integrated self is one aspect that contributes to this neglect.

Prior Conceptions of the Integrated Self. Ideas about the integrated self can be found in writings from various religious and philosophical systems as well as historical eras (Spranger, 1974). Many religious and philosophical traditions, including Hinduism, Buddhism,

Judaism, Christianity, and Islam, have acknowledged and cherished the integrated self, which includes concepts of inner peace, harmony, and self-realization. Modern psychology has incorporated the idea of the integrated self as well, however this idea is still difficult to comprehend scientifically (Koole, McCullough, Kuhl, & Roelofsma, 2010).

Early advancements in the study of the integrated self in psychology can be found in the psychoanalytic paradigm. The creator of psychoanalysis, Sigmund Freud, placed a lot of emphasis on the ego and its struggle with the id. However, Carl Gustav Jung and Otto Rank, two of Freud's erstwhile associates, created theories on the integrated self (Baumeister, 1991; Metcalfe & Mischel, 1999; Leary, 2004). Jung placed a strong emphasis on the individuation process, which entails fusing disparate facets of the psyche into a coherent whole. He saw religious symbols as expressions of the whole person (Kuhl, Quirin, & Koole, 2015). In contrast, Rank saw the will as a constructive force that organizes and unifies the self. He thought that the major goal of psychotherapy should be to strengthen the will (Brooke, 2015).

The notion of the integrated self has also been influenced by Carl Rogers, a well-known name in humanistic psychology. A "fully functioning person" is one who can integrate their own wants and ideals with those of others, maintain emotional awareness without being overstimulated, and learn from mistakes without becoming paralysed by them, according to the idea he put up (Rogers, 1961, 1983). Although Rogers listed the behaviours connected to the integrated self, he did not say if it is a driving force or just a collection of commendable behaviours.

The conception of an integrated self proposed by Rogers' (1961) have a remarkable inspiration for the psychology of the self, and its tremendous influence can be seen in many contemporary theories of social psychology in which authenticity (Kernis & Goldman, 2006), self-esteem (Crocker & Wolfe, 2001), self determination (Deci & Ryan, 2000, 2010), and self-concordance (Sheldon & Kreiger, 2014; Sheldon, 2014) are some well known concepts.

Although an integrated self has still a vague scientific construct, but it has become an integral part of conventional psychology.

Overall, the integrated self has drawn interest in psychology, but there is currently no clear theoretical explanation of the cognitive and neurobiological mechanisms that underlie it. The idea is still being researched and discussed in the industry. By investigating the neurological underpinnings of the integrated self, this uncertainty has been clarified.

Theory of Personality Systems Interaction

The Kuhl (2001) proposed Personality System Interaction (PSI) Theory, which offers a comprehensive framework for comprehending personality functioning, especially in connection to the integrated self, was first put forth in 2001. This theory describes personality as a dynamic interaction between the cognitive, behavioural, and affective processes. According to the hypothesis, our early ancestors' basic biological abilities to observe and navigate their environment gave rise to the development of the self. Included in this are straightforward, nonverbal representations of the organism's own body, which are used by a basic sensory-motor system that is still present in contemporary humans. These representations, which are a part of the "intuitive behaviour system" in the PSI framework, might be thought of as a proto-self. Our non-human predecessors evolved increasingly sophisticated cognitive abilities over time. According to PSI theory, these cognitive abilities independently evolved to serve the dual functions of stabilising world perceptions and real-time control of motor behaviour. This distinction shows that the cognitive mechanisms underlying online motor control and perception have developed independently. On the behavioural side, the development of the conscious mind in humans has allowed individuals to formulate explicit, linguistically portrayed action plans that take into account potential future events (Baumeister & Masicampo, 2010). Modern humans are able to create two distinct sets of high-level mental representations of the self developed by the conscious mind. These mental images aid in the

growth of a conscious self-concept, which is made possible by the special mental abilities we possess. Analytical mental processes and reasoning that are expressly preserved in language serve as a conduit for the conscious self-concept. Explicit self-evaluations in areas like values, self-efficacy, and locus of control can be used to gauge it (Judge, Erez, Bono, & Thoresen, 2003). These assessments are consistent with the perspective of PSI theory on the conceptual self, which is different from the integrated self. Body and emotional states are not directly connected to the conceptual self. It is instead based on measurable physiological experiences and more circumstantial inferences about one's own behavior (Bem, 1972). It may include demands made by other people, which could result in the creation of duties or the "ought self' (Higgins, 1996). In conclusion, PSI theory contends that the dynamic interactions between the cognitive, behavioural, and affective systems give rise to the integrated self. It includes the conscious self-concept, more advanced cognitive abilities, and the proto-self generated from fundamental sensory-motor processes. Understanding these various facets of the self within the context of the PSI framework offers insights into personality functioning as well as how people view and engage with their surroundings. The conceptual self is comparable to the ego in psychoanalysis in the PSI theory. Analytical reasoning and thinking processes that are expressly encoded in language mediate it. Explicit self-evaluations in a number of areas, including values, self-efficacy, and locus of control, can be used to assess the conceptual self. It is based on observable physiological experiences and inferred inferences about one's own behaviour rather than having a direct connection to bodily and emotional processes.

Humans have developed the ability to preserve their life experiences in long-term memory, which is related to perception. When pertinent conditions emerge, people can use their extended memory system to access their prior experiences. The conceptual self can include the standards set by others since it is so simply understood by others. It is possible for this absorption of external expectations to take the form of duties or the "ought self." The extended

memory system is the foundation of the integrated self, according to PSI theory. It is carried out by high-level parallel distributed processing that combines several facets of the person's identity at once. Because concurrent distributed processing does not proceed logically, unlike the conceptual self, the integrated self does not experience full consciousness. However, people's behaviour and preferences might be subtly influenced by the integrated self. In conclusion, the PSI theory makes a distinction between the integrated self, which is based on an extended memory system and incorporates parallel-distributed processing, and the conceptual self, which is mediated by analytical thought processes and language. While the integrated self helps to shape implicit impacts on behaviour and preferences, the conceptual self is influenced by explicit self-evaluations and external expectations. Within the context of PSI theory, an understanding of these components of the self offers insights into how people view themselves and interact with their environment (Conway & Pleydell-Pearce, 2000).

Functional characteristics of the integrated self. The PSI theory-based parallel processing model of the integrated self emphasizes the connection between people's cognitive, emotional, motivational, and volitional processes. It makes a distinction between the integrated self and the conceptual self, which is a propositional system. People that function in a healthy way continually interact between these two facets of who they are. It might be difficult to tell if a certain behaviour is self-determined or influenced by influences outside of the self because human behaviour is multi-determined. The integrated self's functional profile can be defined to meet this problem. This profile aids in determining whether a behaviour is more likely to be attributed to the self or to another personality system. The seven functional parts of the integrated self are described below. They are all products of the high-level parallel processing that creates the integrated self. It's vital to remember that the integrated self's functional profile is selective rather than exhaustive. A fully functioning person is thought to be able to carry out each of these tasks when required. According to Schwartz and colleagues (1996), a positive

connection between trait ratings for these functions points to a healthy level of self-development. State interventions, on the other hand, can fall short since a person who is completely functioning may just engage the functions needed in a given situation.

Making connections with physical, affective, and implicit emotional cues is the integrated self's primary purpose (Quirin, Kazén, & Kuhl, 2009a). The comprehensive feelings of the integrated self include both emotional and physical components, resulting in "emotional landscapes." Analytical thinking, in comparison, frequently concentrates on a single feeling and lacks the diversity and complexity of the experiences of the integrated self (Devinsky, 2000; Gainotti, 2005). According to studies, the right hemisphere of the brain is more strongly and directly linked to both good (Wittling, 1990; Winston, Strange, O'Doherty, & Dolan, 2002; Schweiger, Stemmler, Burgdorf, & Wacker, 2014) and negative emotions (Dawson & Schell, 1982). The modulation of these effects is aided by the right insula and right inferior frontal gyrus, which play important roles in interoceptive awareness, emotional experience, and sympathetic control (Tops, Boksem, Quirin, Ijzerman, & Koole, 2014).

The expanded information processing range results in increased alertness or attentional range, which is the integrated self's second function. High-level parallel processing's increased scope allows for a specific kind of attentional vigilance. The definition of "vigilance" used here, which refers to guardianship and a non-focused style of sustained attention that simultaneously encompasses a wide range of information or infrequently occurring events, is important to note because it is more in line with the term's traditional philosophical meaning. This idea is distinct from how the word "vigilance" has been used in more recent times to refer to threat-related attentional constriction (Brosschot, 2002; Terburg, Aarts, & Van Honk, 2012). According to research, this broad type of sustained attention is supported by a right prefrontal network (Cohen et al., 1988; Posner & Petersen, 1990) that is adversely correlated with brain areas that promote limited attentional focus (like target detection). Additionally, processing inferences

about necessary courses of action involves the left (dorsolateral) prefrontal cortex, whereas processing inferences about potential courses of action involves the right (ventrolateral) prefrontal cortex. (Barbey, Krueger & Grafman, 2009). The personality function of vigilance, according to Kazén, Kaschel, and Kuhl (2008), functions in the background of one's consciousness and alerts the person to stimuli that have substantial personal relevance, such as opportunities to fulfil wishes or carry out plans. Vigilance differs from the conventional understanding of mindfulness in that it is selective. Desbordes and colleagues (2014) defined mindfulness as being open and non-selective towards everything that arises in one's mind without opining on the significance of its contents for the individual. Vigilance contrasts with this.

While vigilance and mindfulness both require a wide range of attention, vigilance differs in that it is selective. It does not downplay the importance of the self, but rather offers a wide, implicit "overview" of any sense or experience that is pertinent to the self. In daily life, vigilance performs a personal surveillance role such as putting more "inner distance" between oneself and others or being aware of intrusions by others. Unlike mindfulness, which is non-selective, vigilance keeps a selective focus on stimuli that are significant to the self.

When contemplating the requirement for instantaneous detection of circumstances where one's personal space is being invaded, the conceptual link between vigilance and parallel processing becomes clear. In order to stay vigilant, a large number of information must exist simultaneously in the background of consciousness. This will allow the person to choose what is compatible or incompatible with themselves. Vigilance is thus analogous to the "border patrol of the self." Therapy in therapeutic settings frequently seeks to increase a patient's awareness of others intruding into their personal space as a strategy of self-defense and autonomy preservation.

Additionally, heightened awareness may support a personality's consistency and coherence. Vigilance prevents an over-reliance on the outside environment by constantly evaluating how choices and behaviours mesh with oneself. It aids in maintaining self-consistency and guards against being excessively affected by outside forces.

The simultaneous analysis of feedback, which enables the assimilation of a variety of outcomes resulting from one's actions, is the third function of the integrated self. While analytical processing only makes note of the effects, feeding the integrated self with the perception of the effects results in the formation of a comprehensive emotional response to the effects as well as linguistic understanding of the response. This also encompasses the kinesthetic responses that the body as a whole has when it encounters the results of one's actions. Individuals develop "response-ability," the capacity to find appropriate answers to any problems posed by a certain activity, through being able to feel the impacts of their own actions and comprehend their personal relevance.

Extended unconscious processing is connected to the fourth function of the integrated self. Making wise and cautious decisions requires simultaneous consideration of a number of elements, including goals, values, possibilities for action, as well as one's own needs and those of others. The integrated self engages in unconscious processing that includes all of these components, enabling a thorough analysis of numerous circumstances, even if they are not readily available to consciousness. Decision-making and problem-solving are aided by this extended unconscious processing (Kuhl, 1994, 2000a).

The capacity to balance one's own needs and those of others, as well as the positive and bad facets of an experience, is the integrated self's fifth attribute. With the use of this ability, people may manage and balance their own emotional demands and states with those of others as well as bring together many elements of an experience to form a coherent understanding. It entails identifying and resolving opposing feelings, wants, and viewpoints in order to promote

psychological health and harmonious interpersonal relationships (Gilligan, 2013). This is known as integrative competence. Many psychological problems, which can be characterized by affect instability, a lack of self-control, a negative self-image, and strained interpersonal interactions, are caused by a lack of cognitive and emotional integration (Linehan, 1993). According to the current viewpoint, these illnesses may be caused by a compromised functioning of the integrated self.

Extended resilience may be referred to as converting weaknesses into strengths. Emotional vulnerability can be transformed into emotional strength, which is the sixth characteristic of the integrated self. The PSI theory states that sensitivity to adverse affect is correlated with emotional susceptibility. People who are experiencing negative affect tend to concentrate more on situations that differ from their expectations and wishes (Kazén, Kuhl, & Quirin, 2015). Only when these divergent experiences are connected back to the preexisting knowledge structures of the integrated self can they be used as a resource for learning and self-development. After the inconsistent experience has been recognized, this access can be obtained by down-regulating negative affect. Therefore, the additional learning possibilities among emotionally weak individuals can only be used when they are able to triumph over negative affect (Kuhl, 2000b). Thus, when combined with affect-regulatory abilities, sensitivity to negative affect can be a benefit.

The deep-seated tendency to think positively about one's existence is the seventh attribute of the integrated self. It entails having an inner sense of security, especially under trying or unpleasant circumstances, and feeling accepted by the world (Diamond & Aspinwall, 2003; Kochanska, Philibert & Barry, 2009). This idea of self-positivity is similar to Erik Erikson's idea of fundamental trust, which forms the framework for subsequent self-esteem and optimism through interactions with the primary carer during infancy (Erikson, 1950; Bowlby,

1969). The ability to exercise self-control, feel secure inside, and develop oneself are all based on trust (Brown, 2014).

In order to deal with challenging circumstances, one must be able to naturally tap into positive emotions (Quirin, Bode, & Kuhl, 2011; Koole & Jostmann, 2004; Koole, 2009). Intriguingly, it has been discovered that engaging the right hemisphere, such as by squeezing a stress ball with the left hand, increases implicit positive affect and implicit self-esteem (Quirin et al., 2014b). Furthermore, according to Winston and colleagues in 2002 and Schore (2001, 2012), the right hemisphere is linked to perspective-taking, trust in others, affect control, and self-development.

Every component of the integrated self is equally significant. We must devote some time and energy to comprehending, growing, healing, and integrating each component if we are to feel complete and live healthy, fulfilling lives. We may require additional healing on some levels since we were injured or experienced trauma there. You may have a wound on the spiritual level, which can be healed by creating your own unique way of communicating with spirit. For instance, if you were taught or raised with strict religious beliefs and later felt that these beliefs were not right for you, you may have rejected the entire spiritual side of life and may not believe in anything at all. Every one of us has experienced some level of disappointment, hurt, or pain that has left us emotionally wounded and in need of recovery (Cox, Abramson, Devine & Hollon, 2012).

Our healing process can be carried out in any method that seems good to us. Everyone has a different personality and develops along their own route. We are all on an evolutionary path, but the majority of us would not be aware of it until something triggers our awakening and we are all actively engaged in the growing and learning process. Life is like school; we are always learning, growing, and taking lessons as we try to understand why we are here (Zahavi, 2005).

Each person has the potential to possess the abilities of the integrated self. But how much of an integrated self each person has acquired varies. The frequency and efficiency of its functions do, in fact, have an impact on how the integrated self develops, according to the "use it or lose it" approach. The integrated self is more likely to grow and strengthen when people continuously engage with and use its components. On the other hand, if these functions are underused or neglected, they may deteriorate with time. The analytical ego, which is connected to analytical thinking and explicit reasoning processes, may be easier for people to reach consciously. This might be as a result of the fact that verbal expression and conscious awareness are both more easily accessed by analytical thought. The integrated self's holistic and implicit processes, on the other hand, which entail sensory and emotional experiences, might function more automatically and unconsciously. Although not all components of the integrated self may be accessible to individuals consciously, its functions can nevertheless have a big impact on actions, choices, and emotional states, and the integrative self's functions may be hindered by factors like negative affect or stress (Deci & Ryan, 2000).

Integration lacks a precise definition in the psychological literature. Integration frequently refers to the editing and hierarchical organization of personal experiences as well as the overcoming of incongruent events to create a continuous and consistent sense of self. An integrated personality has behavioural consistency, a sense of inner continuity over time, and a deep and diverse view of oneself and others. This integrated self allows people to recognise both positive and negative traits in themselves and others. They comprehend themselves and their loved ones. According to Pilarska, (2017) unintegrated or fragmented people have role dispersal and no core identity. Without a constant self, they may adapt to new people and situations. Fragmentation or unintegration can cause inconsistent behaviour, feelings, and self-perceptions. They may have a fractured self-concept due to their inability to establish a coherent identity. The difference between integrated and unintegrated (fragmented)

personalities shows how a coherent self-concept affects behaviour and mental health. An integrated personality helps people negotiate their social world with a clear identity and understanding, while unintegrated people may struggle to find their true self. Unintegration (Fragmentation) is the antithesis of integration or the absence of an integrated self. When a person's experiences of themselves are significantly unintegrated (fragmented), their behavior and emotions are erratic, and they frequently switch between different and opposing self states (Pollock et al., 2001).

According to Bigler, Neimeyer and Brown (2001) people who score higher on the fragmentation scale tend to be less self-assured, more depressed, nervous, and neurotic. Additionally, unintegration (Fragmentation) is thought to contribute to a number of psychopathologies, including drug addiction. (Gara, Rosenberg & Mueller, 1989; Gara, Rosenberg & Woolfolk, 1993; Wildgoose, Clarke & Waller, 2001).

For many addicts, addiction can develop into a chronic illness; they may experience relapses when they don't adhere to treatment, just as people with chronic conditions like diabetes, asthma, and hypertension. These relapses might happen following a protracted time of sobriety. Drug addiction is very challenging to cure for this reason (Sinha, 2011).

Relapse Vulnerability

Relapse happens when a person uses drugs or alcohol again after a time of abstinence. It is a typical setback for those overcoming addiction. In reality, many people in recovery have multiple relapses throughout their lives. According to the National Institute on Drug Abuse (NIDA), drug addiction relapse rates range from 40 to 60%. These recurrence rates are comparable to those of other chronic illnesses including Type 1 diabetes and high blood pressure (Milivojevic & Sinha, 2018).

Relapse does not indicate that treatment was ineffective; maintaining sobriety requires time, effort, and commitment. Addiction is a brain illness that makes people use drugs

compulsively while being aware of the negative social, legal, and health effects. People with this condition who have recovered may relapse into excessive drug or alcohol use. Relapse can be brought on by a variety of circumstances, but for individuals committed to leading healthy, sober lives, long-term recovery is feasible (Shaham, Shalev & Lu, 2003).

Due to the prevalence of addiction relapse, research over the past ten years has concentrated on determining whether there is a biological basis for relapse vulnerability and, if so, whether it is possible to design novel therapies to lower the risk of relapse (Sinha, 2001). According to McKay, Rutherford and Alterman (1995), drug-abusing patients cite stress, depressive mood, anxiety, drug-related cues, temptations, and boredom as the main causes of relapse. They also frequently cite a lack of supportive environmental factors (such as a job, close family ties, or obligations).

Factors. Relapse is more likely when a number of things happen, such as giving in to triggers or skipping out on aftercare after finishing addiction treatment (Mohammadpoorasl, et al., 2012).

Triggers. After a time of abstinence, triggers include ideas, emotions, feelings, sensations, events, and interpersonal connections. For instance, some persons in recovery may experience cravings when passing a familiar drinking venue, such as a bar or restaurant. People may have triggers while depressed or when they go to a gathering where alcohol is served. Stress, insufficient sleep, and numerous physical ailments are additional factors.

Communication with those who abuse drugs or alcohol frequently sets off triggers for people in recovery. After completing addiction treatment, friends who use drugs or drink excessively may exert pressure on others to continue using substances (Ibrahim & Kumar, 2009). The causes of recurrence among former smokers were investigated in a study done by NIDA in 2001. Researchers discovered that typical relapse triggers like stress and

environmental factors played a role. Smoking for pleasure was another often stated factor in relapses (Gust & McCormally, 2018).

Fatigue. Fatigue can result from being physically or mentally exhausted and interfere with daily activities. The impulse to use alcohol or drugs to dull physical or emotional pain might be triggered by too much stress.

Depression. Addiction frequently coexists with the mental health condition of depression. Depressive thoughts might make people lose interest in their activities, oversleep, or have trouble focusing. People in recovery who are depressed could be tempted to use medications to get better.

Physical Anguish. Physical discomfort is linked to relapse in addition to psychological problems like sadness. Reduced pain levels may reduce the chance of relapsing into alcohol use, according to a 2016 study that was published in the journal of Drug and Alcohol Dependence (Griswold, et al., 2018).

Dishonesty. Many recovering individuals lie about emotions like rage and bitterness. As a result, they might come up with justifications for not finishing duties or they might get irritated with people more readily. These emotions may cause someone to relapse into substance misuse.

***Self-Pity*.** The inability to go out with friends to the bar or to parties may disappoint those in recovery. Being self-critical or concentrating on bad situations might be risky because they can trigger relapses (Moos & Moos, 2006).

Relapse stages

Emotional Relapse. You have given a good description of emotional relapse, which is a stage of relapse where a person's ideas, feelings, and actions lay the foundation for a future relapse even if they may not intend to do so. Internal conflicts and behaviour patterns associated with emotional relapse raise the possibility of resuming substance use. Isolation, skipping

meetings, concentrating on other people's problems, and changes in sleeping or eating routines are just a few of the warning signals you noted. These actions and feelings may create a state of vulnerability where relapse is more likely.

The two goals you listed are crucial for preventing emotional relapse. The necessity of preserving one's physical and emotional health as a component of the healing process is emphasised in self-care education. This entails using constructive coping strategies, controlling stress, and getting help when required. Understanding the need of self-care helps people better guard themselves against the development of relapse. Helping patients identify their denial is the second goal, and it is essential for raising awareness and taking preventative steps to avoid relapse. People who are in denial may not be able to recognise the warning signs and may be less motivated to respond. Denial needs to be addressed, and self-reflection is encouraged so that people can become aware of their vulnerability and make decisions to avoid relapsing (Zaidi, 2020).

In general, identifying the symptoms of emotional relapse, encouraging self-care, and addressing denial are important facets of relapse prevention initiatives, giving people the skills and encouragement need to continue their recovery journeys.

Mental Fallback. During a mental relapse, the patient feels an internal conflict between the want to stop using and the desire to remain abstaining. Some signs of a mental relapse are craving a substance, having thoughts about people, places, or things related to past use, exaggerating the positive effects of past use and/or downplaying the negative effects, lying, bargaining, trying to plan ways to use while still in control, looking for relapse opportunities, and planning a relapse.

In this stage, healthcare professionals support patients in recognising and avoiding situations that could lead to a physical relapse. Participants in this stage may experience a noticeably elevated risk of a physical relapse at special events, such as a social gathering,

holiday, or trip, when they may employ mental bargaining to justify their usage. Early in their recovery, some patients could have irrational expectations because they believe they would never again consider using or relapse. Providers must emphasise that fleeting thoughts of using or cravings are common during the recovery process in order to help the patient build the skills necessary to overcome these barriers (Brownell, Marlatt, Lichtenstein & Wilson, 1986).

Physical Receding. The final stage of relapse occurs when a person starts using drugs once more. A "lapse" (the initial use of the substance) and a "relapse" (the continued use of the substance) have been distinguished by certain researchers. This distinction, however, may be detrimental to some individuals because it allows them to downplay the impact of a mistake. The DSM criteria state that most people with substance use disorders have trouble controlling their consumption, making it likely that one drink, for example, will turn into many more if the issue is left unattended. With sustained use, a first lapse might potentially lead to a bigger preoccupation.

When a person thinks their usage will go unnoticed, physical relapses frequently happen. Providers who work with patients in the early stages of rehabilitation must make sure they have the knowledge and abilities to identify these high-risk scenarios and refrain from utilizing (Guenzel & McChargu, 2023).

It has long been understood that addictive disorders are chronic and recurrent (Brandon, Vidrine, & Litvin, 2007). Recent estimates from clinical treatment trials suggest that more than two thirds of patients relapse within weeks to months of beginning therapy (Sinha, Garcia, Paliwal, Kreek & Rounsaville, 2006; Paliwal, Hyman & Sinha, 2008; Hyman, et al., 2008). Studies on 1-year ou tcomes for alcohol, nicotine, weight, and illicit drug usage show that more than 85% of patients relapse and resume drug use within a year of treatment (Brandon, Vidrine, & Litvin, 2007). Data gathered over a 1-year period from 878 individuals were used to examine the percentage of patients who were abstinent upon release from a significant,

publicly funded, Yale University affiliated addiction treatment facility in the New Haven, Connecticut, area. The results of the study showed that recurrence rates increased after one year. The outcomes of addiction relapse can be improved by understanding the mechanisms that increase the likelihood of relapse, identifying sensitive and specific biomarkers for relapse risk, and developing therapies that specifically target relapse risk. These results are in line with earlier observations on relapse rates. The cognitive element of one's self appears to be one of the most important aspects in relapse risk.

Impairment of cognition and vulnerability to relapse. Drug addiction encompasses a variety of behavioral changes, including executive functioning deficits. In fact, changes in the way people make decisions about costs and benefits have been canonically linked to a variety of addictive disorders, such as addiction to alcohol, cocaine (Verdejo-García, Perales & Pérez-García, 2007) amphetamine, heroin and alcohol addiction (Kovács, Richman, Janka, Maraz & Andó, 2017), as well as polysubstance use and gambling disorder (Grant, Contoreggi & London, 2000; Cavedini, et al., 2002; Goldstein & Volkow, 2011; Janke van Holst & Schilt, 2011; Power, Goodyear & Crockford, 2012). Decision-making issues have been linked to drug relapse after drug abstinence (Brewer & Potenze, 2008), and failing to learn the best strategy for a laboratory test like the Iowa Gambling Task (IGT) has been linked to treatment dropout (Stevens et al., 2013; Wang, et al., 2013).

Stress and relapse susceptibility. In the majority of models for addiction relapse, psychosocial stress is either the primary or secondary factor taken into account. Although there has been conflicting empirical evidence regarding the link between personally experienced stress and relapse into drinking (Allan & Cooke, 1985; Kassel, Stroud, & Paronis, 2003), more recent research suggests that personally threatening and persistent life stressors increase the risk of relapse. According to the stress-vulnerability theory (Brown et al., 1995), the presence or absence of risk and protective factors influences whether or not people drink or use drugs

when under intense stress. These risk and protective factors work together to determine a person's psychosocial susceptibility to relapse into addiction. It has been proven in several earlier investigations that stress results from a lack of self-integration (Linehan, 1993). People who struggle to concentrate or integrate all of their identities may have less coping mechanisms, making them more susceptible to stress, which leads to undesirable behaviors like drug abuse.

This risk of relapse elevates drug addiction to a serious issue. Because drug addiction also has serious psychological implications in addition to its physical ones. Additionally, it is evident that the person would physically and psychologically collapse if they repeatedly relapsed.

Outcomes of Addiction to drugs

Drug effects vary from person to person based on the drug's nature and the environment in which it is consumed. The majority of drug use is linked to poor memory and impaired coordination. Some medicines significantly slow down a person's reaction time and concentration. The usual side effects of medications include some bodily changes such elevated blood pressure, heart rate, fever, red eyes, dizziness, and slurred speech (Milkman & Sunderwirth, 2010).

Drug dependence is characterized by depressive symptoms, sleepiness, disorientation, and slurred speech. Drug addicts who use hallucinogen-like substances experience delusion, hallucinations, and paranoid thoughts. Additionally, euphoric, irritable, restless, rapid-speaking, and even panic attack symptoms might be brought on by drugs (Boseley, 2006).

Drugs that contain painkillers can help people with pain symptoms when they are taking those drugs. However, a significant portion of substrates used in the production of addictive medications are currently disregarded as having no medical value and cannot be obtained over-the-counter or with a prescription (American Society of Addiction Medicine, 2001).

Drug addiction is a psychological condition that has a profoundly negative impact on a person's physical and mental well-being. It seriously impairs a person's entire personality. It has an impact on not only the physical but also the social and psychological aspects of life. Additionally, it causes a great deal of stress in a person's life because addicts must deal with social attacks on their personalities. Since no one will relate to them, their relationships are warped. These guilt and shame feelings interfere with their psychological adjustment. Drug users' lives and personalities are significantly impacted by psychological issues including sadness, anxiety, psychosis, and stigma as well as physiological issues like nausea, diarrhea, muscle aches, respiratory issues, cancer, and sexual dysfunction. The psychological, social, and emotional components of their lives deteriorate over time as a result of drugs' long-lasting effects on a person. Without seeking treatment, a person may experience serious psychological maladjustment.

Psychological Adjustment

Adjustment, in the words of McKinney (1960), is "the development of traits and understanding that enables us to meet our personal needs effectively and overcome the frustration or blocks to satisfaction over a period of time." A person cherishes their current skills and gets over physical losses when adjusting (Wright, 1983).

The idea of adjustment has changed with human evolution, and humans are more able than any other living thing to adapt to new circumstances. A person who is in good emotional and behavioral health and who fits well into his or her surroundings, abilities, and habits is said to be well-adjusted. The inference is that each person is engaged in a complex, continuing process of realizing their full potential while responding to and positively altering their surroundings (Gul, 2008).

For mental health, which assures the highest level of mental acuity, psychological adjustment is essential. A person with good adjustment leads an organized existence in which

all of the essential activities of daily living are so regularly scheduled that a significant amount of energy is freed up for more significant and worthwhile endeavors. The best possible performance of mental talents depends on psychological adjustment, which is a requirement for mental health. According to Dhaliwal (1977) and Sabir (1999), well-adjusted person organizes his daily life activities in a worthwhile manner.

Literature Review

Addiction to drugs, psychological adjustment and integrated self

Psychological adjustment has a bad link with drug addiction. A study was done to look at cannabis use's developmental patterns and how they relate to eventual psychological adjusting. According to research, long-term cannabis usage that begins too young is linked to psychological maladjustment. Those who don't use the drug report having the best psychological health (Kerstin, Judith, & Jonathan, 2011).

There are a number of factors that could be to blame for the connection between drug usage and psychological functioning. Problem behavior theory suggests that there may be an underlying element that predisposes people to behavioral issues (including substance use) and poor psychological adjustment. Thus, a widespread spectrum of adjustment issues, including drug use, deviant behaviors, and psychological maladjustment, would have a common etiology shared by "high-risk" individuals. According to Donovan, Jessor and Costa (1991), Fergusson and Horwood (1997), Degenhardt, Hall and Lynskey (2003), it's also plausible that other complicating issues, such as familial dysfunction, may be the root of both drug use and subsequent psychological adjustment.

Another explanation is that lower levels of psychological adjustment lead to drug usage. In particular, those with psychological maladjustment might be more likely to use drugs, perhaps in an effort to lessen their psychological symptoms. The majority of long term studies,

however (Bovasso, 2001; Macleod, et al., 2004), have not backed up this idea of self-medication.

The principal expenses of substance addiction come from substance users' lower usage of mental and physical health services. Significant number of people cite a lack of health insurance as a major deterrent to seeking treatment, and once in treatment, this attitude can prevent patients from receiving the best care (Rasinksi, Woll & Cooke, 2005; Ahern, Stuber & Galea, 2007; Luoma, Waltz & Hayees, 2007; Skinner, Feather & Roche, 2007). Service providers frequently have demeaning attitudes toward addicts.

In addition to these ideas, integrated self also contributes to the understanding of why people frequently choose drug abuse. An explanation of the integrated self can be found in studies on drug abuse behavior, relapse vulnerability, and the psychological adjustment of drug addicts.

According to Wildgoose, Clarke and Waller (2001), personality fragmentation—an unstable and erratic sense of self—is a key factor in drug-related disorders. Patients with substance use problems had a much higher amount of fragmentation than the non-clinical group, according to Pollock et al. (2001). High degrees of fragmentation were found to be positively associated with many facets of psychological maladjustment in their investigation.

Treatment Interventions

According to Substance Abuse and Mental Health Services Administration, addiction is a complex condition that can affect many parts of a person’s life. Only 2.5 million Americans obtained specialized substance use treatment in 2017, despite an estimated 20.7 million Americans needing treatment for substance use disorders (McCance-Katz, 2018).

Individualized approaches to treating addiction are necessary in order to address the disease's signs, symptoms, and underlying causes as well as the effects that substance abuse has on various facets of a person's life. Their social skills, physical and emotional well-being,

and consequences at work, home, school, or with the law are all included in this (Rehm, Fuentes-Afflick, Fisher& Chesla, 2012). The first ever treatment to lessen the negative effects and withdrawal symptoms is detoxification. There are many different types of therapy available to properly treat addiction.

Drug addiction is a severe mental condition that must be addressed for a person to be able to function normally. Treatment for drug addiction is more challenging than for other disorders since it is associated with a variety of psychological and physiological problems. When drug use is abruptly halted, the user will experience withdrawal symptoms, which can occasionally be fatally severe. Treatment for addiction is slow. First, medications are used to remove the effects of drugs from the body, and then further medications are administered to treat withdrawal symptoms. Detoxification is the first phase in addiction therapy, which is carried out for the benefit of the patient so that he would have fewer withdrawal symptoms (Arnold & Hulse, 2005).

Detoxification. Hazardous substances are eliminated physiologically or medically from a live creature, including but not exclusively the human body. Additionally, it can be used to describe the period of withdrawal that follows a protracted use of an addictive substance, during which the body returns to homeostasis. In medicine, detoxification can be accomplished through the removal of ingested toxins, the administration of antidotes, as well as techniques like chelation treatment and dialysis (Online Dictionary, 2013).

It can refer to a variety of things, such as the treatment of acute drug overdoses, the experience of withdrawal syndrome, and the intervention in cases of physical drug dependence. A physical dependence detoxification programme may not necessarily address social factors, psychological concerns, frequently complicated behavioural problems, or the history of addiction

Process steps for drug detoxification. *Evaluation*: Before starting drug detoxification, a patient is tested to identify the exact chemicals that are now present in their bloodstream and the quantity present. Clinicians also assess the patient for possible dual diagnoses, mental/behavioral problems, and co-occurring illnesses.

Stabilization: During this phase, the patient is assisted as they go through the detoxification process. This can be done with or without medicine, but the former is typically more popular. Educating the patient about what to expect during the course of their treatment and recovery is another aspect of stabilization. When necessary, family members of the addict are brought in at this point to get involved and offer support (Connock, Juarez & Jowett, 2007).

The final part of the detoxification process is to prepare the patient for the actual recovery process. This is done by guiding them into treatment. Drug detoxification does not treat the psychological aspects of drug addiction because it solely addresses physical dependence and addiction to substances. Getting the patient's consent to join in a drug rehabilitation program is a requirement of this stage. The U.S. Department of Health and Human Services said in 2006 that managing a substance use disorder can be challenging due to the withdrawal symptoms of fast detoxing substances, which are typically unpleasant and can last for days. While the addict is asleep, some medical professionals use "rapid" or "ultra rapid" detoxification treatments to cut the withdrawal process to just two hours. Rapid detox proponents assert that patients who receive therapeutic drugs like naltrexone while sedated may avoid the excruciating pain associated with such treatments and skip the most unpleasant parts of withdrawal. The medicines can be quite expensive, and critics respond that safety has not been thoroughly established. Anaesthesia patients regularly had withdrawal symptoms when they awoke from their anaesthesia, had a similar study dropout rate (approximately 80%), and some anaesthesia patients encountered major medical issues, according to a clinical trial on "ultra rapid detox" for heroin users. The study contrasted anesthesia-assisted opioid

detoxification with buprenorphine- or clonidine-assisted opioid detoxification. Another 2005 study compared (fast) clonidine-naloxone precipitated withdrawal while under anaesthesia to clonidine-assisted detoxification and discovered no changes in the duration or severity of pain or withdrawal symptoms. They also observed no differences in drug seeking. Additionally, it discovered that oral naltrexone compliance levels were high and that heroin abstinence continued for four weeks after detoxification (Collins, Kleber, Whittington & Heitler, 2005).

Short-term opioid detoxification was determined to be the most effective technique of drug abstinence, but long-term success rates of ongoing therapy were lower. A review of 13 Australian drug treatment trials revealed that methadone maintenance therapies were more cost-effective and that patients were more likely to stick with them (Johnson, Chutuape, Strain, Walsh, Stitzer & Bigelow, 2000; Sydney Morning Herald, 2005).

The core issues that are pushing the person to use drugs as a stress reliever and other elements must be reduced in addition to the severe physical symptoms of drug addiction.

Many forms of therapy. A combination of group and individual therapy sessions are typically used as part of addiction treatment. These sessions aim to teach people in recovery how to become and remain sober as well as how to handle a variety of situations without using drugs or alcohol.

Behavioural therapy. It is arguably the most common therapeutic approach used during drug rehabilitation. From a general behavioural treatment method, several effective treatments have been created (NIH, 2012). These include Cognitive Behavioural Therapy (CBT). A number of problematic substance use patterns can be treated with CBT. Patients who receive CBT techniques are taught to recognise and change their dysfunctional behaviours. By learning coping skills, identifying problematic situations and knowing how to handle them, as well as preventing relapse, CBT can help people. This tactic has a benefit because it can be combined with other techniques. The benefits of CBT continue long after the primary therapy has

completed since it can be utilised to address co-occurring mental or physical health disorders as well (Dobson, 2009; NIH, 2012, McKee, 2017).

Numerous large-scale trials and quantitative evaluations have provided evidence for the efficacy of CBT in treating alcohol and drug use issues (Dutra et al., 2008; Magill & Ray, 2009). At the 52-week follow-up in a study of psychosocial treatment for cocaine dependency, 60% of patients in the CBT condition had clear toxicological screenings, according to Rawson and colleagues (Rawson et al., 2002). The notion that treatment effects persist over time is supported by this data (Carroll et al., 1994).

Contingency Management (CM). A range of substance use disorders, including those brought on by alcohol, opioids, marijuana, and stimulants, may be treated with the help of CM, which is used to encourage or maintain sobriety. This tactic provides concrete incentives to promote desired behaviours, such as maintaining sober. One of CM's key benefits is its capacity to lessen the two main treatment-related issues of dropout and recurrence (NIH, 2012).

Numerous clinical investigations have shown the efficacy of CM for a range of drugs, including alcohol, cocaine, and opioids (Petry, Martin, Cooney & Kranzler, 2000; Higgins, et al., 2000; Petry & Martin, 2002). Meta-analytic analyses (Prendergast et al., 2006; Dutra et al., 2008) found that effect sizes for CM's efficacy across studies are in the moderate range, with some substances (opioids, cocaine) exhibiting greater efficacy than others (tobacco, polydrug use). Researchers have explored the use of lottery-style distribution methods for reinforcers to boost the efficiency of CM systems. For instance, the "punchbowl method" (Sindelar, Elbel & Petry, 2007) offers prizes from a "punchbowl" that can be drawn in exchange for drug-free testing; the majority of prizes have low monetary values, but the inclusion of more uncommon large prizes both saves money and effectively encourages abstinence. In CM techniques, stable or rising reinforcement schedules may be used, where the value of the reinforcer rises as the period of abstinence lengthens (Stitzer & Petry, 2006). With the help of CM techniques,

adaptive behaviours like prenatal visit attendance and medication adherence, as well as contingencies linked to unfavourable drug tests, have been successfully modified (Elk, Mangus, Rhoades, Andres, & Grabowski, 1998; Carroll, et al., 2001).

A relative limitation of CM is the availability of funds for providing reinforcers in clinical settings (DeFulio, Donlin, Wong, & Silverman, 2009).

Motivational Interviewing, or MI. Before selecting a course of treatment, it is important to consider the possibility of adherence to the regimen and the patient's motivation for therapy. To overcome barriers to motivation for change, motivational enhancement interventions have been created and tested (Miller & Rollnick, 2012). Motivational interviewing (MI) is an approach that targets ambivalence towards behaviour change relative to drug and alcohol use in order to increase motivation and adherence to a wide range of other disorders and behaviours, including increasing adherence to CBT for anxiety disorders (Westra, Arkowitz & Dozois, 2009; Merlo et al., 2010). Treatments based on the MI model are applied in both stand-alone interventions and combinations with current SUD treatment modalities. A meta-analytic examination of interventions based on MI identified effect sizes across trials in the small to moderate range for alcohol and the moderate range for drug use, and similar efficacy to active treatment comparisons. These effect sizes were in comparison to a placebo or no-treatment control group. Although there are times when group formats are employed, MI is typically given in an individual context and frequently comprises of just one, extremely brief treatment session. The effectiveness of the treatment may increase with a higher dosage (Burke, Arkowitz, & Menchola, 2003). MI is a method for overcoming ambivalence, assisting persons in recovery to embrace their treatment initiatives and most successfully alter their problematic substance use behaviour. One benefit of MI is that people in recovery develop their motivation and change plan over the course of many sessions, providing them a greater sense of control

over the course of their treatment (NIH, 2012). This is true even though their therapist encourages them to do so.

Dialectical Behavior Therapy or DBT. Although DBT can be applied to a variety of substance addiction situations, it primarily targets severe personality disorders such as borderline personality disorder (NIH, 2012). According to Dimeff and Linehan (2008), DBT helps patients with craving reduction, relapse prevention, action cessation, and the acquisition of healthy coping mechanisms.

Critical behavioral skills are taught by DBT therapists through modeling, instruction, storytelling, practice, feedback, and coaching (Linehan & Wilks, 2015). DBT does this via a number of tools and strategies, like as Mindfulness. The cornerstone of DBT treatment is mindfulness, which is essential to all other skills. People study and put into practice the art of being present. People who have mastered the art of observing what goes on inside—their feelings, thoughts, sensations, and impulses—as well as tuning into their senses and the environment around them can more successfully slow down and concentrate on good coping mechanisms during pain.

Relationship effectiveness. Interpersonal effectiveness strives to repair, maintain, and build good relationship behaviors, which also involves stopping harmful ones, since many DBT patients deal with problems in their relationships. This tactic includes assertiveness training to assist people in setting and enforcing boundaries with others and communicating clearly.

Emotional control. This method focuses on recognizing, naming, and altering an emotional response's detrimental repercussions. Therapists assist patients in having more good emotional experiences by teaching them to detect and manage strong negative feelings and develop an opposite action.

Tolerance for stress. This part of DBT explores and teaches people how to tolerate discomfort and accept unpleasant feelings. The application of acquired strategies, such as

diversion and self-soothing techniques, empowers people experiencing distress or crisis to manage with powerful emotions with a more positive, long-term attitude (Flynn, et al., 2019).

DBT has been examined to date in nine published randomized controlled trials (RCTs) carried out at five research organizations. The findings demonstrate that DBT is effective in lowering a variety of behavioral issues, including substance abuse (Linehan, et al., 2002). In one study of women with BPD and co-occurring substance use disorders, those who underwent DBT demonstrated decreases in substance abuse over the course of a year of treatment (and in the 4-month follow-up) and dropped out of treatment less frequently than those who did not undergo DBT (Chapman, 2006).

Rational Emotive Behavior Therapy or REBT. With the aid of REBT, patients can better understand their own ideas, create better coping mechanisms, think more logically and constructively, and experience healthier emotions. The premise of REBT is that feelings of happiness or unhappiness are not caused by external circumstances; rather, rational thought originates from inside (NIH, 2012).

The most popular type of drug abuse treatment is behavioral therapy. Using appropriate coping mechanisms, identifying triggers and maladaptive thinking, and maintaining sobriety are all possible with behavioral treatment (Ray et al., 2020).

REBT is sometimes used by therapists and other healthcare professionals to treat a range of mental health issues, including addiction (Omeje et al., 2018). The effectiveness of REBT in the treatment of SUD has only been briefly discussed in empirical research studies (David et al., 2018). However, research has shown that those who underwent rational emotive health therapy (REHT), a type of REBT, while receiving treatment for alcohol use disorder (AUD), showed a significant decrease in their frequency of alcohol consumption.

These outcomes were in line with other research showing that exposure to the REBT paradigm of treatment reduced psychological and behavioral disturbances. Rational emotive

health therapy has been shown to assist individuals in lowering their thoughts and sentiments related to alcohol consumption. There was evidence from the study that REHT assisted individuals in cutting back on their alcohol consumption (Omeje, et al., 2018).

Framework Model. The Matrix Model, which was initially created for the treatment of people with amphetamine addictions, combines a number of different therapy strategies. Therapists emphasize rewarding positive behaviors and teaching patients self-esteem, dignity, and self-worth against the backdrop of various strategies. The Matrix Model, according to the National Institute on Drug Abuse, is primarily focused on "relapse prevention, family and group therapies, drug education, and self-help participation" (NIH, 2012).

The concept has received support from numerous evaluations for its applicability and effectiveness with users of methamphetamine (MA). According to Obert et al. (2000), cocaine and methamphetamine addicts appear to respond to therapy similarly, and many continue to improve over time.

According to a study, cocaine addicts who participate in an intensive outpatient treatment approach see a significant, statistically significant, and clinically significant decrease in their cocaine use (Rawson et al., 1995).

According to research by Magura and colleagues (1995), individuals on methadone maintenance who abuse cocaine significantly reduce their usage of cocaine and crack as a result of this treatment strategy. The effectiveness of the Matrix approach has been compared to therapy in an inpatient chemical dependency program using amphetamine users as test subjects. The study's research shed light on the traits of stimulant addicts who would respond best to treatment based on the Matrix model (Castro, Barrington, Schackleton & Rawson, 1992).

Facilitating the 12 Steps. 12-Step facilitation therapy involves recovering individuals in 12-Step peer support groups in an effort to encourage prolonged abstinence. Numerous 12-

Step fellowship kinds, such as Alcoholics Anonymous and Narcotics Anonymous, host meetings (NIH, 2012).

121 people who had been diagnosed with alcoholism and other drug-related disorders participated in the study, and they were monitored for 12 weeks during therapy and 36 weeks after it. TSF recipients were more likely to attend 12-step programs. Furthermore, if taken into account in terms of dimensions, higher TSF participation was linked to better improvements in drug use, and higher 12-step participation predicted declines in drinking and substance use frequency and intensity (Bogenschutz et al., 2014).

Another study examined how much exposure to Stimulant Abuser Groups to Engage in 12-Step (STAGE-12), a 12-Step facilitative therapy, impacted treatment outcomes. At the beginning of the study, as well as 30, 60, 90, and 180 days after randomization, assessments were conducted. When patients with high exposure levels were compared to those with lower exposure levels, the high-exposure patients demonstrated: (1) higher odds of self-reported abstinence from and lower rates of non-stimulant drug use; (2) lower probabilities of stimulant-positive urines; (3) more days of attendance and lower odds of not attending 12-Step meetings; (4) greater likelihood of reporting no drug problems; (5) more days of duties at meetings; and (6) more types of 12-Step activities. Some of these differences persisted at the most recent follow-up, while others gradually lost their significance (Wells, et al., 2014).

All of the aforementioned therapies and techniques are more important than others for treating drug misuse and the symptoms that go along with it, but at a more advanced level, maintaining inner peace is essential for overcoming the problems that come with it. A balanced person is thought to experience fewer psychological and mental health problems.

As the focus of the current study is on various facets of the self, it would be more practical to offer psycho-spiritual therapy to drug users given that it has been previously discussed that drug users have fragmented or unintegrated selves that make them vulnerable to

relapse and, as a result, have poor psychological adjustment (Khalili, Murken, Reich, Shah & Vahabzadeh, 2002). Additionally, because addiction is also thought to be a spiritual disease, traditional Islamically Integrated psychotherapy would be more effective in treating drug addicts. Additionally, it would help them become more self-integrated.

Traditional Islamically Integrated Psychotherapy (TIIP). The dynamic approach of psychological care is called as Traditional Islamically Integrated Psychotherapy (TIIP). Since then, more research aimed at developing this paradigm has been done. The Khalil Center's interdisciplinary team of dual-trained professionals and research on psychological therapy by Islamic scholars led to the creation of TIIP. The TIIP model offers a framework for integrating contemporary behavioural research within a fundamentally Islamic context. The ontological and epistemological frameworks of Islam serve as the conceptual underpinnings of this approach.

The two types of techniques used in practise applications of this model are 1) inherently Islamic psychotherapeutic approaches that are motivated by the Qur'an, Prophetic Tradition, and the traditions of the scholars, particularly of the spiritual sciences of tazkiyah al-nafs such as muraqabah, dua, etc., and 2) adaptation and integration of mainstream interventions that are in line with the tenets of Traditional Islamically Integrated Psychotherapy (TIIP).

Traditional Islamically Integrated Psychotherapy (TIIP) has four main goals for the psychotherapeutic encounter: inkishaf (introspective self-discovery), inqiyad (fostering treatment compliance & motivation), itidal (equilibrium in all aspects of life), and ittihad (holistic integration). Interventions focus on the following elements of the TIIP ontological framework of the human psyche: According to Keshavarzi and Haque (2013), these are (a) aql, or intellect, (b) nafs, or behavioural inclinations, (c) ruh, or spirit, and (d) ihsas, or emotions.

Rationale of the Study

Drug addiction is a severe psychological condition that has a significant negative impact on a person's overall wellbeing and all facets of their life. A system of treatment and rehabilitation for drug users is necessary through which their overall functioning can be improved and a harmony among all aspects of life can be attained. It is important to consider how Islamic integration could be advantageous for the health of drug addicts because it is a developing problem in Pakistan and since it is a Muslim nation, religious and spiritual components should be taken into account for the betterment of these people. This study's findings may make it possible to incorporate religious activities into therapy sessions to help clients psychologically adjust.

In Islam Health is not considered just as an alleviation of disesases from body instead a person is considered healthy if he has aligned with his Fitrah. Addiction is also adisease, which is thought to be occur because of a separation from God, that is deviation from his Fitrah. This separation causes people’s suffering because they fail to live according to the God’s will or direction. Therefore, recovery consists of establishing or reestablishing a connection with God or a higher power. TIIP will help clients in their spiritual growth.

The main objective of this study is to lessen the negative social and psychological effects of drug addiction by using an intervention strategy with an Islamic focus to avoid relapse in drug users. This ongoing research aims to establish a foundation and understanding of the components that make up the complex, multiple situated selves that make up human identity. In order to prevent drug relapse and its detrimental effects on both the long-term mental and psychological health of an individual and the health of society, this study places a greater emphasis on self-integration. We can see from recent studies (Muhammad, Omar, Thoalim, & Mohamad, 2019) that the majority of researchers solely paid attention to drug addiction

prevention. However, little research has been done on how it relates to an integrated self and how an integrated self can be achieved through the use of an integrated Islamic intervention.

According to the integrated self concept, a person should be in good bodily, cognitive, emotional, and spiritual health because these are all intertwined and influence one another. If a person wants to have good psychological health, they must take good care of each of these factors. Human personality is a result of his sublime ideals and thoughts. Human thought is crucial for maintaining mental wellness. Positive thinking helps people overcome obstacles and transforms their fate. Positivity aids in reaching the pinnacle. A human person is made up of a variety of characteristics and requirements. The being will remain in balance if his or her physical, biological, intellectual, emotional, and spiritual requirements are all met; nevertheless, if these needs are not met, the person will also become out of balance. The key to beauty is balance; when it's off, everything seem ugly. Similar to this, when a person's personality is in balance, he or she will be in good mental health; otherwise, they would be in bad mental health (Khalili, Murken, Reich, Shah & Vahabzadeh, 2002). The exterior skeleton, or body, which is made up of body parts, flesh, and blood, is one of two separate elements that Allah gave to man. The other is your inner self, which consists of your soul, Qalb, and Nafs. Desires, lust, and greed have taken root. The governing principle of flesh and blood is nafs. While the soul, which vibrates a man inwardly, is incomprehensible. The soul is the lifeblood of Nafs, whereas Nafs is the lifeblood of the human body. (Inayat 2005). So it is necessary to take the time to research how such actions can be influenced by the Integrated Self.

Each individual has the capacity to develop their integrated self's abilities. But each person has developed a different degree of an integrated self. According to the "use it or lose it" principle, the integrated self may develop as its functions are employed more frequently and productively. Additionally, people may have more access to their analytical ego than their holistic selves, and the integrative self's abilities may be hampered by elements like negative

emotions or stress. In today's ego-driven media milieu, the conceptual self is frequently celebrated more than the entire self. Therefore, it appears to be more and more important to offer chances for holistic self-development. It would be essential to think about how to effectively support self-development in various life circumstances in order to do this (Deci & Ryan, 2000).

Every Muslim aspires to be conscious of how they operate and to reach the state of tranquility and peace that can only be attained by leading a disciplined life in devotion to God.

A scale is needed to get insight into one's component of self, including how it is operating, if it is balanced or aligned with all other aspects, and whether the person is focused on or controlling any one aspect more than the others. And because there has never been a scale created to evaluate one's own functioning, this study will be very helpful in developing such a scale.

Conceptual Framework

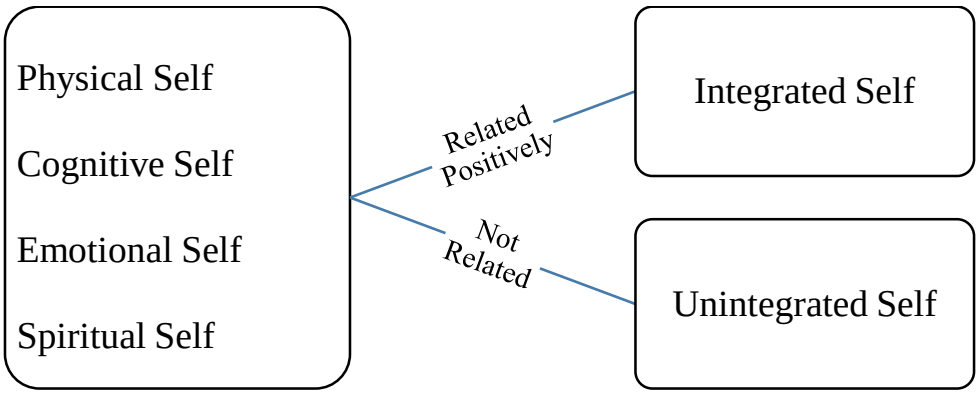


Figure 1

Study I: Scale Construction

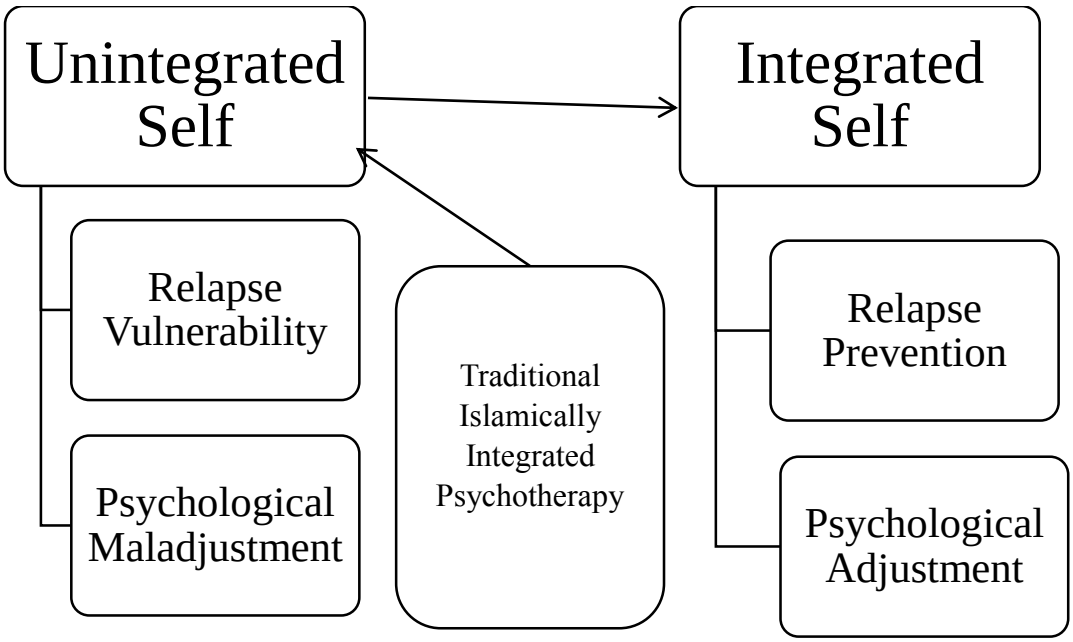


Figure 2

Study III: Phase II Main Study

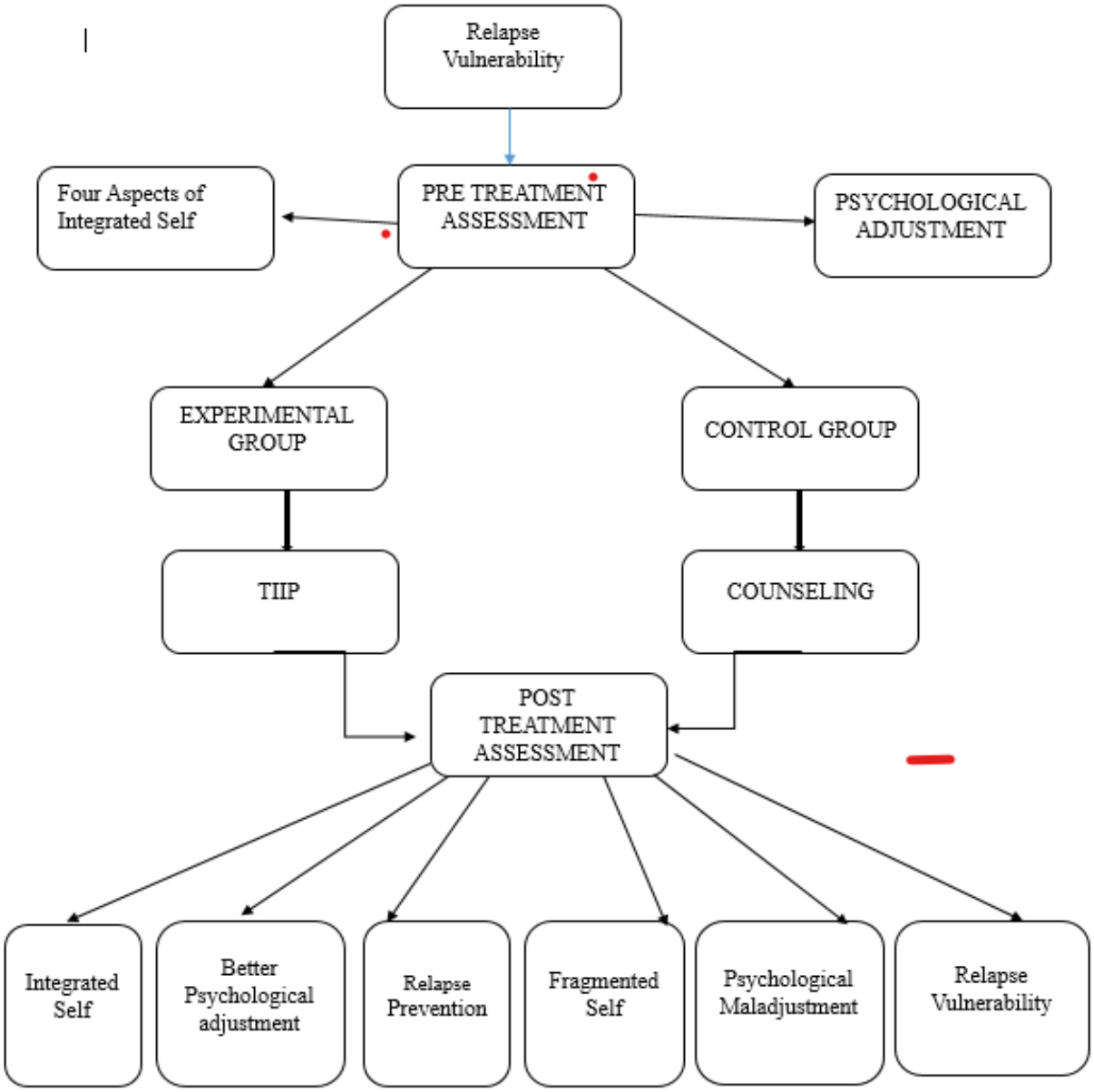


Figure 3

Main study: Sample distribution and procedure

Chapter 2

Method

The present study was comprised of following four parts

Study I: Construction of Integrated Self Scale

Study II: Translation of an Intervention

Study III: Main Study

Study I: Construction of Integrated Self Scale

In study I a scale was constructed and standardized procedure was employed in development of scale. First of all a construct was defined and refined and after certain focus group discussions an item pool was generated. Initially a large pool of items was generated and afterwards some items were supposed to be redundant with respect to its clarity and structure. Afterwards committee approaches were done in order to further purify the items and on the basis of committee approaches some more items get discarded. After the committee approach a scale was administered to a small sample n=20 as a try out to check the language difficulty and any other confusion related to the construct. In try out some more items get deleted. Now the 100 items scale was administered to a large sample that was 404, comprised of both males and females and some drug addicts were also the part of this administration. Retained items were gone through Exploratory Factor Analysis and some more items were discarded. At the end 70 items retained in the final version of Integrated Self Scale. Through factor analysis the scale gets distributed in four factors which were named as Physical, Cognitive, Emotional and Spiritual Self. The number of items in each factor were 14, 18, 18 and 20 respectively.

The 70 items Integrated Self Scale was then analyzed for reliability and validity measures. Psychometric properties established show that the newly constructed scale is a reliable measure having good internal consistency and have a valid construct.

Study II: Translation of Traditional Islamically Integrated Psychotherapy

Study II was comprised of translation and validation of Traditional Islamically Integrated Psychotherapy. This study comprised of 2 phases. In phase I a translation was done. The main emphasis in doing so was to make an Intervention able to be used with less educated individuals who are unable to understand English language. For translation all required steps were gone through. Description of therapy and techniques were first translated into Urdu language which was done by subject experts. After translation a committee approach was done in order to check the feasibility and accuracy of language. The translated version was then back translated into English language in order to attain equivalence between both versions. To gain the conceptual and linguistic equivalence between both version an expert panel was made. By examining the translated and original items it was determined that translated version is also conveying the same concept and meaning. Afterwards a try out was done by applying the translated version on a small sample of clinical and general population.

Study III: Main Study

In study III, in phase I a sample was recruited and selected for main study. For this purpose, Integrated Self Scale, Relapse Vulnerability Scale and Psychological Adjustment Scale were administered to a large sample of 400 individuals, among which 200 were drug abusers while 200 were taken from normal main stream population. The drug addicts were approached through purposive convenient sampling technique and only those drug addicts were included in study who already have received the initial treatment so that they may have completed their detox period. The normal individuals were only taken to make comparisons in patterns of functioning of self with drug addicts. Among 200 drug addicts 40 were selected on the basis of their Self Integration. The addicts who scored poor on Integrated Self Scale were recruited for phase II of this study.

The selected sample was randomly distributed to an Experimental and Control group. After the distribution of sample, a pretreatment assessment was done and all instruments which were used in phase I were employed. The treatment group was then provided with the techniques of TIIP by the researcher while the control group received the general counseling provided by the psychologists present in rehabilitation centers. The number and duration of sessions for both groups were same. After the completion of all sessions a termination session was conducted in which all participants were advised to follow the guidelines provided during sessions in order to stay sober outside the therapy. Afterwards, a date was communicated to them on which post treatment would occur and they were instructed to follow the schedule.

On the decided date the participants of both experimental group and control group, were assessed again and then comparisons were made between pre and post assessments. They were again instructed to visit the rehabilitation center for follow up session.

After 1 month follow up sessions were done, in which only 12 drug addicts from experimental group participated. A semi structured interview was conducted in order to determine their current condition and also to assess the efficacy of TIIP. Content analysis was done and the themes were identified which showed the intervention worthwhile in alleviating their drug using behavior and associated issues.

Chapter 3

Study I

Objectives

The objectives of the present study are as follows:

1. To construct a scale to measure four aspects i-e Physical, Cognitive, Emotional and Spiritual aspect of Integrated self.

2. To validate the Integrated Self scale.

This study consisted of the two phases mentioned below:

Phase I: Integrated Self Scale construction

Phase II: Establishing psychometric Estimates of Integrated Self Scale

Phase III: Validation of Integrated Self Scale

Phase- I: Scale Construction: Integrated Self Scale. The scale construction was done by employing a standard procedure, which is described below:

***Step 1: Defining and Refining the Construct*:** Through brain storming a construct of the self was defined and a theoretical framework was developed. The construct was further cultured by decreasing ambiguities, contamination and deficit. Integrated Self Scale was developed by examining previous literature (Keshavarzi & Haque, 2013; Khalili, Murken, Reich, Shah & Vahabzadeh, 2002) and through consultation by Subject Matter Experts (SME) on Integrated Self and several self-related scales i-e self-Concept Questionnaire, Personal Self Concept Questionnaire and scales related to self Esteem.

***Step 2: Item Generation*:** Construct based approach was used for the construction of Integrated Self Scale. The basic aim was the utility of theoretical approach in the development of scale and the scale must retain good internal constancy and there must be a minimum chance of scale overlays.

Focus group discussion

Four focus group discussions were conducted to establish the item pool for the study. The first discussion centered on the Physical Self and involved seven participants, comprising three Ph.D. scholars, three psychologists, and one medical doctor (MBBS). Subsequently, the second focus group, which comprised three Ph.D. scholars, three psychologists, and one psychiatrist, deliberated on the Cognitive Aspect of Self. In the third focus group, which included the same composition of participants as the second group, the Emotional Aspect of Self was the focal point. The fourth focus group focused on the Spiritual Aspect of Self, involving Ph.D. scholars, psychologists, and a religious scholar. Each aspect of self was thoroughly explored in its respective focus group discussion. Semi-structured interviews were then conducted with all participants to delve deeper into their perspectives. Following the discussions and interviews, themes were identified, and items related to these themes were generated for further analysis.

In addition to the the focus group discussions, previous literature was also pretty profitable in developing an item pool for the current scale. In total 157 items were generated at first which were related to the main construct of the scale.

Step 3: Committee Approach: A Committee was established in order to further refine and narrow down the pool of items. A committee consisted of four individuals including researcher herself and members were related to the field of psychology in any way. All items were discussed one by one from which few items were rearticulated and some were amended slightly so that they can become more comprehendible. While some items were discarded in order to avoid overlapping and misinterpretation. And after this only 130 items were retained.

Step 4: Try Out*:* Initially a small sample (N=20) was selected for administering Integrated Self Scale (ISS). It was done for checking the language difficulty i-e whether

respondents were facing any difficulty in responding the answers or not and to see if there is any repetition of items.

After taking in view the suggestions and opinions given by panel of experts, 30 more items were discarded and Integrated Self Scale got its first version. This step was done in order to check whether Integrated Self Scale is carrying the best meaning or not. And if it is logical and comprehensible for the target sample or not. The Integrated Self Scale comprised of 100 statements. New measure is a four point likert scale with the possible answers 1 = Disagree 2 = Disagree to some extent, 3 = Agree to some extent, 4 =Agree. Psychometric properties were determined afterward.

Step 5: Administration of questionnaire: The scale was then presented to an appropriate sample in order to probe about psychometric properties of newly constructed measure. An already established measure was also administered along with this new measure. It was done in order to evaluate the dissimilarity or overlap among the newly established and already existing scales. For this purpose that scale has been used with which the new scale was theorized to be powerfully associated to examine the convergent and criterion-related validity. Besides, data from current measures has been used for primary and initial examination of construct and criterion-related validity of the new scale.

Participants

In 2nd Phase, a sample (N = 404; men = 202, women = 202) in which 384 were normal individual whereas 20 were drug addicts, was recruited through applying purposive convenient sampling technique. The minimum age of sample was 15 years while maximum was 65 years (M =31.69, SD =9.96). Minimum level of education for individuals to be a part of sample was primary level that is 5 years. It was also verified that individuals participating in study must not suffering from any sort of psychological disorder.

Instruments

Integrated Self Scale. Integrated Self Scale is 70 items instrument. Factor analysis identified only 4 factors instead of multiple factors. Factor I "Physical Self" consisted of 14 items, factor II "Cognitive Slfsisted of 18 items, factor III "Emotional Self" consisted of 18 items while the factor IV "Spiritual Self" consisted of 20 items. Cronbach Alpha Reliability of subscales is .66, .87, .83 and .92 respectively. The scoring of the Scale was done on 4-point likert scale ranging from 1 = Disagree, 2= Disagree to some extent, 3= Agree to some extent, 4= Agree. Only 2 items were reverse scored.

Six Factors Self Concept Scale: An Urdu translated and validated version (Mir, 2015) of the Six Factor Self Concept Scale was used in the present study. This version entailed two subscales, Positive self-orientation & Vulnerability or Negative Self-concept. This scale was used for the purpose of validating the newly constructed Integrated Self Scale. The SFSCS consisted of 36 items, some items were negatively worded. The scale is 7 point Likert-type response format. Total score obtained by adding scores of subscales. SFSCS and its subscales were found reliable and showed good internal consistency.

Procedure

The data was collected through delivering the scale to the sample. But prior to this an informed consent was taken by respondents. General instructions about scale were given to the respondents and they were asked to complete the scales at their ease with honesty. They were also instructed to make it sure that no item left without response. There was no limited duration for the completion of scales, and they can take as much time as they require. After collecting the desired data, scores were computed and further analyzed for results.

Phase II: Psychometric Estimates of Integrated Self Scale

Assessment for the Internal Consistency: After establishing the unidimensionality a reliability can be measured (Gerbing & Anderson, 1988). Although there are pretty some ways

through which reliability of the scales can be assessed, but the most accepted way is Cronbach's alpha in field studies for gauging the scale's internal consistency. The basic purpose to measure reliability is to check whether all items are measuring the same construct or not (Price & Mueller, 1986). After conducting the exploratory factor analysis and deleting all "bad" items, the internal consistency for the newly constructed scale and its subscales had been assessed.

Phase III: Validation of Integrated Self Scale

Step 1: Exploratory Factor Analysis: To establish the construct validity an exploratory factor analysis (EFA) was done first. EFA helps to assess whether the observed relationship among a set of variables align with the underlying theoretical framework or not. It was done in order to select the items from a pool which were best related to the construct. After wards it was also determined how many factors can be formed. So four factors were retained and items get loaded on those four factors.

Step 2: Confirmatory Factor Analysis: To construct the validity of the factor structure of Integrated Self Scale, a confirmatory factor analysis (CFA) was done by using AMOS version 20. This was done by determining the indices for goodness of fit for all 70 items which constituted the Integrated Self Scale. It was done to validate the items for the sample of present study.

Step 3: Construct Validation: The new scales should exhibit content validity as well as internal consistency. These both provide the supportive evidence for construct validity. Additional evidence of construct validity can be attained by investigating the magnitude of correlation of newly constructed scale with some other measures which are assumed to assess the similar constructs (convergent validity). Furthermore it can also be investigated that to which extent they do not relate with different measures (discriminant validity). It also seems worthwhile to examine the relationship of new scale with such variables that are conceived to

be an outcome of the main measure (criterion-related validity). To measure the convergent validity a correlation was measured with Six factors Self Concept Scale (Mir, 2015).

Results

To validate the factor structure of newly constructed scale an exploratory factor analysis was carried out. Prior to that Item total correlation of Integrated Self Scale (ISS) has been computed.

As shown in Table 1, all items are significantly correlating to the cumulative score of Integrated Self Scale and the value of correlation coefficient ranges from .21 to .60.

Table 1

Item Total Correlation of Integrated Self Scale (N=404)

Item No	Corrected Item-total Correlation	Item No.	Corrected Item-total Correlation
1	.24**	36	.35**
2	.25**	37	.32**
3	.36**	38	.50**
4	.32**	39	.42**
5	.51**	40	.42**
6	.37**	41	.48**
7	.36**	42	.32**
8	.22**	43	.44**
9	.43**	44	.41**
10	.31**	45	.45**
11	.28**	46	.41**
12	.21**	47	.49**
13	-.29**	48	.44**
14	.49**	49	.44**
15	.42**	50	.38**
16	.51**	51	.46**
17	.42**	52	.53**
18	.48**	53	.31**
19	.47**	54	.46**
20	.47**	55	.52**
21	.49**	56	.52**
22	.45**	57	.52**
23	.51**	58	.58**
24	.47**	59	.51**
25	.56**	60	.49**
26	.49**	61	.46**
27	.51**	62	.48**
28	.48**	63	.45**
29	.55**	64	.51**

30	.49**	65	.46**
31	.59**	66	.51**
32	.54**	67	.60**
33	.51**	68	.49**
34	.32**	69	.56**
35	.43**	70	.51**

Exploratory factor analysis (EFA). For validation, structuring and reducing the number of the items in the scale EFA was carried out. It will help to find out the under lying phenomenon of the target variable and are not sure about how the variables will relate with each other. It helps in identifying the latent (unobserved) factors, and rebuild the complex data in a meaningful form by retaining all the important information of the original data and removing unnecessary /redundant information (Matsunaga, 2010). EFA is the process for the estimation of the unknown structures in the data set. This is an important point which differentiate it from Principal Component Analysis (PCA). Which is mostly confused with EFA and is widely used as its substitute (Henson & Roberts, 2006). One of the reason for widely using Principal components analysis is that it is a default extraction method in SPSS (Costello & Osborne, 2005). PCA is primarily used to further reduce the variables into their components, while covering as much information as possible with as few components as possible. Whereas the goal of EFA is to explore the latent/underlying forms of the data by uncovering common factors. It is an important differentiation from PCA as it basically means EFA is more appropriate choice when exploring underlying theoretical constructs (Hooper, 2012).

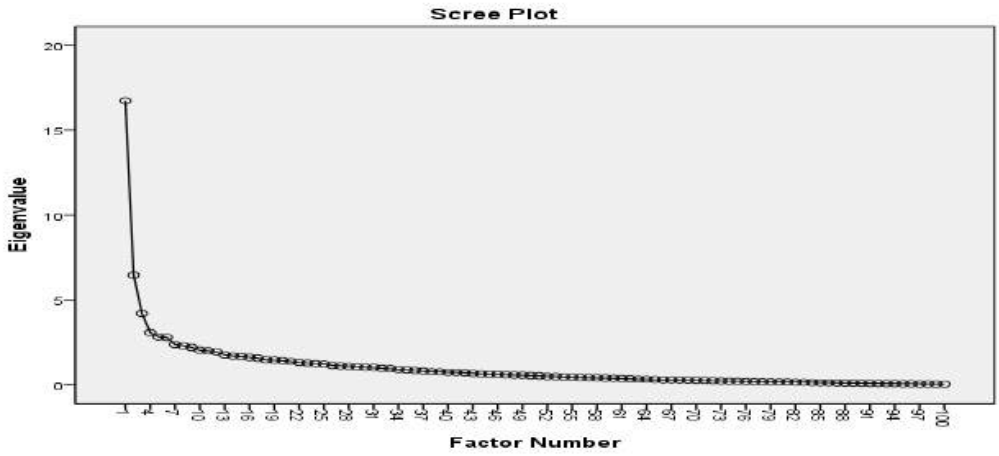
While conducting EFA, a main decision is choosing the type of extraction method. According to Fabriger Wegener, MacCallum, and Strahan (1999), when assumption of multivariate normality is violated, the method to use is principal Factor which is referred as Principal Axis Factoring in SPSS. Principal Axis factoring (PAF) is a type of EFA which is considered superior to PCA as it analyses common variance only which is a key requirement when developing and validating a construct. Moreover, it is also helpful method for recognizing

items that are not related to the intended factor or those which are measuring multiple factors at a time (Fabringar et al., 1999). 100 items of Integrated Self Scale were factor analyzed by Principal Axis factoring technique.

In EFA, one of the main decision is selecting the type of rotation. Rotation makes it easier to interpret the factors. It helps to maximize the loading on each variable on extracted factors whereas minimize on the other factors. Two main types of rotation are orthogonal and oblique. If the underlying factors are thought to be related then oblique rotation is the best choice, and if the underlying factors are considered unrelated then orthogonal rotation is used (Field, 2009). Inter item correlations were calculated to check that whether the items were related or not. The result showed significant ($p \leq .01$) inter item correlations among the items. As the items were correlated, oblique rotation was selected to be used.

Figure 4

Scree Plot showing number of factors in Integrated Self Scale



When the sample size is large that is N>200 we can use the scree plot to re-assess how many factors to extract. And as our sample size is large that is N=404, we are probably safe to rely on both scree plot and kaiser's criteria. There are four dots before the inflexion of the curve so four factors can be retained.

Table 2

Factor Loadings of the Items of Integrated Self Scale Obtained through Principal Component Factor Analysis (N = 404)

Item No.	Items	Factor I Spiritual Self	Factor II Emotional Self	Factor III Cognitive Self	Factor IV Physical Self
s97	اللہ تعالیٰ سے قربت مجھے زندگی کی مشکلات پر قابو پانے کا حوصلہ دیتی ہے ۔	**.89**	.42	.34	.32
s83	میں تمام چیزوں سے بڑھ کر اللہ سے محبت کرتا/کرتی ہوں۔	**.88**	.30	.21	.23
s99	میرا یقین ہے کہ انسانیت کی خدمت سے میرا اللہ سے تعلق مزید مضبوط ہوتا ہے ۔	**.87**	.29	.32	.42
s95	میں اپنا سر صرف اللہ کے آگے جھکاتا / جھکاتی ہوں۔	**.86**	.25	.41	.19
s84	اللہ تعالیٰ کی راہ میں خرچ کرنے سے میرے دل کو سکون ملتا ہے۔	**.85**	.18	.20	.35
s93	اللہ سے گہرا تعلق مجھے اندرونی طور پر مضبوط کرتا ہے ۔	**.84**	.34	.21	.18
s74	مجھے محسوس ہوتا ہے کہ اللہ تعالیٰ میرے دل کی بات سنتا ہے ۔	**.83**	.22	.27	.31
s80	میں اللہ کی دی ہوئی نعمتوں پر اس کا/کی شکر گزارر ہوں۔	**.82**	.23	.45	.38
s98	انسانی فلاح و بہبود کی سوچ مجھے دلی سکون اور اطمینان فراہم کرتی ہے ۔	**.81**	.29	.47	.32
s100	ضرورت مند لوگوں کی مدد کر کے میں اللہ کی قربت حاصل کر سکتا / سکتی ہوں ۔	**.80**	.18	.15	.28
s44	میرے اکثر نظریات میرے علم اور میرے تجربات کا نچوڑ ہیں ۔	.20	.18	**.83**	.32
s94	میں اپنے گناہوں سے توبہ کرتا/کرتی ہوں۔	**.79**	.42	.25	.31
s85	جو صحیح ہے وہ میرے لیے قابلِ قبول ہے۔ جو غلط ہے وہ میری نظر میں حرام ہے۔	**.78**	.24	.30	.41
s45	انسانی رویے اس کی سوچ کی عکاسی کرتے ہیں ۔	.20	.42	**.82**	.23
s40	میرا یقین ہے کہ ہر مسئلے کا کوئی نہ کوئی حل ضرور ہوتا ہے ۔	.28	.25	**.81**	.41
s89	میں اپنے قول کی پاسداری کرتا /کرتی ہوں ۔	**.77**	.44	.21	.19
s48	زندگی کے پر امید واقعات سے مجھے حوصلہ ملتا ہے ۔	.20	**.78**	.32	.20
s82	میں اپنے روز مرہ زندگی کے معاملات میں حکمت و دانائی سے کام لیتا / لیتی ہوں ۔	**.76**	.24	.42	.35
s42	میں زندگی کے تجربات کو سامنے رکھتے ہوئےمستقبل کے فیصلے کرتا /کرتی ہوں۔	.20	.21	**.80**	.27
s21	جب تک کام مکمل نہ ہو میں اپنی توجہ کام پر مرکوز رکھتا / رکھتی ہوں۔	18	.20	**.75**	.38
s78	میں نے اپنا پورا نفس اللہ کے سپرد کر دیا ہے۔	**.77**	.41	.40	.12
s36	میں اپنا کام رکاوٹ کے باوجود با آسانی سر انجام دیتا/ دیتی ہوں۔	.22	.20	**.74**	.23

s73	میں روحانی پاکیزگی کے حصول کے لیے اپنی مذہبی تعلیمات پر عمل کرتا/کر تی ہوں ۔	**.76**	.23	.21	.32
s81	میں ایک با مقصد زندگی گزار رہا / رہی ہوں ۔	**.75**	.18	.17	.20
s90	میں کچھ وقت تنہائی میں اپنی اندرونی کیفیات کو جاننے کی کوشش کرتا /کرتی ہوں ۔	**.74**	.23	.32	.26
s43	میں اپنے روز مرہ کے معاملات میں زندگی کے تجربات سے فائدہ اٹھاتا/ اٹھاتی ہوں ۔	.44	.19	**.73**	.27
s19	میں ایک پر اعتماد انسان ہوں۔	.28	.18	.25	**.88**
s62	مجھے معلوم ہوتا ہے کہ کب میرا رویہ دوسروں کے لیے تکلیف دہ ہو رہا ہے ۔	.40	**.74**	.28	.22
s34	میں ہر طرح کی صورت حال میں نظم و ضبط برقرار رکھنے کی کوشش کرتا/کرتی ہوں۔	.32	.23	**.72**	.23
s35	میں اپنی ترجیحات کو کام کی نوعیت اور اہمیت کی بنیاد پر ترتیب دیتا / دیتی ہوں ۔	.21	.23	**.71**	.31
s38	کوئی رائے قائم کرنے سے پہلے میری کوشش ہوتی ہے کہ میں ثبوت کو تفصیلات سے دیکھ لوں۔	.25	.28	**.70**	.41
s41	میں کسی بھی معاملے میں فیصلہ کرنے سے پہلے اس کے ہر پہلو پر اچھی طر ح غور و فکر کرتا /کرتی ہوں ۔	.19	.24	**.69**	.44
s31	میں دوسرے لوگوں کا نقطۂ نظر سمجھ سکتا/سکتی ہوں ۔	.18	.25	**.68**	.40
s88	میری شخصیت میں عاجزی ہے۔	**.73**	.23	.19	.29
s64	اپنے جذبات سے آگاہ رہنا میرے لیے بہت اہم ہے۔	.39	**.72**	.25	.26
s27	جب مجھے کوئی صحیح طریقے سے سمجھائے تو مجھے ہدایات سمجھنے میں کوئی مشکل پیش نہیں آتی۔	.32	.42	**.67**	.29
s28	میں اپنی توجہ مرکوز رکھتے ہوئے فراہم کردہ معلومات سے متعلق اپنے ذہن میں با آسانی خاکہ سازی کر سکتا/سکتی ہوں۔	.21	.31	**.66**	.28
s65	میں جان سکتا /سکتی ہوں کہ دوسروں کی کس بات نے مجھے پریشان کیا ہے۔	.23	**.71**	**.40**	.20
s29	میں منطقی سوالات کو آسانی سے حل کر سکتا/سکتی ہوں۔	.25	.28	**.65**	.36
s70	میں اپنی زندگی کے تلخ تجربات کے بارے میں سوچتا /سوچتی ہوں۔	.25	**.70**	.31	.33
s57	مجھےمعلوم ہے کہ میں کب اور کیسے خوش ہوتا /ہوتی ہوں۔	.23	**.69**	.29	.32
s8	میں اپنی جسمانی صفائی کا خیال رکھتا / رکھتی ہوں ۔	.21	.40	.41	**.77**
s33	کسی بھی غیر متوقع صورت حال کے پیش نظر میں اپنے منصوبوں کو بدلنے کی صلاحیت رکھتا / رکھتی ہوں۔	.23	.32	**.64**	.35
s69	دوسرے لوگوں کی مدد سے میں پریشان کن حالات میں بھی جلد پر سکون ہو جاتا /جاتی ہوں۔	.22	**.68**	.39	.36
s25	دورانِ گفتگو موضوع پر میری توجہ برقرار رہتی ہے۔	.29	.41	**.63**	.37

s76	میں غیب پر یقین رکھتا/ رکھتی ہوں۔	**.72**	.21	.22	.19
s20	جب میں کسی کام کا آغاز کرتا /کرتی ہوں تو اُسے وقت پر مکمل کرنے کی کوشش کرتا/کرتی ہوں۔	.22	.23	**.61**	.35
s17	مجھے آئینے میں اپنا عکس ناپسند ہے۔	.25	.23	.29	**.74**
s11	میں اپنے لباس کا رنگ موسم کے مطابق منتخب کرتا /کرتی ہوں ۔	.29	.24	.28	**.72**
s71	میں دوسروں کے جذبات کو با آسانی سمجھ سکتا/سکتی ہوں ۔	.32	**.66**	35	.39
s9	مجھے وہ لباس پہننا اچھا لگتا ہے جو میری جسمانی ساخت کی پیمائش کے مطابق ہو۔	.21	.22	.21	**.71**
s61	میں سمجھ سکتا /سکتی ہوں کہ لوگ میرے لیے مشکلات کا باعث کیوں بنتے ہیں۔	.23	**.65**	.27	.34
s18	میرے لیے شخصیت کو نکھارنا ضروری نہیں۔	.19	.28	.25	**.69**
s68	جب میرے ساتھ کچھ برا ہوتا ہے تو میں جلد ہی اس کیفیت سے باہر آ جاتا /جاتی ہوں ۔	.20	**.64**	.31	.32
s63	میں اپنے سوچنے کا انداز بدل کر اپنے جذبات پر قابو پا لیتا /لیتی ہوں ۔	.21	**.63**	.31	.33
s56	میں خراب صورتِ حال سے جلدی نمٹ سکتا/سکتی ہوں۔	.23	**.62**	.34	.39
s54	دوسرے لوگوں کے جذبات کی پرواہ کیے بغیر میں ہر کام اپنی مرضی کے مطابق انجام دیتا /دیتی ہوں ۔	.28	**.61**	.32	.37
s66	میں جلد غصے پر قابو پا لیتا /لیتی ہوں تاکہ وہ مجھ پر زیادہ اثر انداز نہ ہو۔	.21	**.59**	.20	.23
s53	میں جلدی پریشان نہیں ہوتا/ہوتی ۔	.26	**.58**	.30	.32
s67	جب مجھے مایوسی کا احساس ہوتا ہے میں خود کو حوصلہ دیتا/دیتی ہوں ۔	.23	**.57**	.20	.31
s52	میں جذباتی طور پر مضبوط اعصاب کا/کی مالک ہوں ۔	.21	**.56**	.28	.32
s50	میں کسی بھی تکلیف کو باآسانی نظرانداز کر کے آگے بڑھ سکتا /سکتی ہوں۔	.29	**.54**	.32	.34
s14	میری چال پر اعتماد ہے ۔	.29	.42	.41	**.68**
s7	میرے خیال میں وزن کا زیادہ ہونا شخصیت کو متاثر نہیں کرتا۔	.28	.40	.41	**.66**
s1	میں اپنی ظاہری شکل وصورت کے بارے میں فکر مند رہتا /رہتی ہوں۔	.29	.43	.41	**.61**
s4	میں اپنی صحت کا خاص خیال رکھتا/رکھتی ہوں۔	.22	.21	.23	**.62**
s5	میں خود کو چست اور صحت مند رکھنے کے لیے باقاعدگی سے چہل قدمی کرتا / کر تی ہوں۔	.21	.29	.22	**.60**
s12	میرے خیال میں مسکراتے ہو ئے میں جازب نظر لگتا /لگتی ہوں	.19	.21	.22	**.59**
s15	میں اپنے لباس کے بارے میں فکرمند رہتا /رہتی ہوں۔	.24	.21	.22	**.58**
s10	میں سمجھتا/سمجھتی ہوں کہ لباس کا رنگ شخصیت کی عکاسی کرتا ہے ۔	.23	.22	.25	**.57**

s6	اگر میری نیند پوری نہ ہو تو میں ٹھیک طرح سے کام نہیں کر سکتا/سکتی۔	.24	.23	.26	**.56**
Eigen Values		16.72	6.46	4.19	3.08
% age Variance		16.09	5.84	3.49	2.34
Cum Variance		16.09	21.94	25.44	27.78

Table 2 is showing the results deduced through using oblique rotation (i-e., Direct Oblimen) of Principal Axis Factor analysis to find the factor structure and validity of the Integrated Self Scale. Results revealing that Integrated Self Scale is clearly clustered into four separate factors. Communalities indicate the proportion of common variance in a variable. A variable having no specific value of variance have a communality value of 1, whereas a variable sharing no variance with other variables have a communality value of 0 (Thongrattana, 2012). Although there is no cut off point for dropping any variable based on communalities value.

After factor analysis some items were discarded and the final form consisted of 20 items in factor I. All items in factor I were examined clearly and after that its name was finalized which is Spiritual Self. Factor II contained 18 items and according to the features of these items it get its name as Emotional Self. Factor III was also comprised of 18 items and items were measuring cognitive abilities of individual so it is named as Cognitive Self. The fourth factor comprised of 14 items which were measuring physical aspect so it named as Physical Self. Eigen value of Factor I is 16.72 indicates 16.09 % of variance. Eigen value of Factor II is 6.46 which is explaining 5.84% variance. Eigen value of factor III is 4.19 which is explaining 3.49% of the variance. And factor IV is having the Eigen value 3.08 which explains 2.34% of the variance. Table 2 is also showing the cumulative variance which explained by four factors that is 27.78%. According to William, Onsman and Brown (2010), when values of cumulative variance are high it is an indicator of good factor solution however, in social sciences value of cumulative variance can get below 50% and it is still considered acceptable. Furthermore, there is no pre- determined criteria or limit for cumulative variance. Finally out of 100 items, 70 were

selected to be included in the final form of the Integrated Self Scale. Only one item in the final scale was reverse coded.

Confirmatory Factor Analysis

To assess the validity of a theoretical construct or model by examining how well the observed data fits the expected structure, a Confirmatory Factor Analysis was done. It is a type of Structural Equation Modeling that specifically focusing on testing the hypothesized relationship between observed variables and their underlying latent factors.

In simple terms, CFA is used to determine whether the data supports a priori expectations about the relationship between observed variables and the latent constructs they are believed to measure. These latent constructs are often not directly measureable but are inferred based on the observed variables that are thought to be indicators of the underlying construct.

Figure 5

Measurement Model of Integrated Self Scale (70 Items)

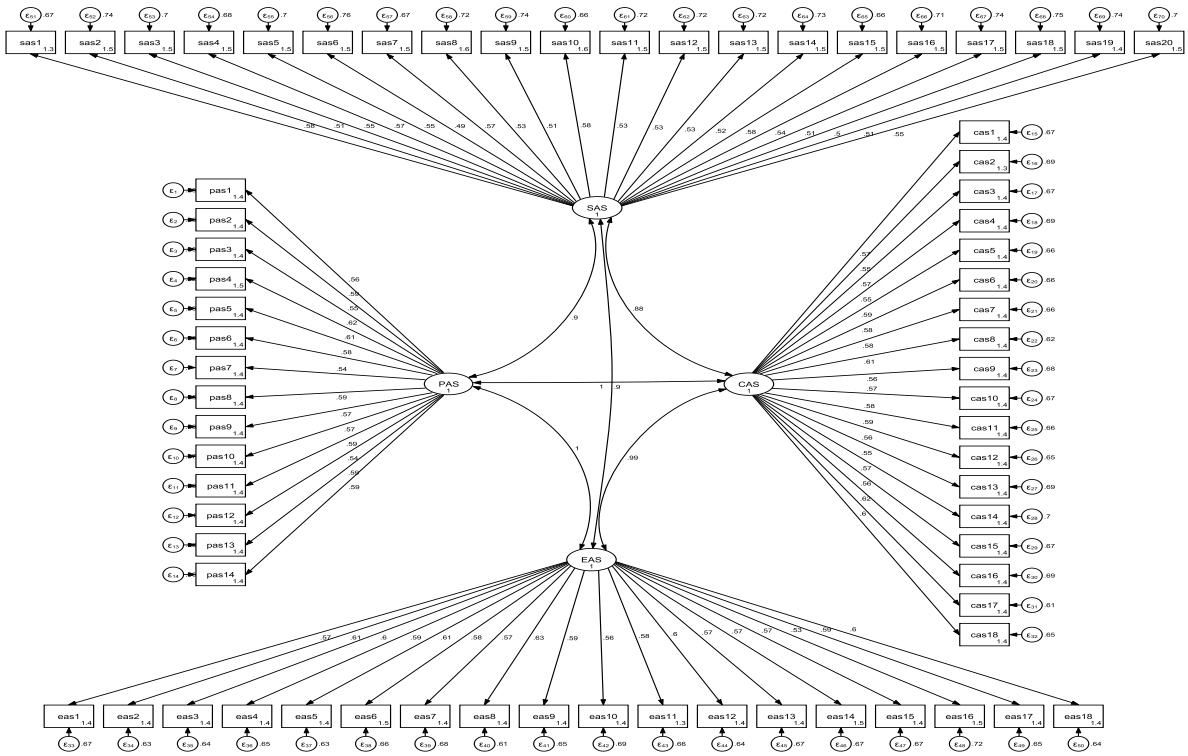


Table 3

Confirmatory factor Analysis (CFA) with items loadings for Integrated Self Scale (N=400).

Item No.	Variables	Factor Loadings
1.	PAS 1	.68
2.	PAS 2	.66
3.	PAS 3	.69
4.	PAS 4	.61
5.	PAS 5	.62
6.	PAS 6	.65
7.	PAS 7	.70
8.	PAS 8	.64
9.	PAS 9	.67
10.	PAS 10	.67
11.	PAS 11	.65
12.	PAS 12	.70
13.	PAS 13	.65
14.	PAS 14	.65
15.	CAS 1	.67
16.	CAS 2	.69
17.	CAS 3	.67
18.	CAS 4	.69
19.	CAS 5	.65
20.	CAS 6	.66
21.	CAS 7	.66
22.	CAS 8	.62
23.	CAS 9	.68
24.	CAS 10	.67
25.	CAS 11	.66
26.	CAS 12	.64
27.	CAS 13	.68
28.	CAS 14	.69
29.	CAS 15	.67
30.	CAS 16	.68
31.	CAS 17	.61
32.	CAS 18	.64
33.	EAS 1	.67
34.	EAS 2	.63
35.	EAS 3	.64
36.	EAS 4	.64
37.	EAS 5	.62
38.	EAS 6	.66
39.	EAS 7	.67
40.	EAS 8	.60
41.	EAS 9	.64
42.	EAS 10	.68
43.	EAS 11	.65
44.	EAS 12	.63
45.	EAS 13	.66
46.	EAS 14	.67

47.	EAS 15	.67
48.	EAS 16	.71
49.	EAS 17	.65
50.	EAS 18	.63
51.	SAS 1	.66
52.	SAS 2	.73
53.	SAS 3	.69
54.	SAS 4	.67
55.	SAS 5	.70
56.	SAS 6	.75
57.	SAS 7	.67
58.	SAS 8	.71
59.	SAS 9	.74
60.	SAS 10	.66
61.	SAS 11	.71
62.	SAS 12	.72
63.	SAS 13	.72
64.	SAS 14	.73
65.	SAS 15	.65
66.	SAS 16	.70
67.	SAS 17	.73
68.	SAS 18	.74
69.	SAS 19	.73
70.	SAS 20	.69
	Composite Reliabilty (CR)	.84
	Average Variance Extracted	.03

Note: PS= Physical Self, CS= Cognitive Self, ES= Emotional Self, SS= Spiritual Self

Values in table 3 indicates that all items are acceptable for being included in Integrtaed Self Scale as all retained items have good factor loadings >.30.

Table 4

Confirmatory Factor Analysis of Integrated Self Scale (Indices of Model Fit) (N=400)

χ2	*Df*	*P*	CMIN/*df*	Fit indices			
				CFI	NFI	TLI	RMSEA
3648.46	2339	.00	1.56	.93	.92	.93	.02

Note. χ2 = Chi-square, *df* = degree of freedom, CFI = Comparative Fit Index, NFI = Non-Normed Fit Index, TLI = Tucker Lewis Index, RMSEA = Root Mean Square Error of Approximation

Above table reveals that for absolute fitness all the indices values are approximately fulfilling the required criteria. CMIN/df is 1.56 which is less than 5, RMSEA is .02 that is < 0.10 (Hooper, et al., 2008). Further for incremental fitness NFI is .92 > 0.9, CFI is .93 > 0.9, TLI is .93 > 0.9. Hereafter the model is fulfilling all the requirements, therefore it is suitable

for determining contribution of variables in measuring Integrated Self. The achieved values indicated an acceptable fitness of the proposed 4 factors 70 items model.

Reliability

Table 5

Mean, Standard Deviation and Alpha Reliabilities of Integrated Self scale, its subscales, Six factors self concept scale and its subscales (N=404)

Scales	K	M	SD	α	Min-Max	Skew	Kurt
Physical Self	14	41.39	4.85	.66	15-32	-.66	.09
Cognitive Self	18	59.60	8.20	.87	21-39	.74	.04
Emotional Self	18	54.88	8.10	.83	21-36	.15	-.69
Spiritual Self	20	70.15	9.27	.92	24-42	.17	-.41
Integrated Self Scale	70	226.01	23.97	.94	92-134	-.09	-.32
Six Factors of Self Concept scale	36	130.2	27.25	.91	7-42	-.08	-.42
Positive Self Orientation	29	150.4	24.68	.92	7-28	.18	.05
Vulnerability	7	20.53	6.23	.67	7-20	.16	-.68

Table 5 is showing the reliability index of the 70 items Integrated Self Scale and its four subscales. The reliability coefficient for ISS is .*94*. High value of Alpha coefficient is indicating that the scale is consistent internally and seems to be a reliable measure to measure the fundamental construct. Alpha values of subscales are also significant which are .66, .87, .83 and .92 respectively. Alpha coefficients of Six factors self concept scale and its subscales are .91, .92 and .67 respectively, which is again showing the consistency of scales.

Table 6

Interscale Correlations for the Sample (N=404)

	IS	SAS	EAS	CAS	PAS
IS	-	.78**	.82**	.89**	.59**
SS		-	.43**	.59**	.23**
ES			-	.66**	.42**
CS				-	.45**
PS					-

PS= Physical Self, CS= Cognitive Self, ES= Emotional Self, SS= spiritual Self. IS= Integrated Self

Inter scale correlations are significant at *p<.01*. It is clear from the results that all subscales show significant correlation with the total scale which is confirming the construct validity of a scale.

Validity. Validity was established by construct validity (Convergent and Divergent validity). Integrated Self Scale was correlated with Six Factors Self Concept scale and three subscales.

Table 7

Inter-scales correlation of Integrated Self Scale and Six Factors Self Concept scale (N=404)

	IS	SC	PSO	Vulnerability
IS	-	.83**	.72**	-.32**
SC		-	.98**	-.22**
PSO			-	-.02*
Vulnerabity				-

SFSCS= Six Factors Self Concept Scale, PSO= Positive Self Orientation, *SC= Self Concept*

It can be inferred from results in table 7 that a positive relationship exists between integrated self, Self Concept and its subscale Positive Self Orientation, which proves that newly constructed Integrated Self Scale has a good convergent validity (r=.83**, p<.01). One of the subscales of Six Factors Self Concept Scale is Vulnerability, which is a negative construct. It has a negative relationship (r=-.32**, p<.01) with integrated self which confirms the discriminant or divergent validity of Integrated Self Scale.

Discussion

The view of the self is referred to a person's experience as a sole, unitary and an independent being that is isolated from others, experienced with stability with respect to time and place. Awareness about one's physical as well as one's internal character along with its emotional life is all referred to as self. Individuals have two types of experiences about their selves. The leading is as an active agent who can influence the world as well as being affected

by the world outside. This nature of the self is typically stated to as I. It mainly emphases on how people experience themselves as dynamos. The second type of self is an object of replication and estimation. According to this sort of self, people usually focus attention to their physical as well as their psychological characteristics in order to envisage the pattern of the skills, qualities, approaches, attitudes, beliefs and feelings that they may have. This type of self is mentioned as me. Major concern of this type of self is to focus on how people observe themselves with respect to the world outside, just like people monitor and anticipate the competency and character of other people (Leary & Tangney, 2002).

Everyone has a self but the experience they have can be quite different from each other. As a result of present study and focusing on previous literature, it has been revealed that self is not a single entity instead it is composed of some factors. All those factors cumulatively make up the Integrated Self. For every human being it is essential to be aware about the functioning of his or her own self. As self is comprising some factors so there are the chances that an individual might not functioning well on any one of the aspect of self or may be his overall functioning is poor. So it's quite necessary for all individuals to be self-aware. This awareness about self is required to create balance between all aspects of self for becoming the highest creation. And this self-knowledge is also essential for mental and psychological well-being. Reflection and self-analysis were the major ways to understand the mental issues and revealing veiled causes. Self-awareness and knowledge about one's functioning of self also influence the way how an individual thinks, feels and behaves in the world.

In the present study for self-analysis a scale was constructed. An Integrated Self Scale consisted of 70 items, which were comprised of four subscales. Subscales are named as Spiritual Self, Emotional Self, Cognitive Self and Physical Self. Integrated Self Scale showed good internal consistency. Reliabilities of the all subscales and Integrated Self scale were high i-e .92, .83, .87, .56 and .94 respectively.

The main objective of the study was to construct a scale to measure one's level of integrated self and different aspects of self. Purpose to construct this scale was to enable an individual to become aware of their self. Before this there are many scales which were measuring the self-concept and self-image of an individual. But this scale is bit different as it is measuring all aspects of self and not only the concept about one's actual and ideal self.

Previous literature indicated that there are various self- related inventories, scales and questionnaires present which measures different facets and factors of self. Goñi, Madariaga, Axpe and Goñi developed The Personal Self Concept Questionnaire (PSQ) in 2011. The questionnaire comprised of four subcategories which were Self-fulfillment, Autonomy, Honesty and Emotional self-concept and total items were 22.

Another popular measure of self concept was developed by Saraswat in 1984 named The Self Concept Questionnaire (SCQ). This questionnaire consisted of 48 statements aiming to measure self-concept across physical, social, temperamental, educational, moral and intellectual aspects of self. A higher sense of self-concept is indicated by higher scores. Another measure was The Twenty Statements Test, although it covers several areas of self-concept but specifically it was devised to measure self-image as a part of self-concept (Kuhn & McPartland, 1954). According to Kuhn (1960) majority of the responses could be categorized as three distinct group i-e social roles, personality and physical descriptions. Another important measure is The Robson Self-Concept Questionnaire. It comprises of 30 statements which are related to various areas of self-concept. High score indicates a higher sense of self-concept (Robson, 1989).

While focusing on these instruments and other than these which are alike, it has been revealed that Integrated Self Scale is measuring four basic aspects of self. It is actually measuring who we are physically, cognitively, emotionally and spiritually. These aspects make it different from other previous measures.

Chapter 4

Study II

Objectives

Following are the objectives of the present study

1. To translate the Traditional Islamically Integrated Psychotherapy (TIIP) in Urdu language
2. To determine the appropriatness of the Urdu translated version of TIIP

Study II comprised of following two phases

Phase I: Urdu translation of Traditional Islamically Integrated Psychotherapy

Phase-II: Try out of translated version of TIIP

Primary objective of this study was to translate the Traditional Islamically Integrated Psychotherapy into Urdu (Pakistan's National Language) to use in the main study.

Phase I: Urdu translation of Traditional Islamically Integrated Psychotherapy. The basic aim of this phase was to get the Urdu version of TIIP that was theoretically comparable in the focused Urdu language. This phase was comprised of three steps which are as follows.

Translation. For the current phase of the study a forward translation method was utilized. For forward translation, a help of five Urdu experts was taken. Two of them were MS scholars; two were PhD scholars while other one was PhD doctor. Each of the five experts translated the intervention along with its techniques autonomously. After accomplishing of translation, the techniques were further studied and appraised by a committee which comprised of five psychologist including researcher herself. Each statement and technique was discussed at length and some statements were rephrased and modified slightly to make them more comprehensive. The main focus of this exercise was to gain conceptual equivalence so that common meaning and legitimate comparison between the original and the target materials can

be provided. The objective was to check whether this translated version was conveying the same contextual meaning as the original Intervention.

Back translation. The Urdu translated TIIP was again translated back into English as an evaluation of initial translation and points of equivalence or discrepancy were identified between the original and translated versions. The three independent translators, who were not exposed to the original version of TIIP, were provided with Urdu translated version of TIIP to back translate it into English. All of them translated that independently. One of the translators was an English Professor while the other two were Masters of English.

Expert panel. After the completion of translation process it was aimed to make the conceptual and linguistic equivalence between the back translations and original version of TIIP, for which the committee approach was carried out. It was thoroughly examined by the committee and was concluded that back translations were matched with the original version of TIIP. The language selection was carefully done as only those words were chosen which are generally being used by Pakistani population. The pattern of the original version had been adapted in the Urdu version.

Phase-II: Try out of translated version of TIIP

The try out was aimed to determine the feasibility, acceptability and practicability of the intervention and its techniques. The translated version of TIIP was administered on a small sample (n=4) to measure its appropriateness and efficacy. Thus, the translated version of TIIP was validated by clinical and general population.

Discussion

The translation of interventions is crucial because it allows for the effective application and adaptation of evidence-based practices from one context to another. By translating interventions, researchers and practitioners can bridge language, cultural and contextual barriers, making the interventions accessible and relevant to diverse populations. This process

ensures that valuable knowledge and findings from research can be implemented and utilized to improve outcomes in different settings, benefiting a broader range of people worldwide.

Translating interventions for drug addicts into Urdu is important to make these resources accessible to Urdu-speaking populations who may be struggling with substance abuse. By providing interventions in the native language, individuals can better understand the content, relate to materials and engage more effectively in the treatment process. Culturally tailored and language appropriate interventions can help reduce stigma, increase participation in treatment programs, and improve the overall effectiveness of the interventions in addressing addiction issues within the Urdu-speaking community. It is essential to ensure that the translated interventions are evidence-based and culturally sensitive to achieve the best possible outcomes for those seeking help for drug addiction in Urdu-speaking regions.

In present study a Traditional Islamically Oriented Psychotherapy (TIIP) was translated into Urdu language. Proper procedure was employed in which first Urdu translation was done by Urdu language experts and then all five translations were discussed in a committee so to remove any ambiguity if exists. After that a back translation into English was done by English language experts, of the Urdu translated version. And this step was done in order to check whether any discrepancy exists between original and back translated version or is it conveying the same contextual meaning. After gaining the conceptual clarity and equivalence the Urdu translated version was applied on a small sample so check its efficacy.

Through tryout it was revealed that translated version was conveying the same meaning and in our community it was more convenient for the population to understand the instruction provided in Urdu language. Although individuals have different mother languages but being a Pakistani Urdu is our national language and every literate individual can easily understand and can respond in Urdu language easily. It is the better and easiest language for communication than English as English is not our first language so the accuracy might be low.

In some previous studies the translation of interventions has been seen and its efficacy has been mentioned too. In a study done in Japan showed the higher treatment efficacy of Japanese language translated intervention for treatment of anxiety related disorders (Yoshinaga et al., 2021). When treatment is provided in native language obviously it would be more effective than when presented in any other language.

Translation of intervention materials can help to build trust between healthcare providers and patients by showing that providers are committed to providing care that is accessible and understandable to everyone. This is important for ensuring that patients feel comfortable seeking and receiving care. Translation of intervention materials can help to promote equity in healthcare by ensuring that all people, regardless of their language or literacy skills, have access to the same quality of care. This is especially important in Pakistan, where there is a large disparity in access to healthcare between rural and urban areas.

The government of Pakistan has translated a number of health education materials into local language Urdu. A non-profit organization called the Indus Medical Foundation has translated a number of medical textbooks into Urdu. These textbooks are used by medical students and doctors in Pakistan. Moreover, A research team at the University of Karachi has translated a number of intervention materials in Urdu for use in a study on HIV/AIDS prevention. Furthermore, another intervention plan SMILES was translated and adapted to indigenize the plan for Pakistani population. This sort of translation helps a lot in healthcare systems (Khan & Batool, 2013).

Chapter 5

Study III

Objectives

Objectives of the study III are as follows:

1. To measure the effect of TIIP on self integration, relapse prevention and enhancement of psychological adjustment in recovering drug addicts.

2. To explore the relationship between self, relapse vulnerability and psychological adjustment of drug addicts.

3. To determine integrated self in recovering drug addicts and non-addicts and their differences.

Hypotheses

The hypotheses of the present study are as follows:

1. Drug addicts have low level of Integrated self than non addicts.

2. There is a negative relationship between relapse vulnerability and psychological adjustment among recovering drug addicts.

3. Integrated self is negatively correlated with relapse vulnerability and positively correlated with psychological adjustment among recovering drug addicts.

4. Integrated Self positively predicts Psychological adjustment while negatively predicts relapse vulnerability among drug addicts.

5. Therapeutic intervention (TIIP) helps to transform Unintegrated self into Integrated self.

6. Therapeutic intervention (TIIP) reduces relapse scores for drug addicts after intervention than before it.

7. Therapeutic intervention (TIIP) helps to improve Psychological adjustment of drug addicts.

8. Experimental group have high level of Integrated Self, low relapse vulnerability and better psychological adjustment than control group in post treatment assessment.

9. There is no difference in level of Integrated self, relapse vulnerability and psychological adjustment of control group in Pre and post treatment assessment.

Study III- Implementation of Intervention

Study III consists of Main study which comprised of further 3 phases.

Phase I: Recruitment and Selection of Sample for main study

Phase II: Main Study

Phase III: Follow Up

Phase I: Recruitment and Selection of Sample for main study

Participants

A purposive convenience sample (*N* = 200 drug addicts, N=200 Non Addicts) was selected for Phase-I of study II. The minimum age of participants was 15 years while the maximum was 65 years (*M* =36.77, *SD* =11.79). Participants should be literate with atleast primary education, so they could become part of the study. While it was taken into account that any drug addict must not having any psychological disorder like depression, personality disorder, schizophrenia etc. A non-clinical sample of 200 individuals was not taking any drugs and belonged to the normal population. Other specifications were same as of the clinical sample.

Procedure

At the outset, a proper approval was taken from rehab centers for conducting the research and for taking information from drug addicts residing in rehab centers. A consent was taken from participants for participation in research. Afterwards scales were provided to the respondents. And they were instructed clearly about scales and their purpose and how to give response to the scales. They were also assured about the confidentiality of their information. They were requested to give their true responses and along with this it was also make sure that they would give response on each item and would not leave any item unfilled. There was an

open time for the completion of scale so the respondents could complete the scales on their ease. Scoring was done after obtaining the data, and then scores were computed and analyzed to test the hypotheses.

Phase-II: Main Study

Research Design

Nonequivalent control group pretest – posttest design type of Quasi experimental design has been used for the current study. Participants were divided into control and treatment groups randomly. The intervention group has been provided with different techniques of Traditional Islamically Integrated Psychotherapy developed by Keshavarzi and Haque while the control group received simply counseling which was provided in rehabilitation centers.

Sample

The sample was selected from already scrutinized drug addicts having unintegrated self- based on the cut off score of Integrated Self Scale, from different rehabilitation centers of Rawalpindi, Islamabad and their surroundings, consisted of 40 recovering drug addicts. Recovering drug addicts were those who already have completed the detoxification process. The individuals having low levels of integrated self were selected for the main study. They were then further devided on even odd basis in experimental and control group. As there was no specific criteria for experimental and control group selection

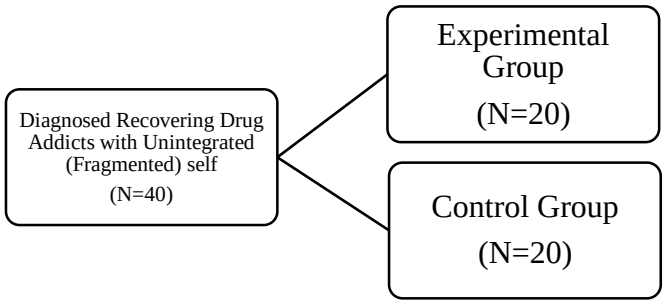


Figure 6: S*ample distribution in experimental and Control group*

Inclusion and exclusion criteria met through a screening and assessment measures.

Inclusion Criteria. Addicts with any type of drug has been the part of a study. Addicts with the history of relapse were considered to be the part of study and their age range was between 15-60 years. Drug addicts having unintegrated (fragmented) self were selected from sample of drug addicts. Only detoxified patients became the part of the study.

Exclusion Criteria. Individual having abusive behavior less than 3 months have not been included in study. Addicts with religions other than Islam have not been the part of this study. Addicts with age more than 70 years were also excluded from the study. Along with this addict having integrated self were excluded from this study. Individuals having Psychotic disorders were also excluded from this sample.

Operational Definitions

Integrated Self. Integrated self is referred to as harmony in all aspects of self i-e Physical, Cognitive, Emotional and Spiritual. All of these elements should relate to each other positively. If not related "self-fragmentation" or unintegration occurs.

High scores on Integrated Self Scale means individual have higher level of integrated self while low scores refer to lower level or unintegrated (fragmented) self.

Relapse Vulnerability. Relapse vulnerability is referred to as a hindrance which can occur during the behavior change process. When an individual tries to progress towards the initiation or maintenance of a behavior, he/she sets a goal (e.g., abstinence from drug use) but that progress is interrupted by a deterioration to the target behavior. Relapse is best hypothesized as a dynamic and ongoing process rather than a distinct or terminal event (Witkiewitz & Marlatt, 2004; Brandon, Vidrine & Litvin, 2007).

Psychological Adjustment. Psychological adjustment is referred as a process through which an individual stabs to cope with matters, and transcends the challenges of life, and this all happens by employing a number of coping strategies and techniques (kaplan & Stein, 1984).

It would be defined as the individual's self control, self confidence, personal strength and the coping strategies used by an individual.

Instruments

Demographic information sheet

The demographic sheet consisted of information related to age, marital and socio economic status, Religion, Sect, Regional background, parental status (Alive or death), Family Type (Nuclear, Joint), Number of siblings, Birth order, type of drug, history of relapse, treatment history, history of present illness, family history, Number of children and educational level and occupation.

Integrated Self Scale

Integrated Self Scale is 70 items instrument. Factor analysis identified only 4 factors instead of multiple factors. Factor I "Physical Self" consisted of 14 items, factor II "Cognitive Self" consisted of 18 items, factor III "Emotional Self" consisted of 18 items while the factor IV "Spiritual Self" consisted of 20 items. Cronbach Alpha Reliability of subscales is .56, .87, .83 and .92 respectively. Integrated self was measured on 4-point likert scale. Ranging from 1 to 4.

The AWARE Questionnaire

The AWARE questionnaire (Advanced Warning of Relapse) was developed to measure the warning signs of relapse. Version 3 was used which have 28 items and was refined by Miller and Harris in 2000. In present study Urdu translated version was used (Nashee, Amjad, Rafique & Naz, 2014). It is 7 pint rating scale. Item 8,14,20,24 and 26 are reversed score items. Higher scores on the scale show more warning signs of relapse in an individual. Alpha Reliability of the scale is .92.

Psychological Adjustment Scale

The Psychological Adjustment Scale (PAS) developed and translated by Sabir (1999), consisted of 27 items which are categorized into five subscales. The alpha reliability of Psychological Adjustment Scale was 0.83 while the split half reliability was found to be 0.85. content validity of all the sub-scales was high which were shown by item total correlation co-efficient values. The five dimensions which can be measured through applying Psychological Adjustment Scale include: Accurate perception of reality, Ability to cope with stress and anxiety, A positive self-image, Ability to express the full range of emotions and Good interpersonal relationship.

Procedure

Step- I: Pre-treatment Assessment. Before starting the therapeutic sessions, pretesting has been conducted on (N=40) drug addicts to measure their Aspects of Self, relapse vulnerability and psychological adjustment.

After pre-test assessment, participants were randomly assigned to the treatment and control group (treatment group $n = 20$; control group $n = 20$). Participants assigned to treatment group have received intervention approximately for 3 months. While counseling which is provided in rehabilitation centers has been employed on control group and number of sessions for both groups was equal.

Step-II: Application of Intervention. In this step different techniques of Traditional Islamically Integrated Psychotherapy were provided to the drug addicts in treatment group. Techniques have been employed in different sessions. Four sessions were scheduled in a week. Intervention has been applied in a form of group therapy. There were total five groups with 4 members each.

Session I & II: History Taking and Rapport Building.

Objectives:

1. To gather comprehensive information about the history and background of addicts, including their addiction patterns and personal challenges.
2. To establish a therapeutic alliance by building rapport and trust between the therapist and the addict.
3. To assess the willingness of the addicts to engage in the therapeutic process and explore their interest or involvement in religious/spiritual practices.
4. To create a supportive environment where addicts feel comfortable discussing their experiences and seeking help.

Session Overview:

The initial sessions in addiction counseling are crucial for setting the foundation of the therapeutic relationship and gathering essential information about the individual's addiction history, personal challenges, and readiness for change. In this particular approach, the therapist integrated considerations of the individual's religious beliefs or interests into the assessment process.

History Taking:

The therapist conducted a thorough assessment of the addict's history, including their substance use patterns, duration of addiction, previous attempts at recovery, and any co-occurring mental health issues. Detailed information was gathered about the addict's personal background, family dynamics, social support network, employment, and legal issues related to addiction. The therapist explored the individual's religious background, beliefs, and practices through open-ended discussion rather than relying on standardized measures of religiosity.

Rapport Building:

The therapist employed active listening, empathy, and nonjudgmental attitude to establish rapport and trust with the addict. Tailored approaches were utilized to engage both friendly and introverted individuals, recognizing that some may take longer to open up and develop trust.

The therapist acknowledged that unique challenges faced by introverted individuals and adopted a patient-centered approach to gradually built rapport over time.

Assessing Willingness and Religious Interest:

The therapist explored the addict's readiness for change and motivation to engage in the counseling process. Through open dialogue, the counselor assessed the addict's interest in integrating religious or spiritual practices into their recovery journey. No specific standardized measures were used to assess religiosity; instead, the counselor observed the individual's level of interest and engagement through general discussion about religious topics.

Outcomes:

Enhanced Engagement: By integrating religious considerations and adopting a patient-centered approach, the therapist facilitatated greater engagement and participation from the addicts in the assessment process.

Trust and Rapport: Through empathetic listening and nonjudgmental attitude, the therapist built trust and rapport with the addicts, creating a supportive environment for open communication.

Comprehensive Assessment: The thorough history-taking process allowed the therapist to gather essential information about the addict's background, addiction history, and personal challenges, laying the groundwork for personalized treatment planning.

Identification of Religious Resources: By discussing religious interests and beliefs, the therapist identified potential resources or supports that may aid in the addict's recovery journey, such as religious communities or spiritual practices.

Tailored Approach: Recognizing the diverse needs and preferences of individuals, the therapist adapted their approach to suit the personality and communication style of each addict, thereby optimizing the effectiveness of the therapeutic relationship.

Session III & IV: Debriefing and Intervention Introduction.

Objectives:

1. To introduce clients to the concept of Traditional Islamically Integrated Psychotherapy (TIIP) and its techniques.
2. To assure clients of the effectiveness and safety of TIIP techniques for behavior modification.
3. To establish trust and confidence in the therapeutic process and the counselor's approach.
4. To prepare clients for engaging in therapeutic interventions grounded in Islamic principles.
5. To clarify any misconceptions and address concerns regarding the use of religiously integrated therapy.

Session III & IV Overview:

The third and fourth sessions in the counseling process focus on introducing clients to Traditional Islamically Integrated Psychotherapy (TIIP) and its various techniques. These sessions aim to provide clients with a clear understanding of how TIIP can be beneficial for behavior modification and to alleviate any concerns they may have regarding its use.

Debriefing on Traditional Islamically Integrated Psychotherapy:

The therapist provided clients with an overview of TIIP, explaining its foundations in Islamic principles and its integration with traditional psychotherapeutic approaches. Clients were briefed on the different techniques employed in TIIP, emphasizing their effectiveness in facilitating behavior modification. The therapist assured clients that TIIP techniques were safe

and do not carry any harmful effects. Clients were encouraged to ask questions and express any concerns they may have.

Introduction to Techniques:

Clients were introduced to specific TIIP techniques that were utilized in their therapeutic journey. Some of these techniques were cognitive restructuring, behavioral activation, mindfulness, and spiritual interventions grounded in Islamic teachings.

The therapist explained how each technique works to address problematic behaviors and promote positive change, emphasizing the role of Islamic principles in guiding the therapeutic process.

Assurance and Reassurance:

The therapist reassured clients that TIIP techniques were solely aimed at behavior modification and do not involve any form of harm or manipulation. Clients were encouraged to express any reservations they may have about integrating religious principles into therapy, and the therapist addressed those concerns with empathy and understanding.

Clarification of Misconceptions:

Any misconceptions or misunderstandings about TIIP and its techniques were clarified by the therapist. Clients were provided with accurate information to dispel any doubts or reservations they may have.

The therapist emphasized the compatibility of TIIP with clients' religious beliefs and cultural values, fostering a sense of trust and acceptance in the therapeutic process.

Outcomes:

Increased Understanding: Clients gained a better understanding of TIIP and its techniques, including how they can contribute to behavior modification and personal growth.

Enhanced Trust: Through clear explanations and reassurances, clients developed trust and confidence in the counselor and the therapeutic process.

Reduced Anxiety: Addressing concerns and clarifying misconceptions helped in alleviating anxiety and apprehension about participating in TIIP interventions.

Readiness for Engagement: Clients felt more prepared and motivated to engage in therapeutic interventions grounded in Islamic principles, recognizing their potential benefits for behavior modification.

Strengthened Therapeutic Alliance: Open communication and empathy fostered a strong therapeutic alliance between clients and the therapist, laying the groundwork for effective treatment outcomes.

Session V & VI: Specification of Treatment Goals.

Objectives:

1. To collaboratively set treatment goals with clients, considering their individual needs, preferences, and readiness for change.
2. To discuss the treatment plan in detail, including the process of therapy, client availability, and addressing any queries or concerns.
3. To emphasize the importance of building a trusting relationship between the client and therapist as the foundation for achieving treatment goals.
4. To outline specific treatment goals related to compliance, introspective self-awareness, achieving psychological equilibrium, and integrating all aspects of self.
5. To motivate clients to commit to the therapy process and complete the treatment to maximize the likelihood of achieving the desired outcomes.

Session V & VI Overview:

During these sessions, the focus is on collaboratively setting treatment goals and developing a detailed treatment plan with the clients. The therapist worked closely with each client to ensure that the goals are tailored to their individual needs and preferences. Emphasis

was placed on the importance of building a trusting therapeutic relationship and addressing any concerns or queries the clients may have about the therapy process.

Collaborative Goal Setting:

The therapist worked with each client to identify specific treatment goals that were relevant to their recovery journey. Goals were set collaboratively, taking into account the client's preferences, motivations, and readiness for change. Emphasis was placed on the importance of building a trusting relationship between the client and therapist as the foundation for achieving treatment goals.

Treatment Plan Discussion:

The treatment plan was discussed in detail with each client, outlining the process of therapy, session frequency, and any additional interventions or techniques that were utilized. Clients were encouraged to discuss their availability and any scheduling concerns they may have. Any queries or concerns about the therapy process were addressed by the therapist.

Specific Treatment Goals:

The therapist outlined specific treatment goals that served as a guide in a therapeutic process. These goals include:

a. Compliance: Building a trusting relationship between the client and therapist to facilitate engagement and compliance with the treatment plan.

b. Introspective Self-Awareness: Helping clients develop awareness of their inner psychological processes to better understand the underlying causes of their addiction.

c. Psychological Equilibrium: Working towards achieving balance and harmony among all aspects of the client's psyche, addressing underlying issues contributing to addiction.

d. Integration of Self: Encouraging clients to integrate all aspects of themselves, including physical, emotional, cognitive, and spiritual dimensions, to promote holistic healing.

Motivation and Commitment:

Clients were motivated to commit to the therapy process and complete the treatment to maximize the likelihood of achieving the desired outcomes. The importance of continuity and consistency in therapy attendance was emphasized, as discontinuation could impede progress towards achieving treatment goals.

Outcomes:

Clear Treatment Plan: Clients had a clear understanding of the treatment goals and plan, enhancing their commitment to the therapeutic process.

Enhanced Trust and Rapport: Collaborative goal setting and open discussion fostered a trusting relationship between clients and the therapist, promoting engagement and compliance with therapy.

Increased Motivation: Clients were motivated to actively participate in therapy and work towards achieving the specified treatment goals.

Improved Self-Awareness: Clients developed greater introspective self-awareness, enabling them to identify and address underlying issues contributing to their addiction.

Continued Engagement: Emphasizing the importance of commitment to the therapy process encourages clients to remain engaged and complete the treatment, maximizing the likelihood of successful outcomes in their recovery journey.

Session VII & VIII: Spiritual Intervention (Nurturing Connection With Allah in Addiction Therapy).

Objectives:

1. To introduce clients to spiritual interventions aimed at fostering a purposeful connection with Allah as a source of motivation and support in their recovery journey.

2. To provide psychoeducation on the role of dhikr (remembrance of Allah) and spiritual practices in nourishing one's spiritual self.

3. To introduce the concept of Tazkiyah e Nafs (purification of the soul) and guide clients in practices such as Muraqba (meditation) and Tafakur (reflection) to gain awareness of self and Allah.

4. To encourage clients to engage in regular prayer (Salah) with concentration and focus, emphasizing its importance in spiritual growth and personal development.

5. To educate clients about the physical, spiritual, and heavenly benefits of fasting (Sawm) and encourage its practice as part of the therapy sessions.

Session VII & VIII Overview:

These sessions focus on incorporating spiritual interventions into the therapeutic process to deepen clients' connection with Allah and support their recovery from addiction. Through psychoeducation and guided practices, clients were encouraged to engage in spiritual activities such as prayer, meditation, and fasting, with the aim of promoting spiritual growth and well-being.

Introduction to Spiritual Interventions:

The therapist introduced clients to the concept of spiritual interventions as a mean of nurturing a purposeful connection with Allah and enhancing motivation in their recovery journey. Psychoeducation was provided on the importance of spirituality in addiction recovery and its role in promoting overall well-being.

Dhikr and Tazkiyah e Nafs:

Clients were educated about the significance of dhikr (remembrance of Allah) and its role in nourishing the spiritual self. The concept of Tazkiyah e Nafs (purification of the soul) was introduced, and clients were guided in practices such as Muraqba (meditation) and Tafakur (reflection) to gain awareness of self and Allah.

Importance of Prayer (Salah):

Clients were encouraged to offer prayers five times a day with concentration and focus, emphasizing the importance of Salah in spiritual growth and personal development.

Guidance was provided on how to maintain focus during prayer and to seek forgiveness for past wrongdoings in Duas (supplications) after Salah.

Fasting (Sawm) and Quran Recitation:

Clients were educated about the physical, spiritual, and heavenly benefits of fasting (Sawm) and encouraged to fast at least two days a week during therapy sessions.

Each therapy session included at least 10 minutes designated for the recitation of the Holy Quran, allowing clients to connect with the divine world and draw spiritual strength.

Outcomes:

Deepened Spiritual Connection: Clients experienced a deeper connection with Allah through spiritual interventions, providing them with a source of motivation and support in their recovery journey.

Increased Self-Awareness: Practices such as Muraqba and Tafakur helped clients gain awareness of their inner selves and their relationship with Allah, facilitating personal growth and introspection.

Improved Concentration and Focus: Engaging in Salah with concentration and focus enableed clients to experience greater spiritual fulfillment and joy in their prayers.

Enhanced Spiritual Discipline: Regular fasting and Quran recitation fostered spiritual discipline and resilience, helping clients overcome challenges and maintained their commitment to recovery.

Holistic Well-Being: Incorporating spiritual practices into therapy promoted holistic well-being, addressing not only the physical and psychological aspects of addiction but also the spiritual dimension of recovery.

Session IX & X: Emotional Interventions (Enhancing Emotional Processing and Adjustment in Addiction Therapy).

Objectives:

1. To utilize emotion-focused psychotherapeutic techniques to facilitate experiential processing of psychological themes, with a focus on emotions.
2. To assess maladaptive emotions and replace them with adaptive ones, promoting integrity and growth in individuals struggling with addiction.
3. To employ Prophetic Empathy as a tool for emotional adjustment and reframing, drawing from Islamic teachings and principles.
4. To incorporate empathic reflection, affirmations, attentional reallocation, and the Two Chair technique to support individuals in changing their emotional responses and interactions.

Session IX & X Overview:

These sessions focus on employing emotion-focused psychotherapeutic techniques to help individuals process and adjust their emotions in the context of addiction treatment. Drawing from principles of Prophetic Empathy and other therapeutic approaches, the therapist worked with clients to assess and replace maladaptive emotions with adaptive ones, fostering emotional growth and resilience.

Assessment of Maladaptive Emotions:

The therapist worked with clients to identify and explore maladaptive emotions that may be contributing to their addictive behaviors. Through open dialogue and exploration, clients were encouraged to express and reflect on their emotional experiences in a safe and supportive environment.

Replacement with Adaptive Emotions:

Clients were guided in replacing maladaptive emotions with adaptive ones, promoting emotional integrity and growth. Psychoeducation was provided on healthy emotional

regulation strategies and coping mechanisms to support clients in managing their emotions more effectively.

Utilization of Prophetic Empathy:

Prophetic Empathy, drawing from the teachings and example of the Prophet Muhammad (peace be upon him), was employed as a tool for emotional adjustment and reframing. The therapist helped clients cultivate empathy towards themselves and others, encouraging compassion and understanding in their emotional responses.

Techniques for Emotional Adjustment:

Empathic reflection and affirmations were utilized to validate clients' emotions and promote self-compassion. Attentional reallocation techniques were taught to help clients shift their focus from dangerous or distressing emotions to positive goals or needs.

The Two Chair technique was employed to facilitate emotional processing and change interactions, allowing clients to explore conflicting emotions or inner conflicts.

Outcomes:

Improved Emotional Regulation: Clients develop skills for identifying and managing their emotions more effectively, leading to greater emotional stability and resilience.

Enhanced Self-Compassion: Through Prophetic Empathy and empathic reflection, clients cultivate a greater sense of self-compassion and acceptance, reducing self-criticism and judgment.

Shift in Emotional Responses: Clients learn to replace maladaptive emotions with adaptive ones, promoting emotional growth and integrity in their recovery journey.

Improved Interpersonal Dynamics: The Two Chair technique and other interactive interventions help clients change their interactions and relationships, fostering healthier interpersonal dynamics.

Increased Emotional Awareness: Clients gain a deeper understanding of their emotional experiences and learn to navigate them with greater awareness and insight, promoting overall emotional well-being.

Session XI & XII: Cognitive Aspect of Psychotherapy (Integrating Quranic Verses and Positive Cognition Techniques).

Objectives:

1. To address cognitive processes and their influence on emotional well-being and functioning.
2. To introduce cognitive restructuring techniques grounded in Quranic teachings to challenge negative thoughts and promote positive cognition.
3. To facilitate the development of adaptive self-talk using Quranic verses as a tool for managing distress and enhancing resilience.
4. To encourage clients to maintain a Positive Hikmah Log, focusing on identifying positive outcomes and hidden blessings in challenging situations.
5. To promote heart purification through Tauba (repentance), Dhikr (remembrance), and Istighfar (seeking forgiveness), emphasizing the spiritual dimension of cognitive healing.

Session XI & XII Overview:

These sessions majorly focused on cognitive processing. As it has been discussed by different scholars (Keshavarzi & Haque, 2013) that cognitions and thought processes influence the other aspects of self and in turn distress and dysfunctioning can be induced. These sessions focus on the cognitive aspect of psychotherapy, utilizing Quranic verses and positive cognition techniques to challenge negative thoughts and promote emotional well-being. Clients were guided in cognitive restructuring, self-talk techniques, and maintaining a Positive Hikmah Log to foster resilience and perspective-taking.

Cognitive Restructuring with Quranic Verses:

Clients were introduced to the concept of cognitive restructuring, which involves challenging and reframing negative thoughts with positive alternatives.

Quranic verses were used as a tool for scriptural reframing, allowing clients to find solace and guidance in the teachings of Islam when facing distressing thoughts or situations.

Adaptive Self-Talk and Quranic Remembrance:

The Self-Talk technique was introduced, wherein clients were encouraged to use Quranic verses as affirmations and reminders during times of distress or low mood.

Clients were provided with specific verses to recall and recite when experiencing negative emotions, promoting a sense of comfort and empowerment through divine guidance.

Positive Hikmah Log:

Clients were assigned to maintain a Positive Hikmah Log, where they record unhappy events along with any positive outcomes or hidden blessings they identify.

Through this exercise, clients learned to reframe their perspective and focus on the positive aspects of challenging situations, enhancing resilience and coping skills.

Heart Purification and Spiritual Practices:

Clients were educated about the significance of heart purification in Islam and its connection to overall well-being and success.

Spiritual practices such as Tauba, Dhikr, and Istighfar were introduced as means of purifying the heart and seeking forgiveness for past wrongdoings. Clients were encouraged to incorporate these practices into their daily lives, reassured that they can engage in Dhikr at any time without the need for ablution.

Outcomes:

Enhanced Cognitive Flexibility: Clients developed the ability to challenge and reframe negative thoughts, promoting a more adaptive and resilient cognitive style.

Increased Emotional Regulation: Utilizing Quranic verses and positive cognition techniques, clients learned to manage distressing emotions and maintain a sense of inner peace and stability.

Improved Perspective-Taking: Through the Positive Hikmah Log, clients gained a greater appreciation for the positive aspects of challenging situations, fostering optimism and gratitude.

Deepened Spiritual Connection: Engaging in heart purification practices and Quranic remembrance, clients strengthened their spiritual connection with Allah, finding solace and guidance in their faith.

Holistic Healing: By integrating cognitive restructuring with spiritual practices, clients experienced holistic healing, addressing both psychological and spiritual dimensions of well-being in their recovery journey.

Session XIII & XIV: Behavioral Interventions.

Objectives:

1. To implement behavioral interventions aimed at refining the Nafs (self) and promoting self-improvement.
2. To utilize Cognitive Behavioral Therapy (CBT) techniques to address fears, prioritize values, and promote a healthy lifestyle.
3. To assist clients in developing a fear hierarchy centered on the primary fear of Allah and adjusting their priorities accordingly.
4. To introduce tools such as the 6 M's booklet and Token Economy to reinforce positive behaviors and discourage drug-related behaviors.
5. To educate clients about the benefits of physical Sunnah, exercise, healthy eating, and lifestyle changes to prevent relapse and promote overall well-being.

Session XIII & XIV Overview:

These sessions focus on behavioral interventions aimed at refining the Nafs (self) and promoting positive changes in behavior and lifestyle. Drawing from principles of Tehdeeb Ul

Akhlaq (self-improvement) and CBT techniques, clients were guided in addressing fears, setting priorities, and adopting healthy habits to prevent relapse and enhance well-being.

Fear Hierarchy Adjustment:

Clients were guided in developing a fear hierarchy, listing their fears in order of priority. Emphasis was placed on adjusting the hierarchy to prioritize the primary fear of Allah, which helped clients overcome worldly fears and anxieties.

Cognitive Restructuring:

CBT techniques were used to challenge negative thoughts and beliefs that contribute to fear and anxiety. Clients learned to reframe their thoughts and prioritize values aligned with their spiritual beliefs, fostering a sense of peace and trust in Allah's will.

Implementation of Behavioral Tools:

Clients were introduced to tools such as the 6 M's booklet, which provided practical guidance on maintaining positive behaviors and avoiding relapse.

Token Economy was utilized to reinforce positive behaviors and discourage drug-related behaviors, providing tangible rewards for adherence to treatment goals.

Lifestyle Modification:

Clients were encouraged to make lifestyle changes to support their recovery journey, including engaging in physical Sunnah practices, regular exercise, and healthy eating habits. Education was provided on the benefits of these lifestyle changes in promoting physical and mental well-being and reducing the risk of relapse.

Outcomes:

Reduced Fear and Anxiety: Clients experienced a reduction in fear and anxiety by prioritizing the primary fear of Allah and reframing negative thoughts and beliefs.

Improved Behavioral Regulation: Behavioral interventions such as Token Economy and lifestyle modification techniques helped clients regulate their behaviors and make positive choices aligned with their recovery goals.

Enhanced Spiritual Connection: By focusing on the primary fear of Allah and incorporating spiritual practices into their daily lives, clients deepened their spiritual connection and found strength and guidance in their faith.

Prevention of Relapse: Lifestyle changes and behavioral tools empower clients to avoid drug-related behaviors and maintain sobriety, reducing the risk of relapse and promoting long-term recovery.

Overall Well-Being: Through a combination of cognitive restructuring, behavioral interventions, and lifestyle modification, clients experienced holistic healing and improved well-being, addressing both psychological and spiritual aspects of their recovery journey.

Session XV: ***Termination Session (Transitioning to Self-Management and Post-Treatment Assessment)*** **.**

Objectives:

1. To empower clients with the knowledge and skills necessary for self-management and continued recovery post-therapy.
2. To reinforce the efficacy of therapy techniques and encourage clients to continue practicing them independently.
3. To provide information about post-treatment assessment procedures and follow-up sessions to monitor progress and provide ongoing support.
4. To conclude the therapy process with a collective prayer for the well-being and recovery of all clients, invoking divine guidance and blessings.

Session XV Overview:

The termination session marks the conclusion of therapy and serves as a transition point for clients to take ownership of their recovery journey. Clients were empowered with the tools and resources necessary for self-management, and arrangements were made for post-treatment assessment and follow-up sessions to monitor progress and provide ongoing support.

Empowering Clients for Self-Management:

Clients were educated about the efficacy of therapy techniques and encouraged to continue practicing them independently. Specific techniques, such as daily prayer with concentration, recitation of the Quran, Exercise, fasting, and Dhikr of 99 names of Allah, were highlighted as beneficial practices for maintaining recovery and spiritual well-being.

Preparation for Post-Treatment Assessment:

Clients were informed about the upcoming post-treatment assessment and the importance of participating in this evaluation to track their progress. The timing and logistics of the assessment were communicated to clients, allowing them to schedule the appointment at their convenience.

Discussion of Follow-Up Sessions:

Clients were briefed on the purpose and format of follow-up sessions, which would involve assessing their adherence to therapy practices and monitoring their overall well-being. The importance of continued support and accountability in the recovery process was emphasized, and clients were encouraged to actively participate in follow-up sessions.

Collective Prayer for Well-Being:

The session was concluded with a collective prayer (Dua) for the recovery and wellness of all clients, invoking divine guidance and blessings from Allah and the Prophet Muhammad (PBUH). Clients were encouraged to maintain a connection to their faith and seek divine guidance and support as they navigate their recovery journey.

Outcomes:

Enhanced Self-Efficacy: Clients felt empowered to continue practicing therapy techniques independently, confident in their ability to manage their recovery journey.

Continued Engagement: Knowledge of post-treatment assessment and follow-up sessions encouraged clients to stay engaged in their recovery process and seek ongoing support as needed.

Spiritual Connection: Clients deepened their spiritual connection and reliance on Allah and the teachings of the Prophet Muhammad (PBUH) for guidance and strength in their recovery journey.

Accountability and Support: The establishment of follow-up sessions provided clients with ongoing accountability and support, promoting sustained recovery and well-being.

Closure and Hope: The collective prayer for well-being served as a moment of closure for the therapy process, instilling hope and optimism for the future as clients embark on their journey towards lasting recovery and wellness.

Step III: Post – Intervention Assessment: As the treatment group completed the therapy sessions, the same participants who have completed the sessions, as some participants did not receive the complete intervention and have dropped out in start or in middle (both treatment and control groups), were assessed again approximately after 3 months. Only n=15 participants in Experimental group, while n=18 participants in control group have completed the session which became the sample for post-intervention assessment. The dropout rate was 25% for experimental group.

For post testing, Assessment tools, used in the Pre-Assessment Phase were administered to assess aspects of self, Relapse Vulnerability and Psychological Adjustment.

Phase III: Follow Up

Phase III has been consisted of follow up sessions.

Sample

Sample of follow up consisted of the drug addicts who were the part of experimental group during study III. Only 12 individuals from experimental group became part of the follow up session.

Procedure

Follow up of clients was done after one month of intervention completion. Researcher approached the clients and afterwards information regarding their current condition was gathered. Some semi structured interviews were conducted in which they disclosed about their feelings and condition and along with this they also gave their opinions about intervention. Most of the subjects found the intervention fruitful in overcoming their drug related problems.

Data Analysis

After getting the data through standardized measures, it has been analyzed using SPSS. For Scale construction and finalization of factors, exploratory factor analysis was done. To measure the differences between experimental and control group as well as pre-test and poet-test results, t-test has been used. Pearson Product Moment Correlation coefficient was applied to find the relationship between integrated Self, Relapse Vulnerability and Psychological Adjustment among drug addicts.

Ethical Considerations

Ethical approval has been granted by ethical Review Board, Department of Psychology, IIUI. Furthermore, Informed consent has also been taken from the participants of the study and they were also assured that the information they were providing would only be used for research purpose and it would be kept confidential and would not be shared at any forum to threaten them. Privacy and secrecy would be maintained.

Results

To accomplish the study objectives and to examine the framed hypotheses, some statistical analyses were done.

Table 8

Mean, Standard Deviations and t-values on Integrated Self Scale and its subscales among addicts (n=200) and non-addicts (n=200)

Variables	Addicts (n = 200) *M (SD)*	Non Addicts (n = 200) *M (SD)*	*t*	*p*	95% *CI* *LL*	*UL*	Cohen's d
Physical Self	24.95 (3.85)	29.23 (3.32)	3.33	.012*	.72	1.33	1.19
Cognitive Self	27.35 (2.89)	32.13 (3.84)	3.59	.003**	.35	1.25	1.40
Emotional Self	27.61 (3.52)	31.32 (3.44)	4.99	.014*	.91	1.68	1.06
Spiritual Self	32.00 (4.06)	36.64 (3.80)	3.87	.004**	-.17	-.57	1.18
Integrated Self	25.12 (7.54)	28.71 (7.65)	3.22	0.002**	-5.58	-1.34	0.46

*df =398, LL= Lower Limit, UL= Upper Limit, **p<.01, *p<.05, ***p<.001*

Table 8 shows the difference between Non addicts and addict individuals on Integrated self and its subscales. The mean column shows that non using individuals are at higher level of physical Self (M=29.23, SD= 3.32), Cognitive Self (M=32.13, SD= 3.84), Emotional Self (M=31.32, SD= 3.44), Spiritual Self (M=36.64, SD= 3.80) and integrated self (M=28.71, SD= 7.65) as compared to drug using individuals. Difference is significant at $p<.01$ and $p<.05$.

Table 9

Mean, Standard Deviation, Alpha Reliabilities and correlations between Integrated Self scale, its subscales, Relapse Vulnerability and Psychological Adjustment (N=200)

Scales	K	M	SD	α	PS	CS	ES	SS	ISS	AWARE	PAS
PS	14	14.49	4.78	.88	-	.43**	.52**	.63**	.91**	-.32**	.18*
CS	18	15.18	2.86	.73			.35**	.89**	.73**	-.18*	.14*
ES	18	13.78	1.4	.75				.57**	.66**	-.25**	.21*
SS	20	18.38	4.76	.87					.88**	-.32**	.19**
ISS	70	23.46	7.4	.84						-.88**	.19**
AWARE	28	2.8	0.42	.82							- .34**
PAS	27	4.43	1.48	.79							-

PSS= Physical Self , CSS= Cognitive Self , ESS= Emotional Self , SS= Spiritual Self . ISS= Integrated Self Scale, AWARE= advance warning of relapse, PAS= Psychological Adjustment Scale

Table 9 is showing the Alpha reliability coefficients of the 70 items of the Integrated Self Scale, its four subscales, Advance warning of relapse Questionnaire and Psychological Adjustment Scale. The Cronbach alpha coefficients for ISS is *.84*. High value of Alpha coefficient is indicating that the scale is internally consistent and is reliable measure to assess the underlying construct.

Alpha values of subscales are also significant. Inter scale correlations are also significant at $p<.05$. It is clear from the results that all subscales show significant with the total confirming construct validity. Correlation coefficient indicates that there is a negative significant relationship between relapse vulnerability and integrated self. While psychological adjustment is positively correlated with integrated self and its subscales.

Table 10

Linear Regression Analysis showing Integrated Self as Predictor of psychological Adjustment (N=200) among recovering drug addicts

		Psychological Adjustment		
			95% CI	
Variable	*β*		LL	UL
Constant	133.21***		113.92	141.28
Integrated Self	.087***		.07	.14
R^2		.38		
F		98.832***		

*CI= Confidance Interval, LL= Lower Limit, UL= Upper Limit, ***p<.001*

Linear Regression Analysis was computed in order to determine the predicting role of integrated self in psychological adjustment. A Regression equation was found significant (R^2 = .38, F (198)=98.832, p<.001). The results of the regression analysis depicted that 38 % of variance is contributed by integrated self in Psychological adjustment of drug addicts. Thus, it is inferred from the findings that integrated self significantly predicts psychological adjustment (β=.087, p<.001).

Table 11

Linear Regression Analysis showing Integrated Self as Predictor of Relapse Vulnerability (N=200) among recovering drug addicts

		Relapse Vulnerability		
			95% CI	
Variable	*β*		LL	UL
Constant	5.34**		4.66	6.01
Integrated Self	-.19**		.01	.25
R^2		.32		
F		7.71***		

*CI= Confidence Interval, LL= Lower Limit, UL= Upper Limit, ***p<.001*

A Linear Regression Analysis which was carried out to determine the integrated self as predictor of psychological adjustment as shown in table 11. A Regression equation was found significant (R^2 = .32, F (198)=7.71, p<.001). It has been revealed by the results of the regression analysis that the integrated self acts as a predictor, which contributed 32 % of

variance in relapse vulnerability among drug addicts. Thus, findings reveal that integrated self significantly negatively predicted relapse vulnerability (β=-.19, p<.05).

Table 12

Means, Standard deviations, t values and Cohen's d of scores of the Graduate (N=80) and undergraduate drug addicts (N=120) on Integrated Self Scale, AWARE Questionnaire and Psychological Adjustment Scale.

	Graduate			Undergraduate					95% CI		
	N	M	SD	N	M	SD	t	*p*	LL	UL	Cohen's d
ISS	80	28.93	7.69	120	23.75	6.63	.58	.01	2.68	1.46	.08
AWARE	80	18.15	3.32	120	27.88	4.17	.45	.03	.915	1.46	.04
PAS	80	38.02	4.23	120	27.43	2.23	.70	.001	1.06	2.24	.09

ISS= Integrated Self Scale, AWARE= Advance Warning of Relapse, PAS= Psychological Adjustment Scale, LL= Lower limit, UL= Upper Limit, CI= Confidence Interval

Results of table 12 shows the mean differences of scores among graduate (N=80) and undergraduate (N=120) drug addicts on Integrated Self Scale, AWARE Questionnaire and Psychological Adjustment Scale. Results indicate that there is a significant difference in integrated self, relapse vulnerability and psychological adjustment of graduate and undergraduate drug addicts. Mean values and SD indicates that graduate drug addicts have higher level of self integration and ultimately have better psychological adjustment than undergraduate drug addicts, while undergraduate have high relapse vulnerability than graduate drug addicts.

Table 13

Means, Standard deviations, t values and Cohen's d of scores of the drug addicts having positive (96) and negative (104) family history of drug addiction on Integrated Self Scale, AWARE Questionnaire and Psychological Adjustment Scale.

	+ve Family History			-ve Family History						
									95% CI	
	N	*M*	*SD*	*N*	*M*	*SD*	*t*	*p*	*LL*	*UL*	*Cohen's d*
PA	96	79.4	8.42	104	82.9	9.25	*2.29*	*.024**	*6.57*	*.480*	*.39*
IS	96	28.0	7.88	104	39.9	8.78	.749	.045*	1.78	3.96	*1.01*
RV	96	39.8	6.64	104	23.5	2.26	2.41	.036*	.162	12.55	*3.29*

**p <0.05, PA= Psychological Adjustment , IS= Integrated Self, RV= Relapse Vulnerability, CI= Confidence Interval, LL= Lower Limit and UL= Upper Limit*

Table 13 shows the mean differences among scores of recovering drug addicts with positive and negative family history on Integrated Self Scale, Relapse Vulnerability and Psychological Adjustment Scale. Results show that that a significant difference exists between psychological adjustment, Relapse Vulnerability and Integrated Self of addicts with positive family history and negative family history. Significant difference indicates that addicts with negative family history have better psychological adjustment and have Integrated Self than addicts with positive family history. The results further indicated that there addicts with positive family history have more vulnerability to drugs relapse as compared to the addicts who have negative family history of drug addiction.

Table 14

Means, Standard deviations, t values and Cohen's d of scores of the drug addicts having positive (132) and negative (68) relapse of drug addiction on Integrated Self Scale, AWARE Questionnaire and Psychological Adjustment Scale.

	+ve Relapse			-ve Relapse					95% CI		
	N	*M*	*SD*	*N*	*M*	*SD*	*t*	*p*	*LL*	*UL*	*Cohen;s d*
PA	132	2.91	1.15	68	4.51	.98	*9.01*	*.003***	*.71*	*1.32*	*1.49*
IS	132	3.56	1.04	68	4.14	.99	3.33	.045*	-.85	-0.17	*0.57*
RV	132	3.67	1.17	68	2.89	1.12	3.59	.004*	-1.08	-0.51	*0.68*

**p <0.05, **p<0.01 PA= Psychological Adjustment , IS= Integrated Self, RV= Relapse Vulnerability, CI= Confidence Interval, LL= Lower Limit and UL= Upper Limit*

Results of table 14 reveals that there is a significant difference in Psychological adjustment, relapse vulnerability and Integrated self of drug addicts having positive and negative history of relapse. Drug addicts having positive history of relapse show low level of psychological adjustment as compared to the addicts having no history of relapse (t=9.01, **p<0.01). Level of Integrated self is also low in addicts having positive history of relapse (t=3.33, *p,0.05). Drug addicts having positive history of relapse also scored more on relapse vulnerability (t=3.59, *p<0.05)

Table 15

One way Analysis of Variance of recovering drug addicts (N=200) using different types of drugs on Psychological Adjustment, Relapse Vulnerability and Integrated Self.

	Source of Variation	*SS*	*Df*	*MS*	*F*	*p*
	Between Groups	.06	3	.02		
PA	Within Groups	5.70	196	.05	.36	.781
	Total	5.77	199			
	Between Groups	752.83	3	250.95		
RV	Within Groups	6542.47	196	68.15	3.68	.015*
	Total	7295.31	199			
	Between Groups	911.73	3	303.91		
IS	Within Groups	8382.82	196	87.32	3.48	.019*
	Total	9294.56	199			

**P<0.05, PA= Psychological Adjustment, RV= Relapse Vulnerability, IS= Integrated Self, SS= Sum of Square, df= Degrees of Freedom, MS= Mean Sum of Square*

Table 15 shows that recovering drug addicts using different types of drugs differs significantly in Relapse Vulnerabilty F (3,196) = 3.68. There is no significant difference in Psychological Adjustment of drug addicts using different drug types. Moreover, results also reveals that the Integrated Self of drug addicts differ significantly among various drug types F (3,196) =3.68. The findings of post hoc analysis also support these results. The Post hoc test revealed significant differences in Integrated Self between the Hash and both the Poly drugs, p = .008, d = 1.62, and Heroin, p = .016, d = 2.60, Heroin and Poly drugs, p = .015, d = 2.48. There were also a significant difference confirmed by post hoc analysis in Relapse vulnerability between the Hash and both Polydrugs, p = .011, d = 1.26, and Heroin, p = .007, d = 2.49, and between the Heroin and Poly drugs, p = .003, d = 2.82.

Table 16

Frequencies and percentages of demographic variables of Experimental Group (N=20) and Control Group (*N* = 20)

Groups	Demographic Variables		Frequency	Percentage
Experimental	Marital Status	Married	14	70%
		Unmarried	03	15%
		Divorced	03	15%
	Education	Above graduation (high)	7	35%
		Below graduation (low)	13	65%
	Family type	Joint family	8	40%
		Nuclear family	12	60%
	Family History of Addiction	Positive	13	65%
		Negative	7	35%
	Type of Drugs Use	Hash	12	60%
		Heroin	5	25%
		Poly Drugs	3	15%
	History of Relapse	Positive	14	70%
		Negative	6	30%
	Treatment History	Positive	14	70%
		Negative	6	30%
	History of Present illness	Less than 3 Years	5	25%
		More than 3 years	15	75%
	Employment Status	Employed	14	70%
		Unemployed	6	30%
	Socioeconomic Status	High	4	20%
		Middle	11	55%

		Low	5	25%
Control	Marital Status	Married	11	55%
		Unmarried	8	40%
		Divorced	1	5%
	Education	Above graduation (high)	9	45%
		Below graduation (low)	11	55%
	Family type	Joint family	12	60%
		Nuclear family	8	40%
	Family History of Addiction	Positive	8	40%
		Negative	12	60%
	Type of Drugs Use	Hash	13	65%
		Heroin	3	15%
		Poly Drugs	4	20%
	History of Relapse	Positive	4	20%
		Negative	16	80%
	Treatment History	Positive	4	20%
		Negative	16	80%
	History of Present illness	Less than 3 Years	17	85%
		More than 3 years	3	15%
	Employment Status	Employed	14	70%
		Unemployed	6	30%
	Socioeconomic Status	High	3	15%
		Middle	14	70%
		Low	3	15%

Table 16 shows frequencies and percentages of demographic variables of experimental group and control group. It also indicates the sample distribution.

Figure 7

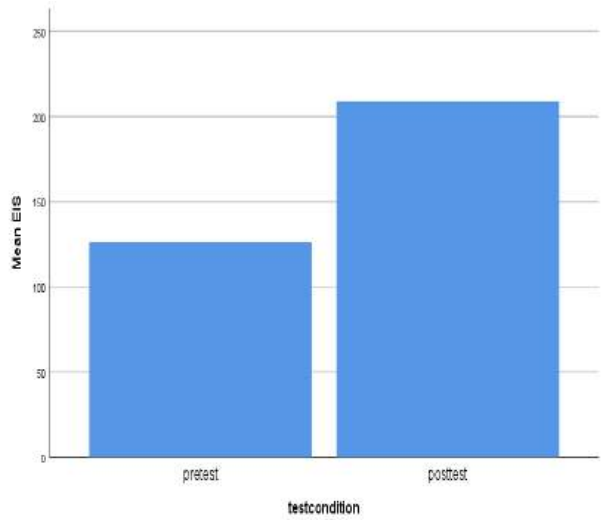


Figure 7 is showing the mean differences in Integrated Self between pretest and posttest assessment of Experimental group.

Note: *EIS= Integrated Self of Experimental group*

Figure 8

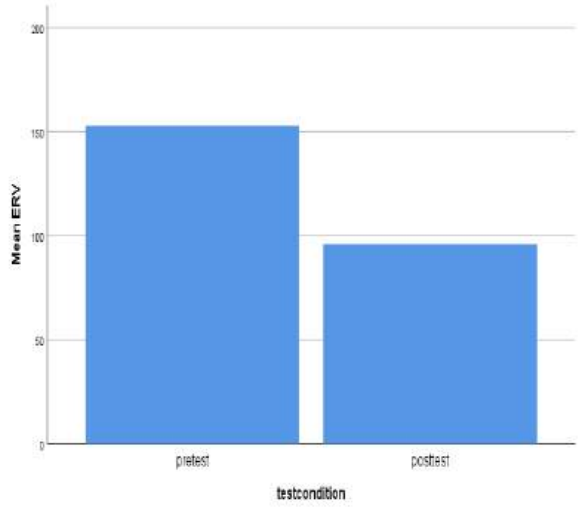


Figure 8 is showing the mean differences in Relapse Vulnerability between pretest and posttest assessment of Experimental group.

Note: *ERV= Relapse Vulnerability of Experimental group*

Figure 9

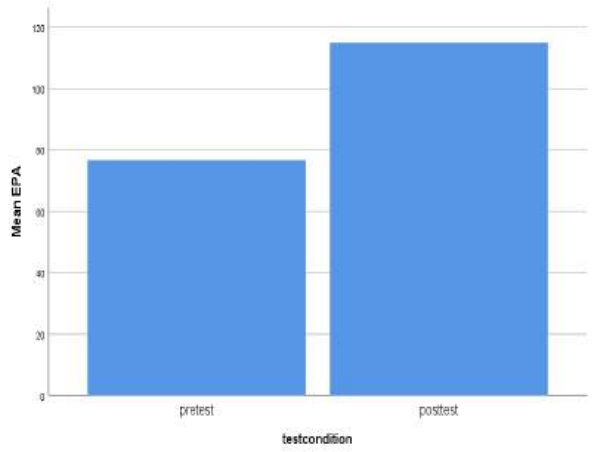


Figure 9 is showing the mean differences in Psychological Adjustment between pretest and posttest assessment of Experimental group.

Note: *EPA= Psychological Adjustment of Experimental group*

Table 17

Mean differences between pretest and posttest assessment on Integrated Self, Relapse and vulnerability and Psychological Adjustment in Experimental Group (N=20).

	Experimental Group Pre and Post Treatment Differences					95% CI	
	M	SD	SEM	t(14)	*P*	LL	UL
Pretest Posttest IS	-81.2	34.8	8.98	9.04	.000	-100.4	-61.93
Pretest Posttest RV	58.13	12.6	3.27	17.78	.000	51.12	65.14
Pretest Posttest PA	-38.13	12.2	3.14	12.14	.000	-44.87	-31.39

IS= Integrated Self Scale, RV= Relapse Vulnerability, PA= Psychological Adjustment , LL= Lower limit, UL= Upper Limit, CI= Confidence Interval

Results of paired sample t-test indicated in table 13 shows that the mean value of Integrated self differs before intervention (M=127.6, SD=12.26) and after intervention application (M=208.8, SD=34.23) at the 0.05 level of significance, t(14)= 9.04, n=15, p<.001, 95% CI for mean difference: -100.4 to -61.93. The average difference between pretest and

posttest assessment is -81.2 which indicates that in post treatment assessment individuals show higher level of Integrated self which is attained due to the intervention. Results also show that relapse vulnerability in pretest (M= 154.13, SD= 5.78) also differs from that in posttest (M=96, SD=8.04) at p<.001 level of significance. The mean difference (M=58.13) indicates that after receiving intervention individuals showed less signs of relapse vulnerability.

Moreover, significant difference in psychological adjustment of drug addicts before (M=76.8, SD=6.23) and after intervention (M=114.93, SD= 10.76) has also been revealed through results. Psychological adjustment of drug addicts get better after receiving the intervention as indicated by the mean difference (M=-38.13).

Figure 10

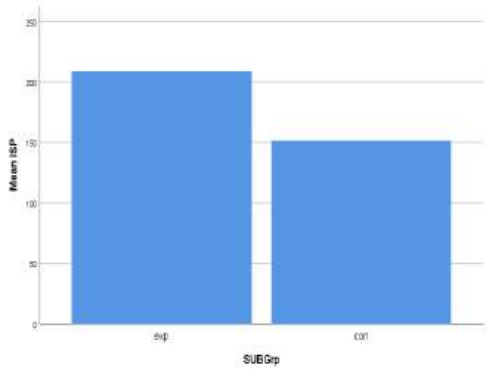


Figure 10 shows the mean differences in Integrated Self among experimental and control group in Post Treatment Assessment.

Note: ISP= *Mean value of Integrated Self in Post Test condition*

Figure 11

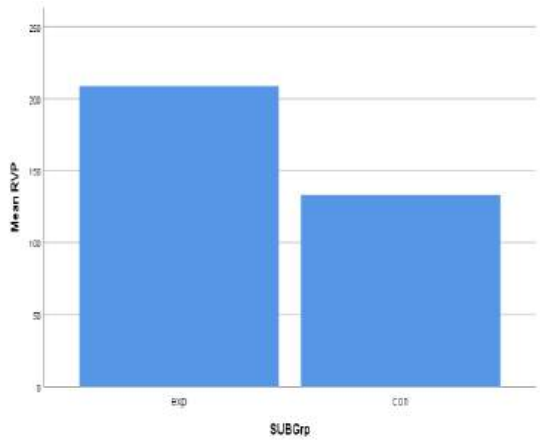


Figure 11 shows the mean differences in Relapse Vulnerability among experimental and control group in Post Treatment Assessment.

Note: RVP= *Mean value of Relapse Vulnerability in Post Test condition*

Figure 12

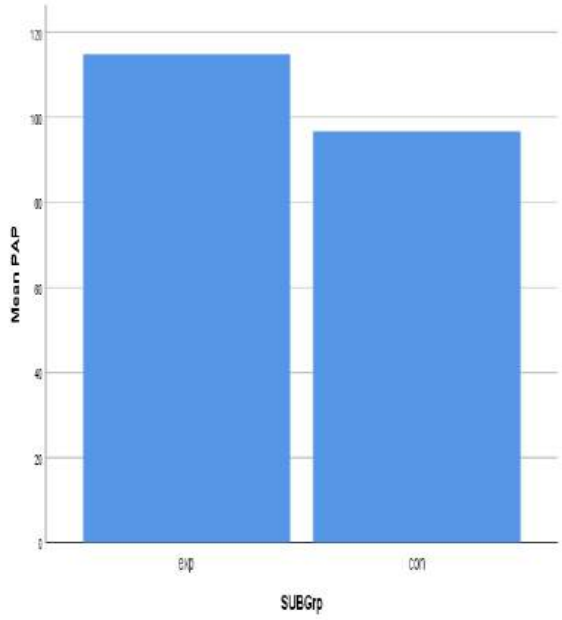


Figure 12 shows the mean differences in Psychological Adjustment among experimental and control group in Post Treatment Assessment.

Note: PAP= *Mean value of Psychological Adjustment in Post Test condition*

Table 18

Mean differences between Experimental (n=15) and Control group (n=18) post treatment assessment of Integrated Self, Relapse vulnerability and Psychological Adjustment of recovering drug addicts.

	Post Treatment Differences					95% CI	
	M	SD	SEM	t(14)	*p*	LL	UL
Ex-Con IS	84.4	42.1	10.87	7.76	.000	61.1	107.7
Ex-Con RV	-36.53	33.2	8.57	18.14	.001	-54.9	-18.14
Ex-Con PA	25.07	9.32	2.41	10.41	.000	19.9	30.2

IS= Integrated Self Scale, RV= Relapse Vulnerability, PA= Psychological Adjustment , LL= Lower limit, UL= Upper Limit, CI= Confidence Interval, Ex-Con= Experimental and Control group

Results of paired sample t-test indicated in table 18 shows that the mean value posttest Integrated self in experimental group (M=208.8, SD=34.23) differs significantly at p<.001 from control group (M=124.4, SD= 11.51). The average difference (M=84.4, SD= 42.1) between experimental and control group posttest assessment indicates that in experimental group the level of integrated self is higher as compared to the individuals in control group. Results also show that relapse vulnerability is higher in Control group (M= 132.5, SD= 30.2) as compared to the experimental group (M=96, SD=8.04) at p<.001 level of significance.

Furthermore, a significant difference in psychological adjustment of drug addicts in Experimental group (M=114.93, SD= 10.76) and control group (M=89.87, SD=5.69) was shown in results. Differences were found significant at p<.001.

Results show the efficacy of intervention provided to the drug abusing individuals.

Figure 13

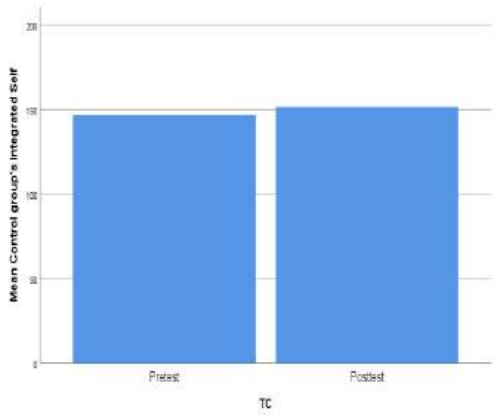


Figure 13 shows the mean differences in Integrated Self of Control group in pre and post intervention assessment.

Figure 14

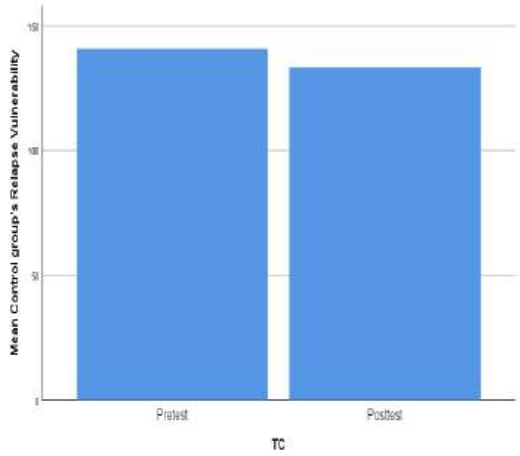


Figure 14 shows the mean differences in Relapse Vulnerability of Control group in pre and post intervention assessment.

Figure 15

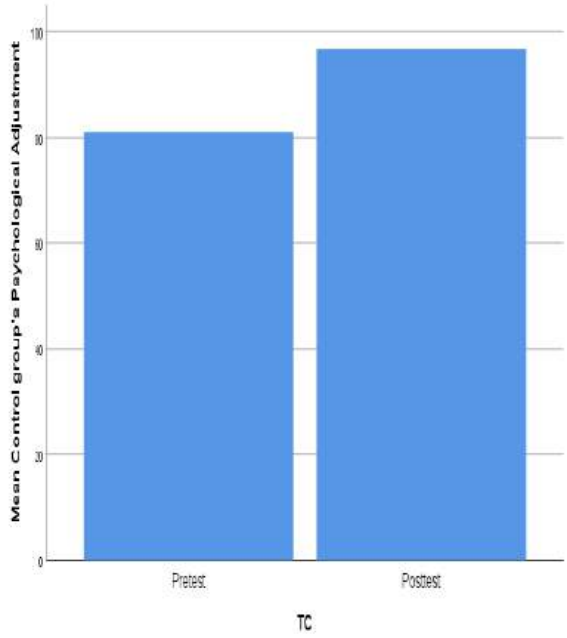


Figure 15 shows the mean differences in Psychological Adjustment of Control group in pre and post intervention assessment.

Note: *TC= Test condition i-e pre test or post test*

Table 19

Mean differences between pre and post treatment assessment of Integrated Self, Relapse vulnerability and Psychological Adjustment of recovering drug addicts in control group (N=20).

	Pre and Post Treatment Differences in Control Group					95% CI	
	M	SD	SEM	t (17)	*p*	LL	UL
Pre-Post IS	-3.11	9.96	2.34	1.32	.203	-8.06	1.84
Pre-Post RV	13.05	27.81	6.55	1.99	.063	-.77	26.8
Pre-Post PA	8.38	10.48	2.47	3.39	.003	-13.6	-3.17

IS= Integrated Self Scale, RV= Relapse Vulnerability, PA= Psychological Adjustment , LL= Lower limit, UL= Upper Limit, CI= Confidence Interval, df= Degree of Freedom

Results of paired sample t-test shows the mean between pretest and posttest assessments in control group. Mean values revealed that there is not any significant difference between pretreatment and post treatment level of Integrated self (M=-3.11, SD=9.96) and relapse vulnerability (M=13.05, SD= 6.55) in control group. Furthermore, it can also be seen in results that Psychological adjustment get better in post treatment (M=88.5, SD= 6.33) condition as compared to pretest condition (M=80.1, SD= 8.06). Difference found to be significant at **p<.01.

Content Analysis

Content analysis is the study of communication artifacts, which might be texts of various formats, pictures, audio or video. Content analysis is used by social scientists to replicate and systematically examine the patterns of communication (Bell, Bryman & Harley, 2011). The major advantage of using content analysis is that the social phenomena can be analysed in a non-invasive nature, rather than simulating social experiences or collecting survey answers. In present study, to determine the feelings and psychological condition of subjects in follow up, a content analysis was done. It was also aimed to get feedback regarding efficacy of TIIP. For this purpose some open ended questions were asked from subjects. What is the difference between your previous and current condition?. How do you find this intervention beneficial?. Frequencies and percentages were then found according to their verbal expressions.

Table 20

Frequency and percentages of content identified by recovering drug addicts in the follow up session (N=12)

No.	Content	*F*	*%*
1	بہتر	11	92
2	منشیات کی طرف دھیان کم جاتاھے	10	83
3	نفسیاتی مضبوطی	8	67
4	احساسی مضبوطی	9	75
5	اللہ تعالیٰ سے قربت	10	83
6	اللہ تعالیٰ کی ذات پر یقین کامل	10	83
7	کچھ بھی نا ممکن نہیں ہے	6	50
8	سوچ میں مثبت تبد یلی	7	58
9	اندرونی سکون	8	67
10	معافی پر یقین	6	50
11	سنت کی پابندی	5	42
12	خلوص نیت	6	50
13	ہر بیماری کا علاج ممکن ہے	7	58
14	فا ئدہ مند	10	83
15	آسان	10	83
16	دلچسپ	8	67
17	روحانی تربیت	7	58
18	دینی و دنیاوی معلومات	6	50
19	نماز کی پابندی	9	75
20	تلاوت قرآن کی پابندی	8	67
21	ورزش کی باقاعدگی	10	83
22	سونے جاگنے کے مقررہ اوقات کی پابندی	9	75
23	اپنی فیملی کو وقت دیتا ہوں	10	83
24	آسانی سے خود پر قابو پا لیتا ہوں	8	67
25	آسانی سے خود کو منشیات سے دور رکھتا ہوں	9	75
26	اپنی جسمانی حالت کا خیال رکھتا ہوں	8	67
27	اپنے مسائل خود حل کرنے کی ممکنہ کوشش کرتا ہوں	8	67

Table 20 shows the content identified by the subjects who participated in research. 92% individuals feel better as they stated “I am feeling better after these activities, my muscles get relaxed and don’t feel anxious in many situations now”. 83% individuals show less inclination towards drugs and 75% stated that they can abstain from drugs, “after receiving this therapy I really don’t have the thoughts about taking drugs and if it happens so I immediately engage myself in any activity I have learnt in the sessions and by doing so I can stay away from drugs”. 67% individuals feel spiritually strong “I have some meaning of life which I have to accomplish, I must submit to Allah and all my deeds should be for the sake of Allah”. 83% stated” I have gain nearness to Allah and I believe that Allah is supreme power, nothing can be done without his will, he is around us all the time and keeps eye on all of our doings, we can’t hide anything from him because he knows each and everything either it is apparent or hidden”. 67% feel inner peace and 50% show faith on forgiveness “by doing all these activities and practices in sessions and even after sessions while doing at home, I strongly experience inner peace, before that I always have the feelings of guilt and remorse but now I strongly believe on power of Dua, whenever I make dua with candid intentions I feel like Allah is answering me and for sure he will forgive me because he is “GHAFOOR and RAHEEM” and I feel very peaceful. 58% individuals find positive change in thoughts “before all this I never thought in a way like I think now. I usually used to think that I can never give up this habit of drug addiction, but now I think in very positive way after getting enough information, I know that just like all other illnesses this illness can also be treated but willpower is very important, nothing is impossible in this world if Allah wills to do so”. 83% individuals find the intervention helpful, easy and interesting. “these activities seems very beneficial and they are quite simple and easy as I can do it at my own. Nothing makes me overburdened and I feel relaxed and comfortable after doing these activities”. 67% individuals stated that they focus on their Physical appearance “now I am more concerned about my physical appearance as I have to offer Namaz five times

a day so I try my best to be neat and clean so when I stand in front of Allah I must not feel ashamed due to my appearance".

67% individuals show self control and ability to solve problems at their own. "Whenever I find myself in any problem I seek help from Allah and due to his remembrance I gain self control. Whenever I feel like I am losing control on myself in anger or something else I start zikr of Allah and I try to avoid the situation for some time and can easily manage everything". 83% individuals' show time management as stated by them "these activities helped me a lot in time management. I can now spare my time for all activities like for exercise, for family and for Ibadat. Before this most of time was consumed in taking drugs and after taking it I could not be able to focus on any of task and then again I used to think only about taking drugs, but now I engage myself in different activities and those thoughts don't bother me".

Discussion

As literature indicated that drug addiction is one of the spiritual disease if we focus on the Islamic perspective. So it can clearly be related that individual having less focused on spiritual self can easily be trapped in drug abusive behavior (Yusuf, 2012).

The aim of the current study was to investigate the integrated self, relapse vulnerability and psychological adjustment among recovering drug addicts. Different demographic variables were also examined. Integrated Self Scale (α= .84), AWARE Questionnaire (α= .82), and Psychological Adjustment Scale (α= .79) were used. All three scales were found to be reliable statistically. A highly significant correlation is indicated in results of present study between integrated self, relapse vulnerability and psychological adjustment, which shows that integrated self strongly negatively correlates with relapse vulnerability while it strongly positively correlates with psychological adjustment.

According to the first hypothesis, a difference in level of self functioning between drug addicts and non-using individuals has been assumed. Results designated in table 8 reveals that there is a significant difference between their level of Integrtaed self. Non addicts showed higher level of integrated self while addicts exhibited lower level (Fragmented Self) of Integrated self. Results revealed that the self plays an important role in choosing abusive behavior. As the individual is not focusing on all of the aspects of his/her self properly so he /she may get involved in such behaviors. As already mentioned in literature that drug addiction is considered as a spiritual disease, so when level of spirituality in an individual is not up to the mark he may involve in such temporary pleasure seeking behaviors. Individuals are focusing more on the bodily needs than the overall functioning of the self. These results are further confirmed by the study in which personality unintegration is considered as an essential cause of the drug related problems Results of another study found significantly low level of self integration in individuals using drugs when compared to the normal population (Pollock et al., 2001; Wildgoose et al., 2001). In addition, the Mental Health and Counseling Center of the university of Texas also reported that low level of integrated self can lead to lack of confidence and psychological development and a greater tendency towards drugs consumption (MacArthur, & MacArthur, 2004). Lack of integrated self can be the root cause of many social and psychological problems which include some crimes, transgression, delinquency and drug abuse (Kahn, & Fawcett, 2007). Many other researchers described that the individuals having higher level of self, exhibited decreased likelihood of drug abuse. It has been added that increased level of integrated self also acts as a predictor of drugs avoidance and relapse prevention (McMurran, 2003, Kounenou, 2010).

A negative relationship between relapse vulnerability and psychological adjustment among recovering drug addicts has also been hypothesized in a study. Results indicated the strong negative correlation among these two variable (Table 9). These findings can also be

supported by the different researches, in which researchers have discussed that early starting of drugs lead to its recurrent use and this relapse may cause psychological maladjustment. Individuals having high relapse vulnerability don't have will power to control this behavior and they have the recurrent thoughts of having drugs so they are unable to focus on any other task of their life. And this long term use leads to psychological maladjustment. At a comparison it has become obvious that only those individuals who have already quitted and withhold the drugs reported the best psychological health (Kerstin, Judith & Jonathon, 2011).

Several mechanisms are thought to be accountable for the relation between psychological functioning and drug relapse. According to the problem behavior theory, there are certain underlying factors, which inclines the individuals for both behavior problems (including substance use) and psychological adjustment. So it could be concluded that there is a common cause of a broad range of adjustment problems, including drug use, deviant behaviors and psychological maladjustment. And that common cause is their self. But it is not necessary that it is the only cause, there may be some other confounding factors which may contribute to their drug using behavior and later psychological adjustment. (Donovan, Jessor & Costa, 1991; Fergusson & Horwood, 1997; Degenhardt, Hall & Lynskey, 2003).

According to the third hypothesis, there is a negative relationship between integrated self and relapse vulnerability and positive relationship between integrated self and psychological adjustment. Results of the study have confirmed this hypothesis (Table 9). Integrated self plays its own role in explaining why people tend to choose abusing drugs. Integrated self can explains which aspects of self are involved in drug abusing behavior, relapse vulnerability and the psychological adjustment of drug addicts.

Wildgoose et al. (2001) introduced a term personality fragmentation (unintegration) that was opposite to the integrated self. It is considered as an unstable and discontinuous sense of self in which there is not any harmony and balance between different aspects of self.

Researcher considered the unintegrated self as being a core constituent of the drug abuse and its related problems. When drug addicts were compared with the non-clinical individuals who were not using any type of drugs, it was found that significantly higher level of self-unintegration (fragmentation) was present in drug addicts (Pollock et al., 2001). Along with this, it has also been reported in their research, that higher levels of self-fragmentation were positively related to psychological maladjustment as well. This strong relationship can explain that relapse vulnerability is an outcome of lower level of integrated self.

It has also been confirmed from results that Integrated self significantly positively predicts psychological adjustment (Table 10) while negatively predicts relapse vulnerability (Table 11). As there are many factors like peer pressure, environment, easy availability of drugs etc in relapse vulnerability of an individual so we can say that self acts as one of the factors in drugs relapse.

Pathology and psychological illness is often considered as an internal psychological unintegration or fragmentation. Thus, integration of the dissimilar parts of the human psyche can contribute to intrapsychic dissonance (Keshavarzi & Haque, 2013). But when related parts are integrated, the psyche or self may work better and can get rid of that pathology.

When graduate and undergraduate recovering drug addicts were compared on integrated self, relapse vulnerability and psychological adjustment it has been seen that graduate drug addicts have more integrated self, have low relapse vulnerability and better psychological adjustment when compared to undergraduate drug addicts (Table 12). If concerning to participants' education, regrettably, very few researches showed the association of level of education to integrated self and relapse vulnerability of the drug addicts (Kulesza, Larimer & Rao, 2013). The available studies indicate inconsistent findings regarding educational differences in experiencing relapse vulnerability associated with integrated self. Kelly, Dow and Westerhoff (2010) found no significant differences between educational levels

relapse vulnerability among the drug abusers. Less education or leaving school at an early age are associated with more disordered and chaotic drug use (Rhodes, Lilly, Gomex et al., 2009). But it can be speculated that if individual is highly educated he may take special care of his self. He will consider all aspects equally important so will try to maintain harmony among them. So he will have integrated self and eventually he will show less abusive behavior and in turn may exhibit better psychological adjustment.

It has also been revealed that drug addicts having positive family history of drug abuse showed lower level of Integrated Self, more relapse vulnerability and psychological maladjustment as compared to the addicts whose parents were not using drugs (Table 13). The parents who are using drug addicts, their children are more prone to use drugs as they get this craving through their genes. Off springs of drug addicts have increased vulnerability of drug addiction (María-Ríos, & Morrow, 2020) and sometimes they show more negative emotions and destructive behaviors. It is evidenced by a family study of drug users that children of drug addicts exhibited negative child behavior (Cook, Kelley, Stewart & Golden, 2004). Due to lack of knowledge people treat drug addicts harshly. Drug addicts have positive family history receive more criticism from society which can hurt their self-esteem and ego. If they want to quit the abusive behavior they again opt for it just to keep their ego protected. They have more chances of relapse despite of several treatments. And despite of their sober behavior, society does not accept them as people around them always use to taunt them and give them harsh remarks due to their family history. Psychological adjustment is disturbed when drug addicts become victim of this mal treatment from society. Psychological mal adjustment is harmful not only for addicts but also for his family and even for whole society.

When comparisons were made in different drug types with respect to integrated self, relapse vulnerability and psychological adjustment, it has been that a significant difference is found in overall functioning of hash, heroin and alcohol abusers. Heroin is one of the most

treacherous and relapsing drug. Once used, an individual gets addict of it within 24 hours. When not found individuals feel severe withdrawal symptoms. The integrated self is a person's sense of identity and self-worth. Drug use can have a negative impact on the integrated self by leading to feelings of shame, guilt, and worthlessness. It can also damage relationships and make it difficult to achieve goals. Each addictive substance has different stigma attached to it. And accordingly drug addicts have different levels of psychological adjustment. Heroin addiction is considered most serious and hazardous form of addiction. Substance dependence has a consequent relationship with psychological adjustment (Kerstin, Judith & Jonathon, 2011). A study indicated that hash individuals show less mall adjustment as compared to heroin addicts (El-Sayed Bauomey Mohamed, 2022). Hash creates psychological mall adjustment in individuals when use for longer period of time.

As discussed earlier that hash and alcohol are sometimes not considered as an addictive substances or they are considered less dangerous form of addictive drugs. The users of these drugs are not thought to be addicts in some areas because chances of relapse are somewhat lower than the heroin addicts. They experience lower level of guilt and shame and as a result they can function properly in different aspects of life. Their psychological adjustment is not greatly affected by substance abuse. A study by Shedler and Block (1990) indicated that hash addicts were best adjusted in population when compared with heroin individuals. Frequent heroin users were mall adjusted and they showed discrete personality syndrome manifested by interpersonal isolation, poor impulse control and marked emotional distress.

Individuals who have already a history of relapse show more vulnerability to drug relapse, have lower level of Integrated self and psychological maladjustment (Table 14). When individuals experience a relapse, it often reinforces the neural pathways associated with the addictive behavior. These pathways become more ingrained and automatic, making it easier for the person to fall back into the same behavior when facing triggers or stressors. The brain's

reward system becomes sensitized to the substance or behavior, heightening the vulnerability to relapse. Individuals with a history of relapse might struggle with emotional regulation. They may experience intense emotions and have difficulty managing them in healthy ways. This emotional dysregulation can make it harder for them to handle cravings and triggers, increasing the likelihood of relapse and sometimes they might develop cognitive biases that lead them to underestimate the negative consequences of their addictive behavior. They might have a distorted perception of their ability to control their use and believe that they can handle "just one more time," which can contribute to repeated relapses. All of these things are directly associated to their psychological maladjustment as well. Then are unable to cope up the situation just because they are not psychologically healthy enough (Sinha, 2008).

Relapse is considered as an unescapable part of the recovery process, and individuals usually experience relapse when they start seeking treatment to quit their drug using behavior (Melemis, 2015). However, the relapse stabilization can reduce the perseverance for providers, patients, and support individuals, and it will help to prevent the relapse from occurring.

Innumerable individuals face immense adverse consequence of relapses (Vivolo-Kantor et al., 2018). The most common relapse prevention strategy includes therapeutic interventions. For many individuals either in the healthcare system or in society focus, relapse is considered as a consumption of drugs after seeking treatment and quitting them and it has been problematic for the individual. Though, consumption of drugs is the very last step in the relapse, and individuals usually neglect earlier events in a relapse. This negligence prevents the efficacy of interventions at earlier stages.

Relapse prevention is found to be a crucial part of recovery process. If an individual encounters frequent relapse, he/she may not progress positively in overcoming addictive behavior. This frequent relapses may hinder his/her functioning in either of their aspects of life (Volkow, Wang, Fowler, Tomasi & Telang, 2011).

In a present study it was hypothesized that Traditional Islamically Oriented Psychotherapy (TIIP) is fruitful in achieving high level of integrated self and in turn relapse prevention occurs and an individual can have better psychological adjustment. Results of the study indicated a significant difference in all variable value between pretest and post test results of experimental group (Table 17). TIIP is not based on a single approach instead it focuses on all elements of human self i-e physical, behavioral, emotional, cognitive and spiritual. When all elements of self are approached and get treated then obviously the self would attain harmony in all these aspects. The first goal of this intervention is to get awareness about self, secondly to get balance between all aspects and finally to integrate all aspects of self so an individual can experience sense of integrated self. After attaining this state of integration, the believer achieves a harmony with the will of God such that all their actions and deeds are now being directed by God's desires. The previous step of i'tidāl has well-informed them to get rid of clinical pathologies (takhliyah) through treatment. Through this process an individual gains insight about their psycho-spiritual capacities and further development of positive virtues and traits is made possible. The reestablishment of a holistic balance between all aspects of self is envisioned to provide a patient with an insight into themselves which can ultimately allow the patients to work as their own therapists. And he/she become able to identify independently when and why they are deviating from this unity or the equilibrium which has been achieved earlier (Richards et al., 2015).

According to the need of Muslim society and an explosion of emerging literature in spirituality and Islamically oriented mental healthcare, an interest in spirituality-oriented psychotherapies is increasing enormously day by day (Richards & Bergin, 2004; Pargament, 2007, 2013). Muslim community demands for mental health services within an Islamic context.

TIIP is a combination of techniques based on cognitive, behavioral and emotional therapies. As discussed earlier pathologies are caused by disintegration of elements of self. In this regard TIIP acts very affectively in treating such issues (von Hammerstein, 2019). Previous studies also proven the logical utility and efficacy of empirical psychotherapies (Resick, Monson, & Chard, 2016). In another study it has been discussed that experiential therapies provide a sense of discovering all aspects of self which works as a magic for treating pathologies caused by the self deterioration (Pascual-Leone & Greenberg, 2006).

The overreaching goals of TIIP are self awareness, equilibrium and integrative unity of all aspects of self. This integration tends the formation of internal unity through which believer achieves a harmony between his actions and God's desires. They totally surrender to the will of God, they like and dislike for the only sake of God. So when it is related to the drug abusive behavior, it seems very obvious that an individual can understand that these things are prohibited by Allah so he/she must have to quit it. Furthermore, an individual starts focusing on unity of purpose which helps the individual to move beyond the basic needs of survival and this experience can prompt the psychological adjustment (Worthington, Hook, Davis & McDaniel, 2011).

Chapter 6

Discussion

Drug abuse can be likened to menacing creatures, draining the vitality and life force of the youth and transforming once-harmonious homes into nightmarish landscapes. It manifests as an unrelenting, irresistible, and regular consumption of substances that pose not only physical threats but also grave risks to mental and psychological well-being. The pervasive rise of drug addiction within our society is alarming, as individuals find themselves ensnared in a web of dependency. This escalating epidemic of drug addiction disrupts the normal rhythm of daily life, impeding individuals from engaging in their routine activities. Furthermore, it acts as a formidable barrier, preventing addicts from achieving their life goals and aspirations. The singular focus of those ensnared by drug abuse becomes centered on obtaining, using, and managing their drug intake, to the detriment of their personal and professional endeavors (Jabeen et al., 2018).

Sometimes, people feel them too bright and sharp, too powerful, and having too much self control to become addictive. But this is their misconception as addiction can trap anyone. Because there are some drugs like heroin, which make an individual addict within 24 hours of their first ever use. It is not only affecting that single human being instead it has a negative impact on whole society. It can cause deformities in one's body because it has severe impacts on body as different systems get impaired and malfunctioned due to drugs. It can cause problems in family structure, when an individual is having a psychological impairment obviously he would be unable to perform his duties well and he would mistreat his family so the family structure would in turn get deteriorated. An addict needs drugs at any cost whether he is able to afford it or not, so when an individual is unable to buy the drugs he would be engaged in law breaking activities like stealing and robbery, in this way drug addiction would contribute to the delinquency in society. But it does not mean that if once they have lost control and get addicted, they can never get back to their lives. If they start seeking help for their

problems, there are more chances that they can gain control of their life once again (Singh & Gupta, 2017) .

There are many factors which can contribute in drug abusive behavior but when focusing on personality and aspects of self it has been seen that if individual do not focus on each and every aspect of self properly he may get some psychological problems and drug addiction is one of them (Bleidorn, & Ködding, 2013).

Limitations and Suggestions

Even though a great effort has been put by the researcher, still the present study is having the following limitations.

As far as results interpretation has been considered following concerns should be taken into account. As most part of the sample for scale construction was taken from different educational institutes, therefore characteristics of these institutes may influence the results. In order to curtail this limitation, more sample should be taken from different walks of life to assess the actual unevenness. In future Institutinal comparisons can be made to check whether results get affected or not.

Second, the data was gathered through self-report measures so there is a need to take a common method-bias into account. Third, there may be an issue of generalizability due to small sample size and use of cross-sectional survey design. This limitation can be overcome by taking a larger sample that should be from different parts of Pakistan having diverse cultural and ethnic backgrounds.

Only structured questionnaires were used in current research and any other mean to gather information about drug addicts was not used. It did not let to explore other causes except their functioning of self behind their drug use. In depth interviews are also suggested to gather detailed information about the causes of their drug abusing behavior.

Stigmatization poses a significant limitation in this study due to the usage of the term "drug addiction." It is recommended that future studies refrain from employing such stigmatizing language. Stigmatization arises when terms like "drug addiction" are utilized as they tend to carry negative connotations, portraying addiction as a moral failing rather than a complex medical condition. This stigma can lead to individuals feeling ashamed or reluctant to seek help, exacerbating the challenges they face. By avoiding stigmatizing terms and adopting more neutral or person-centered language, researchers can contribute to reducing societal biases, improving access to support services, and fostering a more empathetic understanding of substance use disorders.

In Pakistan it is considered bad if any female is using drugs. A large number of females are abusing drugs but to conceal this reality from society their addiction problem is not being disclosed. For this reason very rarely females come to the rehabilitation centers for treatment, so due to inaccessibility of female sample only males were surveyed. Results of the present study could not be generalized to female population as no data has been gathered related to females and it doesn't explore the role of integrated self in female drug users. Female drug users should also be approached so gender wise differences can also be determined.

The dropout rate was high as first of all patients are not willing to enter into the treatment sessions for a longer period of time and if they do so after some time they quit the therapy. It is the dire need to make people aware that drug addiction is a psychological disorder if the root cause is not subjugated it can cause relapse. Researches should be done in this area to enhance their knowledge about the causes of drug addiction.

Implications

The present study can have the following possible implications.

The current study was aimed to develop an instrument which could measure the integrated self of an individual. This newly constructed measure has been validated and it can

be used in different studies. Self is an important variable which has effect on almost all aspects of life. So this measure will add an important contribution in literature. It might open the way for further research in this genre specifically in Pakistan.

In addition to this, TIIP has also been translated and validated which can help future researchers and clinical practitioners to deal with different disorders by enhancing their self-integration.

Conclusion

Current study was focused to understand what the self is and whether there are some aspects of self or it is a unit. For this purpose a scale was constructed using standard procedure of scale construction. After that a cross-sectional survey designed was employed to collect the data from different individuals of Rawalpindi/Islamabad. Sample was comprised of both male and female individuals. The findings of the study reveal that there are four basic aspects of self which are positively related with each other. If individuals score higher it means that they have higher level of integrated self. The future researchers can use this scale in settings with different sample.

It can be also be concluded from the results that drug addiction is caused by disharmony in different aspects of self, and it also effects psychological adjustment of drug addicts. Disintegrated or fragmented self can act as a covariate of psychological maladjustment among drug addicts. Individuals having low integrated self have high relapse vulnerability and they are psychologically less adjusted and individuals having high level of integrated self are better to psychologically adapt to the situations. Besides, it is also concluded that harmony and integration in different aspects of self can be achieved through utility of some interventions. As in this study, TIIP proved to be efficacious in self integration.

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Appendix A

Informed Consent

I the student of PhD Psychology, Department of Psychology, International Islamic University, is conducting a research to study self and its impact on relapse vulnerability and psychological adjustment of drug addicts. For this purpose, the need of your cooperation is essentially required. The responses obtained and demographic data provided by you will be kept confidential and would be used merely for the research purpose.

I would be glad for your kindness which will support me in my present research project. If you agree to participate in the present study, kindly lend your consent by signing this sheet.

Regards

Signature Researcher

Signature Participant

_____

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Appendix B

ذاتی کوائف نامہ

نام:

عمر:

جنس:

تعلیم:

پیشہ:

مذھب:

بہن بھائیوں کی تعداد:

ترتیب پیدائش:

والدین حیات ہیں / وفات پا چکے ہیں:

ازدواجی حیثیت:

خاندانی نظام:

سماجی و اقتصادی حیثیت:

منشیات کی قسم:

بیماری کا دورانیہ:

خاندان میں کسی کو نشے کی بیماری:

کیا آپ بار بار نشے کی بیماری میں مبتلاء ہو جاتے ہیں:

علاج کا دورانیہ:

Appendix C

Integrated Self Scale

برائے مہربانی ذیل میں دیے گئے بیانات کو غور سے پڑھیں اور اپنی شخصیت کو مد نظر رکھتے ہوئے دیے گئے بیانات میں سے انتخاب کیجئے۔

جسمانی پہلو					
نمبر شمار	بیانات	متفق	کسی حد تک متفق	کسی حد تک غیر متفق	غیر متفق
۱۔	میں اپنی ظاہری شکل وصورت کے بارے میں فکر مند رہتا / رہتی ہوں۔				
۲۔	میں اپنی صحت کا خاص خیال رکھتا / رکھتی ہوں۔				
۳۔	میں خود کو چست اور صحت مند رکھنے کے لیے باقاعدگی سے چہل قدمی کرتا / کرتی ہوں۔				
۴۔	اگر میری نیند پوری نہ ہو تو میں ٹھیک طرح سے کام نہیں کر سکتا / سکتی۔				
۵۔	میرے خیال میں وزن کا زیادہ ہونا شخصیت کو متاثر نہیں کرتا۔				
۶۔	میں اپنی جسمانی صفائی کا خیال رکھتا / رکھتی ہوں ۔				

۷۔	مجھے وہ لباس پہننا اچھا لگتا ہے جو میری جسمانی ساخت کی پیمائش کے مطابق ہو۔				
۸۔	میں سمجھتا/ سمجھتی ہوں کہ لباس کا رنگ شخصیت کی عکاسی کرتا ہے۔				
۹۔	میں اپنے لباس کا رنگ موسم کے مطابق منتخب کرتا/کرتی ہوں۔				
۱۰۔	میرے خیال میں مسکراتے ہوئے میں جاذب نظر لگتا/ لگتی ہوں				
۱۱۔	میری چال پر اعتماد ہے۔				
۱۲۔	میں اپنے لباس کے بارے میں فکر مند رہتا /رہتی ہوں۔				
۱۳۔	مجھے آئینے میں اپنا عکس ناپسند ہے۔				
۱۴۔	میں ایک پر اعتماد انسان ہوں۔				
فکری پہلو					
نمبر شمار	بیانات	متفق	کسی حد تک متفق	کسی حد تک غیر متفق	غیر متفق
۱۔	جب میں کسی کام کا آغاز کرتا/کرتی ہوں تو اُسے وقت پر مکمل کرنے کی کوشش کرتا/کرتی ہوں۔				
۲۔	جب تک کام مکمل نہ ہو میں اپنی توجہ کام پر مرکوز رکھتا/رکھتی ہوں۔				

۳۔	دورانِ گفتگو موضوع پر میری توجہ برقرار رہتی ہے۔				
۴۔	جب مجھے کوئی صحیح طریقے سے سمجھائے تو مجھے ہدایات سمجھنے میں کوئی مشکل پیش نہیں آتی۔				
۵۔	میں اپنی توجہ مرکوز رکھتے ہوئے فراہم کردہ معلومات سے متعلق اپنے ذہن میں باآسانی خاکہ سازی کر سکتا/سکتی ہوں۔				
۶۔	میں منطقی سوالات کو آسانی سے حل کر سکتا/سکتی ہوں۔				
۷۔	میں دوسرے لوگوں کا نقطۂ نظر سمجھ سکتا/سکتی ہوں۔				
۸۔	کسی بھی غیر متوقع صورت حال کے پیش نظر میں اپنے منصوبوں کو بدلنے کی صلاحیت رکھتا/رکھتی ہوں۔				
۹۔	میں ہر طرح کی صورت حال میں نظم وضبط برقرار رکھنے کی کوشش کرتا/کرتی ہوں۔				
۱۰۔	میں اپنی ترجیحات کو کام کی نوعیت اور اہمیت کی بنیاد پر ترتیب دیتا/دیتی ہوں۔				
۱۱۔	میں اپنا کام رکاوٹ کے باوجود باآسانی سرانجام دیتا/دیتی ہوں۔				
۱۲۔	کوئی رائے قائم کرنے سے پہلے میری کوشش ہوتی ہے کہ میں ثبوت کو تفصیلات سے دیکھ لوں۔				
۱۳۔	میرا یقین ہے کہ ہر مسئلے کا کوئی نہ کوئی حل ضرور ہوتا ہے۔				

۱۴	میں کسی بھی معاملے میں فیصلہ کرنے سے پہلے اس کے ہر پہلو پر اچھی طرح غور و فکر کرتا /کرتی ہوں۔				
۱۵۔	میں زندگی کے تجربات کو سامنے رکھتے ہوئے مستقبل کے فیصلے کرتا / کرتی ہوں۔				
۱۶۔	میں اپنے روزمرہ کے معاملات میں زندگی کے تجربات سے فائدہ اٹھاتا / اٹھاتی ہوں۔				
۱۷۔	میرے اکثر نظریات میرے علم اور میرے تجربات کا نچوڑ ہیں۔				
۱۸۔	انسانی رویے اس کی سوچ کی عکاسی کرتے ہیں۔				
احساسی پہلو					
نمبر شمار	بیانات	متفق	کسی حد تک متفق	کسی حد تک غیر متفق	غیر متفق
۱۔	زندگی کے پر امید واقعات سے مجھے حوصلہ ملتا ہے۔				
۲۔	میں کسی بھی تکلیف کو با آسانی نظر انداز کر کے آگے بڑھ سکتا / سکتی ہوں۔				
۳۔	میں جذباتی طور پر مضبوط اعصاب کا / کی مالک ہوں۔				
۴۔	میں جلدی پریشان نہیں ہوتا / ہوتی۔				

۵۔	دوسرے لوگوں کے جذبات کی پرواہ کیے بغیر میں ہر کام اپنی مرضی کے مطابق انجام دیتا / دیتی ہوں۔				
۶۔	میں خراب صورتِ حال سے جلدی نمٹ سکتا / سکتی ہوں۔				
۷۔	مجھے معلوم ہے کہ میں کب اور کیسے خوش ہوتا / ہوتی ہوں۔				
۸۔	میں سمجھ سکتا / سکتی ہوں کہ لوگ میرے لیے مشکلات کا باعث کیوں بنتے ہیں۔				
۹۔	مجھے معلوم ہوتا ہے کہ کب میرا رویہ دوسروں کے لیے تکلیف دہ ہو رہا ہے۔				
۱۰۔	میں اپنے سوچنے کا انداز بدل کر اپنے جذبات پر قابو پالیتا / لیتی ہوں۔				
۱۱۔	اپنے جذبات سے آگاہ رہنا میرے لیے بہت اہم ہے۔				
۱۲۔	میں جان سکتا / سکتی ہوں کہ دوسروں کی کس بات نے مجھے پریشان کیا ہے۔				
۱۳۔	میں جلد غصے پر قابو پالیتا / لیتی ہوں تاکہ وہ مجھ پر زیادہ اثر انداز نہ ہو۔				
۱۴۔	جب مجھے مایوسی کا احساس ہوتا ہے میں خود کو حوصلہ دیتا / دیتی ہوں۔				
۱۵۔	جب میرے ساتھ کچھ برا ہوتا ہے تو میں جلد ہی اس کیفیت سے باہر آجاتا / جاتی ہوں۔				

۱۶۔	دوسرے لوگوں کی مدد سے میں پریشان کن حالات میں بھی جلد پر سکون ہو جاتا / جاتی ہوں۔				
۱۷۔	میں اپنی زندگی کے تلخ تجربات کے بارے میں سوچتا / سوچتی ہوں۔				
۱۸۔	میں دوسروں کے جذبات کو با آسانی سمجھ سکتا / سکتی ہوں۔				
روحانی پہلو					
نمبر شمار	بیانات	متفق	کسی حد تک متفق	کسی حد تک غیر متفق	غیر متفق
۱۔	میں روحانی پاکیزگی کے حصول کے لیے اپنی مذہبی تعلیمات پر عمل کرتا / کرتی ہوں۔				
۲۔	مجھے محسوس ہوتا ہے کہ اللہ تعالیٰ میرے دل کی بات سنتا ہے۔				
۳۔	میں غیب پر یقین رکھتا / رکھتی ہوں۔				
۴۔	میں نے اپنا پورا نفس اللہ کے سپرد کر دیا ہے۔				
۵۔	میں اللہ کی دی ہوئی نعمتوں پر اس کا / کی شکر گزار رہوں۔				
۶۔	میں ایک با مقصد زندگی گزار رہا / رہی ہوں۔				
۷۔	میں اپنے روزمرہ زندگی کے معاملات میں حکمت و دانائی سے کام لیتا / لیتی ہوں۔				

۸۔	میں تمام چیزوں سے بڑھ کر اللہ سے محبت کرتا/کرتی ہوں۔				
۹۔	اللہ تعالیٰ کی راہ میں خرچ کرنے سے میرے دل کو سکون ملتا ہے۔				
۱۰۔	جو صحیح ہے وہ میرے لیے قابلِ قبول ہے۔ جو غلط ہے وہ میری نظر میں حرام ہے۔				
۱۱۔	میری شخصیت میں عاجزی ہے۔				
۱۲۔	میں اپنے قول کی پاسداری کرتا/کرتی ہوں۔				
۱۳۔	میں کچھ وقت تنہائی میں اپنی اندرونی کیفیات کو جاننے کی کوشش کرتا/کرتی ہوں۔				
۱۴۔	اللہ سے گہرا تعلق مجھے اندرونی طور پر مضبوط کرتا ہے۔				
۱۵۔	میں اپنے گناہوں سے توبہ کرتا/کرتی ہوں۔				
۱۶۔	میں اپنا سر صرف اللہ کے آگے جھکاتا/جھکاتی ہوں۔				
۱۷۔	اللہ تعالیٰ سے قربت مجھے زندگی کی مشکلات پر قابو پانے کا حوصلہ دیتی ہے۔				
۱۸۔	انسانی فلاح و بہبود کی سوچ مجھے دلی سکون اور اطمینان فراہم کرتی ہے۔				
۱۹۔	میرا یقین ہے کہ انسانیت کی خدمت سے میرا اللہ سے تعلق مزید مضبوط ہوتا ہے۔				
۲۰۔	ضرورت مند لوگوں کی مدد کر کے میں اللہ کی قربت حاصل کر سکتا/سکتی ہوں۔				

Appendix D

AWARE Questionnaire (Urdu)

" 7" ضے "1برائے ھہربنی ھنذرجہ ریل بیبنبت کو پڑھیں اور ہر بیبی کے لئے ایک عذد پر "
کے درھیبی نشبنذہی کیجئے کہ حبلیہ طور پر اپّ کے لئے کص حذ تک درضت ہے۔ برائے
ھہربنی ہر بیبی کے لئے صرف ایک عذد پر ہی نشبی لگبئیں۔

بیبنبت	کبھی نہیں	بہت کن	کبھی کبھبر	نطبتبً اکثر	اکثر	تقریببً ہویشہ	ہویشہ
1 . ھیں اپنی نشے ضے پبک رہنے کی صلاحیت ھیں غیر یقینی یب پریشبنی ھحطوش کرتب/کرتی ہوں۔	1	2	3	4	5	6	7
2 . ھیری زنذگی ھیں بہتطبرے ھطبئل ہیں۔	1	2	3	4	5	6	7
3 . ھیں شذیذ ردِ عول یب اضطراری طور پر برتبؤ کرتب/کرتی ہوں۔	1	2	3	4	5	6	7
4 . ھیں خود ھیں ہی رہتب/رہتی ہوں اور تنہب ھحطوش کرتب/کرتی ہوں۔	1	2	3	4	5	6	7
5 . ھیں اپنی زنذگی کے ایک پہلو کو بہت زیبدہ ھرکس جطتجو رکھتب/رکھتی ہوں۔	1	2	3	4	5	6	7
6 . ھیں گھبراہٹ، اداضی، بے پروائی یب افطردگی ھحطوش کرتب/کرتی ہوں۔	1	2	3	4	5	6	7
7 . ھیں خیبلی پلاؤ پکبنے/تخیل آرزوئی ھیں ھشغول رہتب/رہتی ہوں۔	1	2	3	4	5	6	7

7	6	5	4	3	2	1	8. وہ ھنصوبے کبھیبة ہوتے ہیں جو ھیں بنبتب/بنبتی ہوں۔
7	6	5	4	3	2	1	9. ھجھے توجہ ھرکوز کرنے ھیں دشواری ہوتی ہے اور ھیں خواۃ دیکھنے کو ترجیح دیتب/دیتی ہوں کہ چیسیں کیطی ہو ضکتی ہیں۔
7	6	5	4	3	2	1	11. ھیرے لئے چیسیں صحیح کبم نہیں کرتیں۔
7	6	5	4	3	2	1	11. ھیں الجھب ہوا ھحطوش کرتب/کرتی ہوں۔
7	6	5	4	3	2	1	12. ھیں اپنے دوضتوں ضے نبراض ہوتب/ہوتی یب تنگ پڑ جبتب/جبتی ہوں۔
7	6	5	4	3	2	1	13. ھیں غصیلا یب ھبیوش ھحطوش کرتب/کرتی ہوں۔
7	6	5	4	3	2	1	14. ھیری کھبنے کی عبدات اچھی ہیں۔
7	6	5	4	3	2	1	15. ھیں جکڑا ہوا ھحطوش کرتب/کرتی ہوں جیطے نکلنے کب کوئی راضتہ نہیں۔
7	6	5	4	3	2	1	16. ھجھے ضونے ھیں دشواری ہوتی ہے۔
7	6	5	4	3	2	1	17. ھیں اداضی کے لوبے دورانیے ھحطوش کرتب/کرتی ہوں۔

بیانات	کبھی نہیں	بہت کم	کبھی کبھار	نسبتاً اکثر	اکثر	تقریباً ہمیشہ	ہمیشہ
18. میں سچ میں پراہ نہیں کرتا/کرتی کہ کیا ہوتا ہے۔	1	2	3	4	5	6	7
19. مجھے ایسا محسوس ہوتا ہے کہ چیزیں اس قدر بری ہیں کہ مجھے نشہ ہی کرنا چاہیے۔	1	2	3	4	5	6	7
20. میں صحیح سوچنے کے قابل ہوں۔	1	2	3	4	5	6	7
21. میں اپنے لئے افسوس محسوس کرتا/کرتی ہوں۔	1	2	3	4	5	6	7
22. میں نشہ کرنے کے بارے میں سوچتا/سوچتی ہوں۔	1	2	3	4	5	6	7
23. میں دوسرے لوگوں سے جھوٹ بولتا/بولتی ہوں۔	1	2	3	4	5	6	7
24. میں پر امید اور با اعتماد محسوس کرتا/کرتی ہوں۔	1	2	3	4	5	6	7
25. میں عام طور پر دنیا پر غصہ محسوس کرتا/کرتی ہوں۔	1	2	3	4	5	6	7
26. میں نشے سے پاک رہنے کے لئے کام کر رہا/رہی ہوں۔	1	2	3	4	5	6	7
27. میں خوف زدہ ہوں کہ میں اپنے حواس کھو رہا /رہی ہوں۔	1	2	3	4	5	6	7
28. میں بے اختیار ہو کر نشہ کر رہا/رہی ہوں۔	1	2	3	4	5	6	7

Appendix E

Psychological Adjustment Scale

ہدایات

اس سوال نامے میں کچھ بیانات لکھے ہوئے ہیں۔ ہر بیان کو غور سے پڑھیں اور جواب دیں۔ کہ آپ کے متعلق یہ بیان صحیح ہے یا غلط۔ یا ان دونوں میں سے ایک بھی صورت نہیں۔ یعنی نہ صحیح ہے نہ غلط۔ آ گر آپ کے متعلق یہ بیان صحیح ہے تو مزید سوچیں کہ کتنا اور کس قدر صحیح ہے۔ یا بلکل صحیح ہے؟ اسی طرح اگر آپ ایک بیان سے اتفاق نہ کرتے ہوں تو بتائیں کہ وہ بیان آپ کے متعلق کس قدر غلط ہے یا بلکل غلط۔ ہر بیان باقی بیانات سے الگ ہے۔ اس لئے ہر بیان کا جواب دیں۔ اور ہر بیان کے لیے صرف ایک ہی جواب دیں۔ ہر بیان کے سامنے دی گئی خالی جگہوں میں سے (جو کہ پانچ درجوں کی عکاسی کرتی ہیں) جو آپ کے لیے سب سے مناسب ہے اسی پر درست (✓) کا نشان لگائیں۔ آپ کی سہولت کے لیے نیچے ایک مثال دی گئی ہے تا کہ آپ جان لیں کہ بیانات کس طرح کے ہوں گے۔ اور ان کے جوابات ظاہر کرنے کا کیا طریقہ ہے۔

نوٹ:- آپ کی تمام معلومات صیغہ راز میں رکھی جائیں گی۔

مثال:

بیان:-

میں اکثر اپنے مقاصد حاصل کرنے میں کامیاب رہا/رہی ہوں۔

بلکل غلط/کسی قدر غلط/نہ صحیح نہ غلط/کسی قدر صحیح/بلکل صحیح

نمبر شمار	بیانات	بلکل غلط	کسی قدر غلط	نہ صحیح نہ غلط	کسی قدر صحیح	بلکل صحیح
1	میرا ہنسنا اور رونا مکمل طور پر میرے اختیار میں ہے۔					
2	اگر میرے مقصد کے حصول میں رکاوٹیں آئیں تو میں بڑی اہمت سے ان کا سامنا کرتا/کرتی ہوں۔					
3	زندگی میں اپنے مقاصد طے کرنے سے پہلے میں سوچتا/سوچتی ہوں/کہ ان مقاصد کو حاصل کرنے کی صلاحیت بھی مجھ میں موجود ہے یا نہیں۔					
4	مجھ میں سخت الجھن یا مشکل کا سامنا کرنے کا حوصلہ نہیں۔					
5	یقیناً مجھ میں خود اعتمادی کی کمی ہے۔					
6	اگر مجھے اندازہ ہو جائے کہ میں جو کام کرنے والا/کرنے والی ہوں اور اس کے اثرات اچھے نہ ہوں گے تو میں خود کو وہ کام کرنے سے روک لیتا/لیتی ہوں۔					
7	مجھ سے بہت سے کام ایسے ہو جاتے ہیں جن پر مجھے بعد میں پچھتانا پڑتا ہے۔					
8	مجھے شاذ و نادر ہی یہ محسوس ہوا کہ زندگی نے مجھے دھوکہ دیا یا مایوس کیا۔					
9	میں صرف دوسروں کے عیبوں پر ہی نظر نہیں رکھتا/رکھتی بلکہ ان میں موجود خوبیوں کو سراہتا/سراہتی ہوں۔ اور ان کا احترام کرتا/کرتی ہوں۔					

10	میں اپنی صلاحیتوں سے مکمل طور پر واقف ہوں۔					
12	میں کبھی اپنے احساسات اور جذبات کا اظہار کھل کر نہیں کر سکا/کر سکی۔					
13	اگر میں کسی مشکل میں گرفتار ہوں تو دوسروں کی مدد لینے میں ہچکچاہٹ محسوس نہیں کرتا/کرتی۔					
14	مجھے عموماً امید ہوتی ہے کہ میں جو بھی کام کروں گا/گی اس میں کامیاب رہوں گا/گی۔					
15	مجھ پر آسانی سے جنون چڑھ جاتا ہے۔					
16	مجھ میں اتنی لچک موجود ہے کہ میں اپنی شخصیت میں مثبت اور صحتمند تبدیلیاں لاسکوں۔					
17	میں خود کو ایک خاصی مضبوط شخصیت کا مالک سمجھتا/سمجھتی ہوں۔					
18	میں ایک خوش طبع شخص ہوں/خاتون ہوں۔					
19	میں جذباتی طور پر ایک سردانسان واقع ہوا ہوں/ہوئی ہوں۔					
20	اس دنیا میں کسی پر بھی اعتبار نہیں کرنا چاہیے۔					
21	میرے کئی دوست/سہیلیاں ہیں۔					
22	میری زندگی معنی، مقصد اور سمت رکھتی ہے۔					
23	اکثر اوقات میں سوچے، سمجھے بغیر اپنا ردعمل ظاہر کر دیتا/دیتی ہوں۔					
24	جب میں اپنے اردگرد رونما ہونے والے واقعات اور حالات سے کوئی نتیجہ اخذ کروں تو اکثر اوقات مجھے پتہ چلتا ہے کہ بیشتر لوگوں نے مجھ سے بہت مختلف نتائج اخذ کئے ہیں۔					
25	دوسروں کے جذبات کو ٹھیس نہ پہنچانے کی کوشش میں میں اکثر اپنے جذبات کا اظہار نہیں کر پاتا/پاتی۔					
26	جب میں مشکلات سے دوچار ہوتا/ہوتی ہوں تو جلد ہمت ہار جاتا/جاتی ہوں۔					
27	مشکلات سے نظریں چرانے کی بجائے میں آگے بڑھ کر ان کا مقابلہ کرتا/کرتی ہوں۔					
28	میں اپنی مصروفیات کے متعلق پہلے سے منصوبہ بندی کر لیتا/لیتی ہوں۔					

Appendix F

Six Factor Self Concept Scale (SFSCS)

کچھ لوگوں کی خصوصیات پر مشتمل ایک فہرست نیچے دی گئی ہے. ہر خصوصیت کے لئے نشان دہی کرے کہ وہ آپ کے خیال سے کس قدر آپکی شخصیت کی وضاحت کرتا ہے. کسی بھی جواب کی نشاندہی کرنے سے پہلے اپنی زندگی کے تمام موجودہ تجربات, بشمول اپنے کام, خاندان, سکول اور سماجی صورتحال کو مدنظر رکھیں.

	بیانات	کبھی نہیں اور تقریباً کبھی بھی آپ کے بارے میں درست نہیں ہے 1	عموماً آپ کے بارے میں درست نہیں ہے 2	کبھی کبھار لیکن بہت کم آپ کے بارے میں درست ہے 3	بعض اوقات آپ کے بارے میں درست ہے 4	اکثر آپ کے بارے میں درست ہے 5	عموماً آپ کے بارے میں درست ہے 6	ہمیشہ یا تقریباً ہمیشہ آپ کے بارے میں درست ہے 7
1	میرا ساتھ پُرلطف ہوتا ہے							
2	محنتی							
3	غالب ہونے والا							
4	آسانی سے شرمندہ ہونے والا/ والی							
5	خداداد صلاحیت کا مالک							
6	وفادار							
7	مضبوط							
8	دوستی کرنے والا/ والی							
9	مفید							

	بیانات	کبھی نہیں اور تقریباً کبھی بھی آپ کے بارے میں درست نہیں 1	عموماً آپ کے بارے میں درست نہیں ہے 2	کبھی کبھار لیکن بہت کم آپ کے بارے میں درست ہے 3	بعض اوقات آپ کے بارے میں درست ہے 4	اکثر آپ کے بارے میں درست ہے 5	عموماً آپ کے بارے میں درست ہے 6	ہمیشہ یا تقریباً ہمیشہ آپ کے بارے میں درست ہے 7
10	اعتماد کی کمی							
11	قانون کی پابندی کرنے والا/ والی							
12	زور آور							
13	خاص صلاحیتوں کا مالک							
14	پہلے سے منصوبہ بندی کرنے والا/ والی							
15	ملنسار							
16	آسانی سے دکھی ہونے والا/ والی							
17	ایک رہنما کی طرح برتاؤ کرنے والا/ والی							
18	سچا							
19	اپنے ہی بارے میں سوچنے والا/ والی							
20	مؤثر طریقے سے کام کرنے والا/ والی							
21	وفادار							

	بیانات	کبھی نہیں اور تقریباً کبھی بھی آپ کے بارے میں درست نہیں ہے 1	عموماً آپ کے بارے میں درست نہیں ہے 2	کبھی کبھار لیکن بہت کم آپ کے بارے میں درست ہے 3	بعض اوقات آپ کے بارے میں درست ہے 4	اکثر آپ کے بارے میں درست ہے 5	عموماً آپ کے بارے میں درست ہے 6	ہمیشہ یا تقریباً ہمیشہ آپ کے بارے میں درست ہے 7
22	جارحانہ / غصہ والا / والی							
23	جس سے آسانی سے بات کی جا سکے							
24	ذہین اور فطین							
25	گھبراہٹ میں غلطی کرنے والا / والی							
26	ایمان دار							
27	کام وقت پر ختم کرنے والا / والی							
28	خوشگوار							
29	طاقتور							
30	تخلیق کار							
31	لوگوں کے دیکھنے پر پریشان ہونیوالا / والی							
32	قابلِ بھروسہ							
33	کام پر توجہ مرکوز کرنے والا / والی							

Appendix G

Traditional Islamically Integrated Psychotherapy

روایتی اسلامی طرز سے مربوط نفسیاتی علاج

۔(اگرچہ مغرب کے اندر شعبہ نفسیات کا قیام انیسویں صدی میں وجود میں آیا، تاہم مسلم دنیا میں انسانی نفسیات کو موضوع بنانے والے فلسفیانہ مباحث

نویں صدی کے اوائل ہی سے موجود تھے Badri,2013;Qureshi and Rehman,2015;Awaad and Ali,2015,2016تب

سے کئی مسلمان فلسفیوں اور دانشوروں نے اس موضوع کو زیر بحث لایا۔ ان میں سے چند ایک کے نفسیاتی معالجے سے متعلق ڈھانچے (فریم ورکس) بھی

نے اسلامی طرز پر مربوط نفسیاتی معالجے کا ایک فریم ورک بنایا جس میں انہوں نے صحت، عوارض Haque(2013 اور Keshvarziموجود ہیں۔

،ہیومنا ئٹو لوجیاور علمی اتکے حوالے سے اسلامیعقائد کا خاکہپیشکیا۔ یوں اسخاکے میں صحتکو ایک ایسے مجموعے کے طور پر دیکھا جاسکتا ہے

جس میں مط بیعوارضکے برعکسنیک رویوں، عقائد اور روحانی طریقوں کا حصول شامل ہے۔

اسلامی عقائد کے لحاظ سے دیکھا جائے تو ہر فرد خدا سے جڑنے کی ایک فطری اور اساسی خواہش لیے ہوئے پیدا ہوا ہے جو کہ مناسب سماجی میل ملاپ

کے ذریعے نمو پاتیہے۔ ن ت ب ج ی اانسانروحانیبالیدگیحاصلکرنے کا ذمہدار ہے اور صحت انسانی نفسیات کے متعلقہ حصوں کی پرورش سے حاصل ہوتی

ہے اور ایک فرد کو خدا کی ذات سے متعلق شعور حاصل کرنے اور روحانی استطاعت کا مکمل فہم حاصل کرنے کی اجازت دیتی ہے۔ یوں، انسانیزندگی کا اصل مقصد قرب

Keshvarzi and) خداوندی کا حصول ہے جس کے تحت واجبی صحت کی نچلی حدود اخروی نجات کے حصول سے حاصل ہوتی ہیں

۔ حقی قی اگر ایکمسلمانہر طرحکے طبیعوارضسے محفوظہے تو یہاسکیتندرستنہیں بلکہاگر ایکفرد کے نفسکی Haque 2013)

روحانی تطہیر اس کی صحت و تندرستی کی نشانی ہے۔ مثالکے طور پر، ایکفرد نرگست تپسند شخصیتکیخرابیکیآخری حد تک نہیں پہنچ سکتا اگرچہ نشہ

آور خصلتیں بہت سنگین روحانی بیماریاں ہیں جو ممکنہ طور پر اس دنیا میں ذاتی و سماجی مسائل کے ساتھ ساتھ آخرت میں بھی سزا کی ضمانت دے سکتی

ہیں۔ لہذا نرگست تکبیرخصلتیں مداخلتکے دائرہکار میں آتیہیں کیونکہکردار کیاسیجامیوں سے پاک ہونا ضروری ہے۔

انسانی نفسیات کا اندرونی ڈھانچ

اور قلب (دل) کو انسانی نفسیات کے جامع حصوں کے (روح (جذبے (نے عقل (ادراک،) نفس (طرز عمل، 2013) Haque (اور Keshvarzi

خاکے میں شامل کیا جس کے مطابق قلب یا دل مکمل طور پر انسانی تندرستی اور بیماری پر مشتمل ہے۔ یاد رکھیں کہ دل کی اصطلاح جسمانی ساخت کے

ساتھ ساتھ روحانی پہلو کو بھی ظاہر کرتی ہے۔ کسی بھی دائرہ اقتدار کی ان پٹ دل کی سیاہی یا چمک ظاہر کرتی ہے۔

دل پر انسانی نفسیات کے عناصر کا خاکہ

انسانی نفسیات کے عناصر

اثرات

معرف- عقل دل- قلب

وج •

منطق / دلیل •

خیالات •

عقائد •

علم •

ات •

یصعت

بر تاؤ کے میلان- نفس

بھوک •

خواہشات •

جنسی ضرورت •

جذبہ-روح

احساسات •

لاشعوری عناصر •

خواب 1.

بصارت / اولین مقصد 2.

تزکیہ نفس 3.

اچانک بیداری 4.

حکمت •

ے مقصد اور معن •

جذبہ-احساس

خراب روی •

خارجی محرکات کا رد عمل •

اندرونی جذبات •

تشکیل شخصیت کے خصائ

نرت تسگ

تکبر •

- حس
- جلن
- دھوکا
- خودشناسی
- مہربانی
- کشادگی
- شرمانا
- شات سی گی

سلوک کے تاثرات

تعلقات پر اثرات

:مندرج ذیل پر باقی اثرات

1. عقل
2. نفس
3. روح
4. احساساتی روی کا جھکاؤ

- بھوک
- خواہشات

جنسی ضرورت •

نے نفس کے رجحان کو طرز عمل کے جھکاؤ کے طور پر ترجمہ کرنے کا فیصلہ کیا۔ اس کا جوہر اندرونی طور پر برائی Haque(2013) اور Keshvarzi نہیں ہے بلکہ نفس، اس کی تربیت اور تنظیم کی بنیاد پر روی کے رجحانات کی خود بخود عکاسی کرتا ہے۔ اس کی غیر تربیت یافتہ حالت میں نفس لذت پسند سے جوڑا جاسکتا ہے۔ تاہم تطہیر 'کہ وہ خود کو خوش کرنے اور اپنی بنیادی جسمانی خواہشات کو پورا کرنے کے لیے کام کرتی ہے ' ہے اور فرائیڈ کے تصور اور تربیتکے ذریعے نفسا پنینشو ونما کے مراحل (امارہ، لوامہاور مطمت ی ہ) سے آگے بڑھتا ہے اور فطریطور پر نیکاور خدائیطرز عمل کی طرف مائل ہوتا ہے۔ عقل کسی فرد کی ذی شعور قوت کا نام ہے۔ یہ خالصتا منطق، استدلال اور حاصل شدہ دانشورانہ عقائد پر کام کرتی ہے۔ یہ ماضی کے علم اور تجربات کی بنیاد پر بھی اپنے نتائج کا تعین کرتی ہے۔ روح انسان کا جذبہ اور حیاتیاتی قوت ہے اور اس کا مقصد مقدسات سے وابستگیہے، روحانی ذکر؛ معن اور مقصد کی پیاس؛ الوہیت کی آرزو۔ یہ تینوں ایک دوسرے سے ہم آہنگ ہیں اور ان میں سے کسی ایک کی خرابی باقی تمام عناصر کو متاثر کرتی ہے۔ مثال کے طور پر، عقائد میں بگاڑ پیدا کرنے والی علمی عقلیت اور روحانی طریقوں میں کمی بالآخر دل کو سخت کرنے کا موجب بن سکتی ہے۔ ہم نے احساس یا جذبات کو علیحدہ طور پر ایک ڈومین میں شامل کرنے کا اعادہ کیا ہے حالانکہ پہلے اصل مضمون روح کے طور پر درج کیا گیا تھا۔ یہ جذباتی نظری میں اہم پیش رفت کے باعث ہے جو پہلے درج انسانی ڈومین کے اصل غزالی تصور میں اضافے کی ضمانت دے سکتی ہے۔

(وجود کے سماجی سیاق وسباق کا ڈھانچ (اجتماعی حوالے سے

اسلام انفرادیت کے بجائے معاشرے کے اجتماعی نکتہ نظر پر زور دیتا ہے جس کے نتیجے میں تمام مسلم ثقافتیں مربوط ہیں۔ چودھویں صدی کے ایک عالم اور مورخ ابن خلدون نے کہا کہ:

انسانی فطرت میں خونکے رشتوں اور رشتہداروں کا ساتھ، مہر دیاور پیار تحفہا لٰہیہے جو باہمیتعاونا ور مدد کا باعثبنتا"

ہے۔(Rosenthal,1969,pg#98)"

ابن خلدون نے ایک معاشرے کے اندر مدد اور مطابقت کو معاشرے کی فلاح وبہبود اور خوشحالی کا عنصر سمجھا۔ صنعتی انقلاب کے بعد جدید مغربی

:نے کہا2001)Fischer (معاشرے مذہبی طور پر متقی کی رعایت کے ساتھ انفرادیت کی طرف راغب ہوئے؛جیسا کہ

اکثر انفرادیت کو ہٹا دیتا ہے("ص#)367(عقیدہ(روحانیت"

مع ست وں کے ساتھ وابستہ رہے ہیں، تاہم اسکے بہتسے نقصانا تانسانکیسماجی(Quasi-free) (اگرچہ اہم معاشی فوائد انفرادی طور پر نیم آزاد

اور نفسیاتی زندگی سے بھی جڑے ہوئے ہیں۔ایک تجزی کے نتائج کے مطابق انفرادیت اور اجتماعیت کے درمیان ثقافتی اختلافات دنیا کے مختلف

۔خاص طور(Oyserman, Coon, Kemmelmeier,2002) (حصوں سے انسانی طرز عمل میں فرق کو سمجھنے کے لیے توجیہہ فراہم کرتے ہیں

۔لہٰذا(Edara,2016)(پر مشرقی ثقافتوں سے تعلق رکھنے والے افراد کے لیے روحانی بالادستی کو انفرادیت کے ساتھ منفی طور پر منسلک دکھایا جاتا ہے

انسانی نفسیات کے کام کرنے کے جامع ماڈل میں سماجی سیاق وسباق کا ڈھانچ لازمی طور پر شامل ہونا چاہیے۔جیسا کہ شکل نمبر2 میں دکھایا گیا ہے کہ اس

فریم ورک میں افراد نہ صرف اپنے کام کے داخلی پہلوؤں پر توج مرکوز کرتے ہیں بلکہ خارجی نظام کو بھی ذہن میں رکھتے ہیں۔

ایک شخص کے عمومی وجود(مکمل وجود) کے سیاق وسباق کا فریم ورک

نفس، عقل، احساس اور روح)پر توج مرکوز)اس فریم ورک کے مطابق، ایک جامع و مکمل زندگی گزارنے والے افراد اپنی نفسیات کے داخلی عناصر

کرتے ہوئے اپنے ارد گرد کے ماحول کے ساتھ روحانی نشوونما کے لیے تعلق بنائے رکھتے ہیں۔اسلامی حوالے سے، انسان ایک مربوط سماجی گروہ سے

کہا جاتا ہے۔میدبر آں، ماحول(تعلق رکھتے ہیں اور اپنے سماجی وخاندانی تعلقات کے ذمہ دار ہوتے ہیں جنہیں حقوق العباد(خدا کے بندوں کے حقوق

کے ساتھ یہ تعلقات غیر انسانی پہلوؤں تک پھیلے ہوئے ہیں جیسے جانوروں کے حقو قاور ان کی دیکھ بھال۔کسی داخلی وجود کے تمام پہلو ماحول سے متاثر

کی تحقیق نے دماغ کی تشکیل پر ماحول کے اہم اثرات کا جائزہ لیاEpigenetics ہوتے ہیں۔انسان بالکل ایسے باہم جڑے ہوئے ہیں جیسے

کی ترقی، کسی بچے کے ساتھ بچپن میںSchema۔مثال کے طور پر، منفی خیالات پیدا کرنے والے خودکار(Roth and Sweatt,2012)(ہے

منفی رویہ رکھنے کے نتیجے میں ہو سکتی ہے۔لہٰذا کسی بھی ادارے کی صلاحیتیں براہ راست اس کے ماحول سے متاثر ہو رہی ہوتی ہیں۔

علاج کے حد درج اہداف اور تبیلی کے اصول

(ملاحظہ ہو:)انکشاف(خود شناسی،)اعتدال(نفسیاتی روحانی توازن،7.3 ٹی آئی پی میں،نفسیاتی عوارض کے علاج کے تین بڑے اہداف ہیں(شکل

اور اتحاد(وجود کی وحدت)۔انکشاف کسی کی موجودہ حالت اور رجحانات کی خود شناسی سے متعلق دریاف ہے۔گیارہویں صدیعیسوی کے ایک مسلمان

:فلسفی اور سنیاسی ابو حامد محمد الغزالی نے روحانی صحت کے حصول کی وضاحت کرتے ہوئے ایک اسلامی روایت کا حوالہ دیا ہے کہ

"اگر اللہ کسی بندے کی بھلائی چاہتا ہے تو اسے اس کے نفس کی خامیوں سے آگاہ کر دیتا ہے"

در حقیقت بہت سے مسلم دانشور اور تاریخی معالجین جیسے ابو بکر الرازی،ابو علی بن مشکاویہ،شاہ ولی اللہ اور ابوزید البلخی نے اپنے علمی روی،طرز عمل

اور روحانی نفوس میں خود شناسی کے حصول کو ترجیح دی ہے (Arberry,2007; Badri, 2013;Hermansen,1982;Keshvarzi and

۔اپنی ذات سے متعلق آگہی رب کے ساتھ اور دوسرے لوگوں کے ساتھ مضبوط تعلق استوار کرنے میں بھی مدد گار ثابت ہوتی(Haque, 2013

ہے۔الغزالی اس مقصد کے حصول کے لیے دو اہم طریقوں کا حوالہ دیتے ہیں۔پہلا تصوف کا روایتی راستہ ہے،جس میں فرد اپنے آپ کو صوفی کے رنگ

انسان کی داخلی نفسیات فطری اور سماجی ماحول اللہ سے تعلق۔دوسرا طریقہ یہ ہے کہ کسی

(Khalaf,2014) (میں ڈھال لیتا ہے،ایک روحانی سرپرست(مرشد)کو اپناتا ہے اور مدد کے لیے اس کی تلاش کرتا ہے

ایسے شخص کو تلاش کیا جائے جو انسانی روی اور اس کی اصلاح میں عمل کے ماہر کے طور پر کام کر سکے تاکہ خود شناسی سے متعلق آگاہی کے عمل کو

آسان بنایا جاسکے۔ان دونوں طریقوں کا جدید مطالعہ انٹرو ینشن کے دوران مریض کے حالات وواقعات کو قرآنی آیات واحادیث کی روشنی میں انٹرپریٹ کیا جائے گا۔

اس مقصد کے لئے انٹرو ینشن ٹیکنیک کا استعمال کرتے ہوئے جسمانی،عقلانی،احساسی اور روحانی سطح پر تبدیلیاں لائی جائیں گی۔اس میں مندرجہ زیل ٹیکنیک کا ستعمال کیا جا

ے گا۔

1۔ عقلانی

2۔احساسی

3-نفسانی

4-روحانی

عقلانی انٹرویشن

1-خود کلامی (Self talk)

اس ٹیکنیک میں تھراپسٹ مریض کی منفی خود کلامی کو قرآن اور احادیث کی روشنی میں مثبت خود کلامی میں تبدیل کرے گا۔ یہاں پر ہر مریض کی ضرورت کے مطابق قرآن اور احادیث کا حوالہ استعمال کیا جاے گا۔ مثبت خود کلامی کے کچھ حوالے ذیل میں پیش کیے گیے ہیں جن سے تھراپسٹ مدد لے سکتے ہیں۔

"اللہ کی رحمت سے مایوس مت ہو"

"انسان کے لئے وہی کچھ ہے جس کی وہ کوشش کرتا ہے"

" اللہ میرے ساتھ ہے" (9:40)

"میں اللہ پر توکل کرتا ہوں"(3:159)

" اللہ مجھ سے محبت کرتا ہے کیوں کے میں اس پر بھروسہ کرتا ہوں"

2۔ Scriptural Reframing

اس ٹیکنیک میں ذہنی خیالات کی تشکیل نو کی جائے گی اور قرآنی آیات کی روشنی میں مباحثہ کرتے ہوئے مریض کے منفی خیالات اور اس کے سوچنے کے انداز میں تبدیلی لائی جائے گی۔

مثال کے طور پر اگر کوئی مریض اپنے حالات وواقعات سے تنگ اور ناخوش ہو تو اس کے اندر یہ سوچ پیدا کی جائے گی کہ اللہ تعالی قرآن میں فرماتا ہے کہ

"ہو سکتا ہے کہ تم کسی چیز کو ناپسند کرتے ہو مگر اللہ نے اس میں تمھارے لئے کچھ اچھا رکھا ہو"

3-مثبت حکمت ڈائری(Positive Hikmah Log)

اس ٹیکنیک میں مریض سے اس کے ان حالات کی لسٹ بنوائی جائے گی جن سے وہ ناخوش ہے۔ اس کے بعد باری باری ہر واقعہ میں چھپی ہوئی اللہ کی حکمت کو تلاش کیا جائے گا۔ اور مریض کو کہا جائے گا کہ وہ اپنے پاس ایک ڈائری بنائے جس میں وہ اسی طرح روزانہ کے واقعات میں چھپی ہوئی اللہ کی حکمت کو لکھتا جائے۔

"اور تم اپنے رب کی کون کون سی نعمتوں کو جھٹلاؤ گے"

واقعہ	جن چیزوں نے مجھے پریشان کیا	ممکنہ اچھی رحمتیں

4- God's Compass

مریض کو اس بات کا احساس دلایا جائے گا کہ آپ کا ہر عمل اللہ تعالی کو راضی کرنے کے لئے ہونا چاہئے اور اس کے بدلے کی امید صرف اللہ سے رکھیں۔ اس مقصد کے لئے مندرجہ ذیل سرگرمی کی جائے گی۔

زمین پر ایک دائرہ بنایا جائے گا۔ اس کے بعد مریض کو کہا جائے گا کہ اپنا کوئی اچھا اور نیک عمل یاد کرے۔ جب مریض وہ یاد کرے گا تو اس کو کہا جائے گا کہ اس عمل کے ساتھ وہ اس دائرے میں داخل ہو جایے۔ (اس دائرے کا ذہنی خاکہ بھی بنایا جاسکتا ہے)۔ اس کے بعد اس سے ڈسکس کیا جائے گا کہ اس کے اچھے اعمال اسکو اللہ سے قریب کر رہے ہیں اور اللہ اس کا محافظ بن جائے گا۔

5- Islamic Psychoeducation

سب سے پہلے مریض کو اسلامی تعلیمات کی روشنی میں سائیکو ایجوکیشن مہیا کی جائے گی اور ہیومن سائیکی کے کچھ عناصر کی وضاحت کی جائے گی۔

الف–تدبیر بمقابلہ اختیار

انسان اپنے حالات کو بہتر بنانت کے لئے اقدامات کر سکتا ہے لیکن ان حالات کو اس کی مرضی کے مطابق ڈھالنے کا مکمل اختیار اس کے پاس نہیں بلکہ اللہ تعالی کے پاس ہے۔ جیسا کہ اللہ تعالی قرآن میں خود فرماتا ہے

"بے شک اللہ تعالی ہر چیز پر قادر ہے" (12:21)

“And Allah is predominant in his affairs” (12:21)

“To Him belongs the keys of Heavens and the Earth. He extends provisions to whom He wills and restricts (it)” (42:12)

ب-احتساب کے مراحل : Levels of Accountability

اللہ دیکھ رہا ہے: Being Observed

ہمارا ہر عمل خواہ ہم سب کے سامنے کریں یا چھپ کر اللہ تعالی کو اس کی خبر ہے۔ جیسا کہ اللہ تعالی قرآن میں فرماتا ہے

"بے شک اللہ ہر چیز دیکھتا اور سنتا ہے" (4:58)

"اور اللہ اپنے بندوں کو دیکھنے والا ہے"(3:15)

اللہ پرکھ رہا ہے۔Being Evaluated

"اس دن لوٹیں گے لوگ الگ الگ ہو کر تا کہ وہ دیکھ پائیں اپنے اعمال، پس جہ ذرہ برابر اچھا عمل کرے گا وہ اسے دیکھ لے گا اور جو ذرہ بھر برا عمل کرا گا وہ بھی اسے دیکھ لے گا"(6:8)

"اور نیکی کا بدلہ نیکی ہی ہے"۔(55:60)

ج- قلب کی صفائی

مریض کو یہ بتایا جائے گا کہ زندگی کے کسی بھی میدان میں کوئی بھی کامیابی حاصل کرنے کے لئے ضروری ہے ہم اپنے قلب کو صاف رکھیں۔ اس کام کو کرنے کے لئے ہماری نیت صاف ہو کیوں کہ کسی بھی کام کا انحصار ہماری نیت پر ہوتا ہے۔

"بے شک اعمال کا دارومدار نیتوں پر ہے"

حضرت محمد ﷺ نے فرمایا: "انسانی جسم میں ایک ٹکڑا ایسا ہے کہ اگر وہ ٹھیک کام کرے تو پورا جسم ٹھیک کام کرتا ہے اور اگر وہ بیمار ہو جائے تہ پورا جسم بیمار ہو جاتا ہے اور وہ ٹکڑا دل ہے"

دل کو صاف کرنے کے لئے زیادہ سے زیادہ توبہ، ذکر اور استغفار کیا جائے گا۔

نفسانی انٹرویشن

مریض کے کردار اور نفس کی اصلاح کے لئے اس کی روزمرہ کے معمول میں تبدیلی لائی جائے گی۔

جسمانی ورزش اور کھیل

متوازن اور صحت بخش غذا

خشوع و خضوع کے ساتھ پانچ وقت کی نماز کی ادائیگی

نوافل کا اہتمام

ہفتے میں دو روزے

قرآن پاک کی تلاوت

صبح شام کے اذکار

حضور پاک ﷺ کی سنت کی پیروی

ٹوکن اکانومی

خوف کی درجہ بندی

مریض سے کہا جائے گا کہ وہ اپنی زندگی میں موجود خوف کی درجہ بندی کرے۔ اس کے بعد ہم اس درجہ بندی کو درست کریں گے اور مریض کو بتائیں گے کہ کیسے ہم اپنے خوف کی ترتیب کو ٹھیک کر کے اپنے خوف پر قابو پا سکتے ہیں۔ ہمارے خوف کی ایک اہم وجہ دنیاوی خوف ہے جبکہ اللہ کا خوف دنیاوس خوف سے پہلے ہونا چاہئے کیونکہ اللہ تعالیٰ کا خوف دنیاوی خوف کو ختم کرنے میں مدد کرتا ہے۔

روحانی انٹرویشن

روح انسانی ذات کا ایک اہم پہلو ہے اور اگر اس کو دبا دیا جائے یا اس پر توجہ نہ دی جائے تو پوری ذات پر اس کے منفی اثرات مرتب ہوتے ہیں جس کی وجہ سے ذات عدم توازن کا شکار ہوتی ہے اور بلآخر وہ غیر ہم آہنگی بیماری کا سبب بن جاتی ہے۔

دین کے ساتھ تعلق کو اکثر و بیشتر ٹرانزیکشنل اپروچ کے ذریعے سمجھا جاتا ہے نہ کہ ٹرانسفورمیشنل کے۔ اس کی وجہ سے انسان کا روح سے تعلق ختم ہو جاتا ہے۔ مگر روح ایک ایسا انسانی پہلو ہے جس کا براہِ راست تعلق الہامی تعلیمات سے ہے۔

علم حاصل کرنے کا ایک اہم ذریعہ مطالعہ ہے جس کے ذریعے دین کو گہرائی میں سمجھا جا سکتا ہے۔ علم براہِ راست اللہ تعالیٰ سے بھی حاصل کیا جا سکتا ہے۔ اسلامی اقدار میں اس علم کو معرفت کہتے ہیں اور یہ نفسیاتی صحت کا ایک اہم حصہ ہے کیونکہ روحانی شفا حاصل کرنے کا یہ ایک اہم ذریعہ ہے۔

تزکیہء نفس: جہاد بالنفس اور تزکیہء نفس ہمارے نفس کو صاد کرنے کا ایک اہم ذریعہ ہے۔ اس سے ہمارے نفس کے اوپر چڑھا دنیاوی خول اتر جاتا ہے اور دل اللہ تعالیٰ کی طرف مائل ہو جاتا ہے۔

مراقبہ: اس تکنیک میں مریض کو یہ سکھایا جائے گا کہ وہ اپنی ذات کے تمام پہلوؤں پر توجہ مرکوز کرے اور روحانی ذریعے سے اللہ تعالیٰ سے رابطہ قائم کرے۔

مریض کو ایک آرام دہ جگہ پر بٹھایا جائے گا۔ وہ آنکھیں کھلی بھی رکھ سکتا ہے اور بند بھی۔ وہ اپنی تمام تر توجہ اپنے دل کے جسمانی مقام پر رکھے گا مگر اس کے ساتھ ساتھ اپنے تمام جسم کی آگاہی کو بھی قائم رکھے گا۔

تفکر: ایک اور تکنیک تفکر ہے جس کا مقصد اللہ تعالیٰ پر غور کرنا ہے۔ مریض کو کہا جائے گا کہ وہ اللہ تعالیٰ کی بنائی ہوئی چیزوں پر غور و فکر کرے۔ یا اپنے اندرونی روحانی مرکز پر اپنی توجہ مرکوز کرے تا کہ وہ اللہ تعالیٰ کی تخلیقات کا گواہ بن سکے۔ اور بجائے اپنی ذات کے وہ اللہ تعالیٰ سع رابطہ قائم کر سکے۔

عبادت: اللہ تعالیٰ سے براہِ راست تعلق قائم کرنے کا بنیادی ذریعہ عبادت ہے۔ نہ صرف مذہبی اعمال بلکہ ہر وہ کام جو اللہ کی رضا کے لئے کیا جائے عبادت میں شامل ہے۔

اللہ تعالیٰ نے فرمایا: "میں نے جنوں اور انسانوں کو اپنی عبادت کے لئے پیدا کیا"۔ (51:56)

عبادات میں مشغولیت پر بہت زور دیا گیا ہے کیونکہ ان ہی عقیدت مندانہ اعمال کی وجہ سے ہم اللہ تعالیٰ کی قربت اختیار کر سکتے ہیں۔

نماز: اپنے مریض کے مسائل اور اس کی روحانی واقفیت کو مدِ نظر رکھ کر مختلف عبادات کی سفارشات پیش کی جائیں گی۔ جیسا کہ کچھ لوگ نماز نہیں پڑھ رہے تو ان کو یہ کہا جائے گا کہ وہ نماز شروع کریں۔ مگر کچھ مریض ایسے بھی ہوں گے جو کہ پہلے سع پانچ وقت کی نماز ادا کرتے ہیں مگر ان کی نماز میں خشاع و خضوع کی کمی ہے اور ان کا یہ عمل صرف جسمانی ہے اور عبادت کا مقصد پورا نہیں کر رہا تو ان کو سکھایا جائے گا کہ نماز میں خشوع و خضوع کا اہتمام کریں۔

دعا: سیشن کے دوران کلائنٹس کے ساتھ مل کر دعا کی جائے گی تا کہ ان کو دعا کا طریقہ سکھایا جا سکے۔ اور ان کے حق میں دعا بھی کی جائے گی کہ اللہ تعالیٰ ان کے دل کھول دے تا کہ وہ اللہ کا نور حاصل کر سکیں۔ ان کو یہ بھی بتایا جائے گا کہ دعا اللہ اور بندے کے درمیان بات چیت کا ذریعہ ہے۔ اللہ تعالیٰ فرماتا ہے:

"تم مجھے بلاؤ، میں جواب دوں گا"۔ (40:60)

نماز اور دعا کے ذریعے ہم اللہ تعالیٰ سے گفتگو کر سکتے ہیں مگر قرآن مجید ایک ایسا ذریعہ ہے جس میں خود اللہ تعالیٰ ہم سے براہِ راست گفتگو کرتا ہے۔ اسلام میں قرآن مجید رہنمائی کا ایک مرکزی ذریعہ ہے جہاں مسلمان یہ سیکھتے ہیں کہ اللہ تعالیٰ ان سے کیا چاہتا ہے اور ایک مخصوص رہنمائی میسر ہو جاتی ہے جس کی ہم پیروی کر سکتے ہیں۔

قرآن مجید نہ صرف ظاہری کردار کو درست کرنے کا نسخہ ہے بلکہ اس کی تلاوت کے ذریعے اللہ تعالیٰ سے براہِ راست قلبی رہنمائی بھی حاصل کی جاسکتی ہے۔ "قرآنِ پاک تمام انسانیت کے لیے شفا ہے۔"

احساسی انٹرویشن

رحمدلی اور ہمدردی: Prophetic Empathy

حضرت نعمان بن بشیر سے روایت ہے کہ حضور پاک ﷺ نے فرمایا" تمام مومنین ایک جسم کی مانند ہیں۔ اگر جسم کے کسی ایک حصے کو تکلیف پہنچے تو پورا جسم بخار میں مبتلا ہو جاتا ہے"۔

اس حدیث میں یہ بیان کیا گیا ہے کہ تمام مسلمانوں کو ایک دوسرے کا خیال رکھنا چاہئے اور ایک دوسرے کے ساتھ ہمدردی کرنی چاہئے۔ حضرت انس سے روایت ہے کہ حضرت محمد ﷺ نے فرمایا" وہ شخص مومن نہیں ہو سکتا اگر وہ اپنے بھائی کے لئے وہ چیز پسند نہ کرے جو وہ اپنے لئے کرتا ہے"۔

ان تمام مثالوں سے یہ بات واضح ہے کہ دوسرے شخص کے ساتھ ہمدردانہ رویہ رکھنا کس قدر اہمیت کا حامل ہے۔ اس تکنیک میں نہ صرف اپنے کلائنٹ کی بات کو غور سے سنا جائے گا بلکہ اس کے ساتھ اپنی سچائی، جذبات اور ضروریات کی بات بھی کی جائے گی۔ اس تکنیک کا مقصد صرف کلائنٹ کو قائل کرنا نہیں ہوتا بلکہ پہلے اسکی تمام باتوں کو سن کر پھر اپنے احساسات اور ضروریات کو پیش کیا جائے گا تاکہ اس کو یہ بات سمجھائی جاسکے کہ وہ کس طرح اپنی ضروریات کو ایک اچھے طریقے سے پورا کر سکتا ہے۔

Empathic Reflection

اس تکنیک میں تھراپسٹ اپنے جذبات کو ملحوظِ خاطر رکھتے ہوئے کلائنٹ کے احساسات کو تسلیم کرتا ہے۔ مثال کے طور پر" آپ کو میری تنقید سے خوف محسوس ہو رہا ہے، کیا میں صحیح سمجھ رہا ہوں؟"

Empathic Affirmation:

اس میں کلائنٹ کے جذبات کی تصدیق کی جاتی ہے۔ مثال کے طور پر" آپ بالکل ٹھیک کہ رہے ہیں، میں آپ کے احساسات کو سمجھ رہا ہوں

Transformation : اس تکنیک میں کسی بھی منفی احساس کو کسی مثبت احساس کے ساتھ بدل دیا جاتا ہے۔

Attentional Reallocation:اس میں مریض کی توجہ کو ایک احساس سے ہٹا کر دوسرے احساس پر مرکوز کیا جاتا ہے جیسا کہ بلنی نے اپنے کلائنٹس کی اینگزیٹی کو اینگر کے ساتھ تبدیل کیا۔

اس کے علاوہ اپنی تمام تر توجہ کسی نئی ضرورت پر مرکوز کرنا یا اپنے لئے کسی اور مقصد کا انتخاب کرنا۔

Changing Interaction

اس تکنیک میں کلائنٹ کو جس بھی رشتے سے تعلق میں دشواری آرہی ہو اس کو ذہن میں رکھتے ہوئے تھراپسٹ یا پھر گروپ کے باقی افراد میں سے کسی کو ان کی جگہ رکھ کر اور اس کے لئے Two Chair Technique استعمال کی جائے. ۔ان سے تمام تر شکایتیں بیان کی جائیں گی گی