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Effect of Resilience on Psychological Well-Being among Individuals with Substance Use Disorder: Moderating Role of Religiosity

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ABSTRACT

Substance use disorder (SUD) critically effects mental health around the world and affects operating in every aspect of a person's life. Resilience aids in Improvement and is seen as a protective component. The resilience and well-being relationship can be affected by devotion, but very few Researches on SUD study the moderating role of religiosity, specifically in Muslim-majority countries. The modern study focused on the relationship of resilience, psychological well-being, and religiosity amid SUD individuals. The study also focused on forecasting psychological well-being by the components of resilience, as well as the role of religiosity as a moderator in the resilience and psychological well-being relationship. A cross-sectional research pattern was used to enlist fifty male heroin users (ages 18 to 35) at drug rehabilitation centers in Rawalpindi and Islamabad, Pakistan, using comfort sampling. The Connor-Davidson Resilience Scale (CD-RISC; $\alpha = .81$), Mental Health Continuum Short Form (MHC-SF; $\alpha = .65$), and Index of Religiosity ($\alpha = .64$) were the three record collection tools used. Data were examined by correlation, regression, and moderation analysis using SPSS version 23. Resilience had a weak positive relationship with religiosity ($r = .190$, $p < .01$) and average positive correlation with psychological wellbeing ($r = .561$, $p < .01$) and linear reversion analysis showed that resilience, had a positive linear relation with psychological wellbeing ($\beta = .307$, $R^2 = .094$, $F = 4.99$, $p = .030$). On the other hand, moderation study showed that religiosity, acted as a poor moderator of the relationship of resilience and psychological wellbeing at all stages of the moderator (minimum: Effect = .1404, $p = .102$; average: Effect = .0343, $p = .582$; maximum: Effect = -.0718, $p = .435$). Again, resilience acts as a separate predictor of psychological well-being among individuals who have SUD, anyway of their level of religiosity. As a primary constituent of SUD, resilience warrants absorbed attention in treatment. The puzzling absence of the moderating position of religiosity may be due to the eccentricities of the sample and should be analyzed in the context of more comprehensive studies with different populations and an adequate duration.

Introduction

Contextual Background

Worldwide, Substance use disorder (SUD) is a developing major public health issue. The crisis affects families, individuals, and entire society. The World Health Organization (WHO) recognizes that substance use disorders (SUDs) affect hundreds of millions of people. The large load of disease, premature death, and psychosocial disorder are all attributable to SUDs. In Pakistan, the use of substances, especially heroin, is of grave issue. Millions of people are affected, and the available rehabilitation facilities are grossly insufficient to meet the demand. People with SUDs have higher stages of anxiety, stress, and depression, and experience a refuse in their functioning in most regions of life. This makes the presence of protective psychological factors necessary for the design of clinical study and interventions (Poudel et al., 2016).

The protective psychological factors of clients with substance use disorder (SUD) are Crucial to evolve comprehensive clinical interventions and guidelines. Two factors that are currently being researched are resilience and religiosity. These two factors are being examined as having the potential to alleviate some of the harmful psychological effects of substance use and improve the recovery method. The effects of religiosity and resilience have still not been sufficiently studied and perceived in the context of Islamic cultures.

Theoretical Framework and Core Constructs

Resilience

Resilience is the skill to adapt and retrieve from challenges and difficulties and significant stressors associated with major life changes. Resilience contains the capacity to tolerate the dire condition and preserve an overall sense of well-being while enduring to function effectively and healthily. It is worth noting that resilience is not the escape of the challenging situation; it is the capacity to cope with the position and grow above it (Fleming & Ledogar, 2008). People who have resilience display the ability to govern their emotions, solve the problem at hand, sustain a positive outlook, and use their social network (support) during difficult condition (Bonanno, 2004).

The research of resilience is guided by various theories. Based on Bronfenbrenner's ecological systems theory, resilience is the product of the several levels of the engaging environment, from the direct relationships to the broad social systems (Ozdogru, 2011). The hazard and protective factors theory states that resilience is a product of the serendipitous defensive factors that include positive surviving skills and good self-esteem (Nawi et al., 2021). Stemming from Masten's experimental systems theory, resilience is also distinguished as the interplay of the individual's capabilities and the environment's character (Masten, 2019). Resilience is the fundamental convictions that a flexible capacity is the product of a therapeutic aim that can be evolved and increased over time (Southwick et al, 2014; Rutter, 2012).

Psychological Well-Being

Psychological well-being Include multiple components. Diener et al. (2002) suggested that positive personal development, psychological states, and overall satisfaction with one's life also play significant parts in psychological well-being. A prominent model created by Ryff (2014) suggested six dimensions. These involve personal growth, self-acceptance, aim in life, positive association with others, and mastery of the environment. According to Seligman (2011), flourishing combines positive emotions with commitment in relationships and in the larger project of things, a sense of achievement.

Psychological well-being can also be observed through the lens of Self-determination Theory (SDT). In specific, Ryan and Deci (2000) argued that pleasure of three psychological needs—autonomy, competence, and relatedness—is the basis of psychological well-being. Building on this, Fredrickson (2004) recommended the broaden-and-build theory of positive reaction. According to this thesis, positive feelings construct flexible modes of thinking and acting which in turn produce psychological resources for well-being and for added resilience. According to several theorists, psychological well-being Include a combination of several Methods. Substance use disorders interrupt these processes. (Keyes, 2005; Huppert & So, 2013).

Religiosity

The term 'religiosity' refers to one's devotion to and participation in religious beliefs and activities. Religiosity comprise of many aspects: devotion, religious belief, ethics, and community and spiritual participation. The processes that Culturally construct religiosity in individuals are social, family, and personal experiences, rationally created societal and existential thought, and spirituality (Wulff, 1997; Emmons & Paloutzian, 2003). Providing culture support, a moral compass and meaning, and a means of clarifying pain and discomfort, religiosity may also provide individuals a reserve to cope with adversity and its detrimental effect on psychological health (Paloutzian & Park, 2013).

Considerable descriptive theories have been developed concerning religiosity. One is social-intellectual theory, which suggests that religiosity is culturally constructed and learned through modeling (Bandura, 2012). From the viewpoint of attachment theory, the Divine is a secure base, the source of safety and comfort (Bretherton, 1992). Experiential theories focus on religiosity's capacity to meet the needs to make perception of suffering and death (Watson & Schneider, 2016). In the framework of social interchange theory, religious participation is a way to obtain social support, guidance, and a sense of community (Cook et al., 2013).

Review of Literature

Research has been developing on resilience, religiosity, and well-being of those with substance use disorders (SUD). Findings continue to be varied amid different populations and different situation.

Khrame et al. (2014) examined spirituality, resilience, and quality of life and found positivity, among the SUD sample of 120 individuals in Iran. These findings associate with each other. Moreover, Mehran et al. (2011) stated that amid their sample of 100 SUD individuals in Italy, both religious involvement and resilience related with an increased quality of life, showing that both are protective aspect in the recovery process.

The study done by Yang et al. (2020) analyzed the relationships of spirituality, religion, substance use, resilience, and adaptation and found that among the 377 Latinx individuals in the U.S. with greater involvement in religion and greater spirituality developed in lesser substance use, and that resilience was a moderating factor of the religion-sp substance use correlation. In a Brazilian research sample of 120 individuals with SUD, Beraldo et al. (2019) recounted that both increased resilience and religiosity resulted in a greater quality of life, making it essential to combine resilience and spirituality into the treatment system.

Weinandy and Grubbs (2021) associated religious beliefs and resilience positively within the same sample of 135 individuals with SUD from Iran and stated that religious beliefs power increase the capacity to cope dynamically. Papanikolopoulos and Kaprinis (2022) found that in Northern Ireland, among young adults with higher stages of adversity, enlarged religiosity was a resilience factor, while amidst those with reduce levels of adversity it was not. Finally, Kasen et al. (2006) study reported comparable findings.

(2012) stated that in an Australian sample, religiosity was positively correlated to resilience, and mental well-being mediated this relationship.

In line with the COVID-19 pandemic, Vuzic et al. (2022) focused on young adult populations and examined the relationship between religious and spiritual well-being, supposing psychiatric symptoms, and the existence of addictive conduct. Klainin-Yobas et al. (2021) analyzed the relationship between the constructs of stress, resilience, and psychological well-being using structural equation modeling, and found that resilience played a significant mediating role in the stress-well-being relationship. Padmanabhanunni et al. (2023) displayed the mediating role of resilience in the relationship between role stress and psychological well-being in the situation of the pandemic.

Gap Identification and Rationale

Existing study significantly documents the independent relationships of resilience and religiosity with psychological well-being and recovery-related results. However, some gaps persevere. First, the moderating impact of religiosity on the resilience-well-being relationship has been mostly overlooked in the literature, especially in relation to clinical samples with SUD. Second, research on the multiple features of religiosity has been focused on the West and in Christian settings, with no studies performed on Muslim populations, in which the demonstration of religiosity may be qualitatively different. Third, literature on South Asia in general and on rehabilitation in South Asian countries particular, has very little study on heroin users. The current research effort to fill these gaps. It investigates if religiosity acts as a moderator in the resilience-well-being relationship of heroin users in rehabilitation centers in Pakistan. This study has the potential to design recuperation models that merge the psychological and the spiritual constituent of recovery and are socially appropriate and clinically related.

Research Aims and Hypotheses

This research focused on three regions. The first was to understand the relation between resilience, psychological well-being, and religiosity of those with SUD. The second was to understand if resilience expected psychological well-being of those with SUD. And the third was to understand if religiosity performed as a moderator in the relation of resilience and psychological well-being of those with SUD.

From the theoretical and empirical evidence, the following were the hypotheses:

- **H1:** The relation of resilience and psychological well-being and religiosity of those with SUD is positive and significant.
- **H2:** The psychological well-being of those with SUD is positively and considerably predicted by resilience.
- **H3:** The relationship of resilience and psychological well-being of those with SUD is significantly moderated by religiosity.

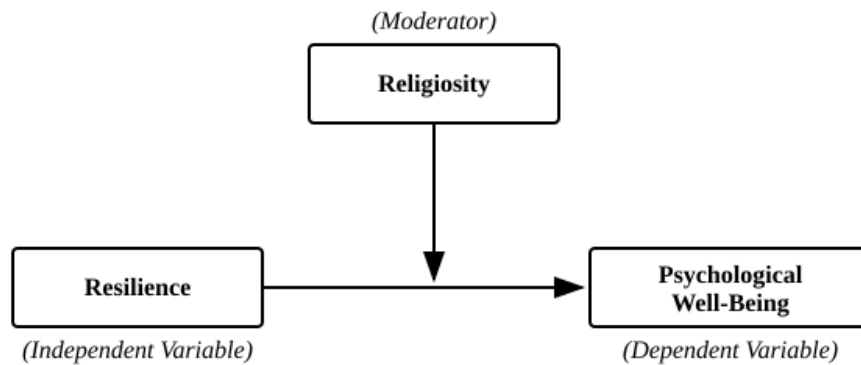


Figure 1. Conceptual Framework: Moderating Role of Religiosity in the Resilience–Psychological Well-Being Relationship

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Methods

Study Design and Ethical Considerations

This study used a cross-sectional structure. The research took place at the Department of Psychology, Ability of Social Sciences, International Islamic University Islamabad, Pakistan. Ethical approval was obtained from the review board in the organizations. Prior to the collection of data, informed permission was obtained from all the study's participants. Participants were secured confidentiality as well as the accurate to refuse and the right to withdrawal. All processes adhered to the ethical usual of the statement of Helsinki and institutional directives. This research occupied a cross-sectional structure because of the investigative aims of the study and the limited approach to a clinical rehabilitation population (Padmanabhanunni et al., 2023).

Participants and Sampling

The members in this study were fifty male heroin users from drug rehabilitation centers in Rawalpindi and Islamabad, Pakistan. Their ages were among 18 and 35. A comfort sampling process supported sample collection from different rehabilitation centers like past similar studies in these types of clinical setups (Poudel et al., 2016; Kharama et al., 2014).

Male heroin users in the age variety of 18 to 35 and who were hospitalized in drug rehabilitation centers in the Rawalpindi Islamabad passage were included. Age-based exclusion requirements were set at 18 years and 35 years. While this sample was small, it is coordinated with other studies of this kind and is reflective of the restriction of this technical clinical setting.

Measures and Instruments

Connor-Davidson Resilience Scale (CD-RISC)

Connor Davidson Resilience Scale (CD-RISC) was used to calculate resilience. The CD-RISC is a self-worth standardized measure consisting of twenty-five items that concentrate on an individual's ability to tolerate and recover from hardship and struggle, flexibility to change, view of the world, and positivity. (Connor & Davidson, 2003). The CD-RISC is a 25-object measure, and each item is ranked on a 5-point likert scale (0 = Not at All True, 4 = Always True). Total scores can range from 0-100. A maximum score is indicative of higher resilience. The CD-RISC has sufficient and strong psychometric properties over multiple populations. The original CD-RISC measure has a stated Cronbach's alpha of .87. For the current research, the CD-RISC measure had a reported Cronbach's alpha of .81. This shows that the measure is of good quality and has a good amount of internal uniform.

Mental Health Continuum Short Form (MHC-SF)

Psychological well-being was calculated by the Mental Health Continuum Short Form (MHC-SF) (Keyes, 2002) and the Urdu version by Faran et al. (2015). The original version includes 14 items that cover emotional, social, and psychological well-being on a continuum of languishing to successful. Each participant is asked to rate the items on a 6-point Likert-type scale from 0 (never) to 5 (every day). The total score is the sum of the aspect scores and is understood as a measure of mental health and well-being. The translated version had an alpha reliability of .91 (Faran et al., 2015). For the current study, the Cronbach's alpha was .65, which is below the approved level of .70, but may be due to the sample size and the population with the study's clinical qualities (Keyes, 2005).

Index of Religiosity

The Index of Religiosity which measures Religiosity, evolved in 1996 by Rehman and Aziz at the National Institute of Psychology, Quaid-i-Azam University. The Index of Religiosity is a 27-item Urdu questionnaire created to measure three factors of Religiosity containing religious faith, religious ideology/doctrine, and religious effect. Among the psychometrics, the Index of Religiosity reports a Cronbach's alpha of .83 in the normative sample. In the current study, the Index of Religiosity measured a .64 Cronbach's alpha week sample. This measure was used in the present study as an implement to measure Religiosity in a Pakistani Muslim population, considering the social and linguistic aspect.

Procedure

The Rawalpindi Islamabad region has multiple drug rehabilitation centers from which data have been assembled. After acquiring ethical clearance, the researcher talked with the administrators of rehabilitation centers to get authorization for data collection. The eligible members were neared personally, and the aim and the methods of the study were described to them. Questionnaires were administered only if participants gave their approval. Members first completed a segment sheet and then completed the three measurement scales in a counterbalanced arrange. All measurement scales were administered in Urdu. The primary ethical factors were met in every level of the data collection method.

Statistical Analysis

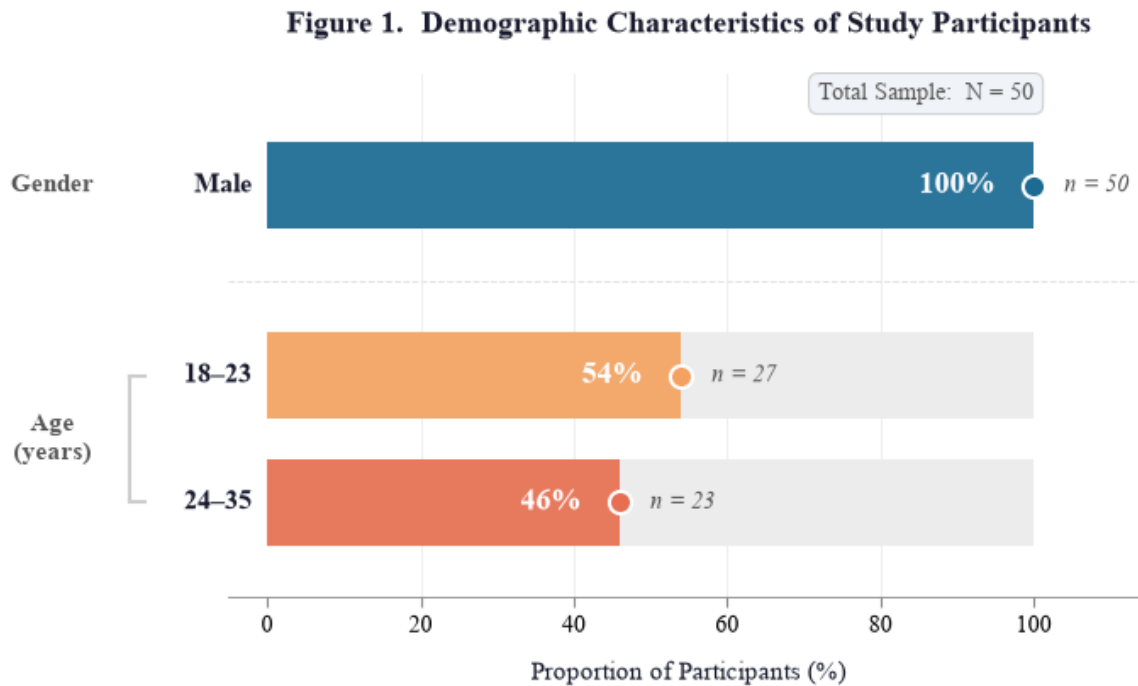
Statistical analyses were performed using the Statistical Packages for Social Sciences (SPSS) version 23. Several detailed statistics including means, standard deviations, and categorical frequencies and percentages were computed for each study unstable. The properties of study variable dissemination were analyzed using the skewness and kurtosis statistics. The Cronbach's alpha statistic was used to conclude the internal consistency reliability of the measurement apparatuses. The relationships between the study unstable of resilience, psychological well-being, and religiosity were analyzed using the Pearson's product-moment correspondence coefficient statistic. In this research, as in similar studies (Krentzman, 2013; Klainin-Yobas et al., 2021), resilience was assumed to predict psychological well-being and was appraised using multiple linear regression examination. The religiosity as a potential moderator intervening the psychological well-being and resilience relationship was appraised using the moderation analysis in the PROCESS macro (Hayes, 2013), using the suggested moderation analysis in the current studies of protective factors of SUD (Padmanabhanunni et al., 2023; Yang et al., 2020). A p-value of .05 was an importance threshold in this research.

Results

Sample Characteristics

The sample comprised 50 male heroin users in rehabilitation, as observed in the demographic profile (Figure 1). All the sample (100%) were male. Most of the sample were 18-23yrs (54%, $n = 27$). 23 ($n = 23$) were 24-35 years old.

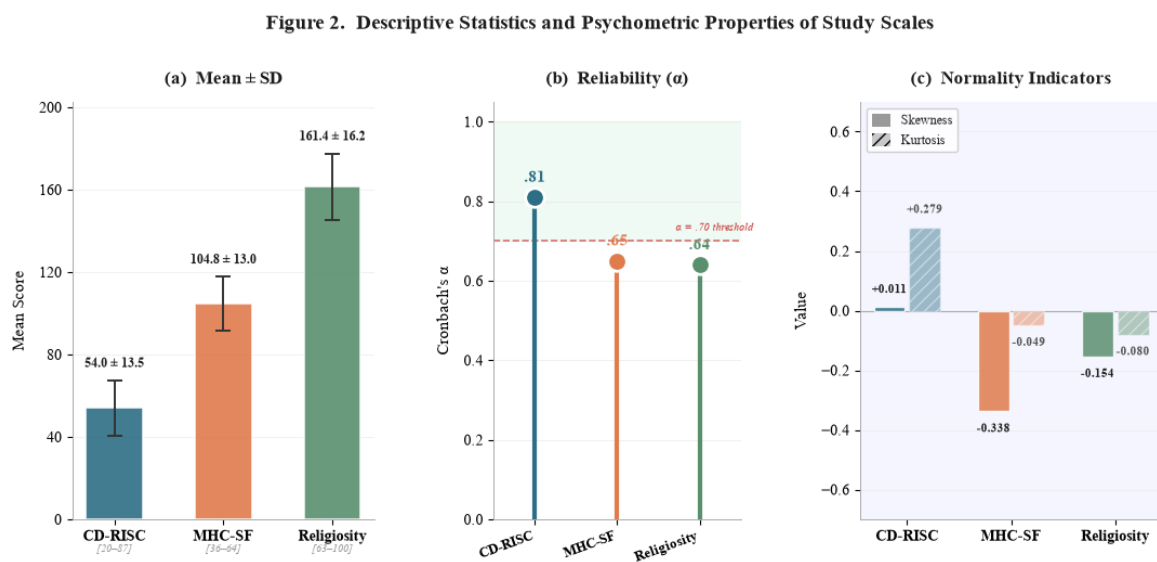
Figure 1



Psychometric Properties and Descriptive Statistics

Expressive statistics and psychometric characteristics of devices used in the study are illustrated in Figure 2. The scales displayed reasonable distributional properties; the values for skewness and kurtosis were in the interval of ± 2 . Thus, the distribution for the scales can be presumed to be (approximately) normal, allowing the use of parametric statistical processes.

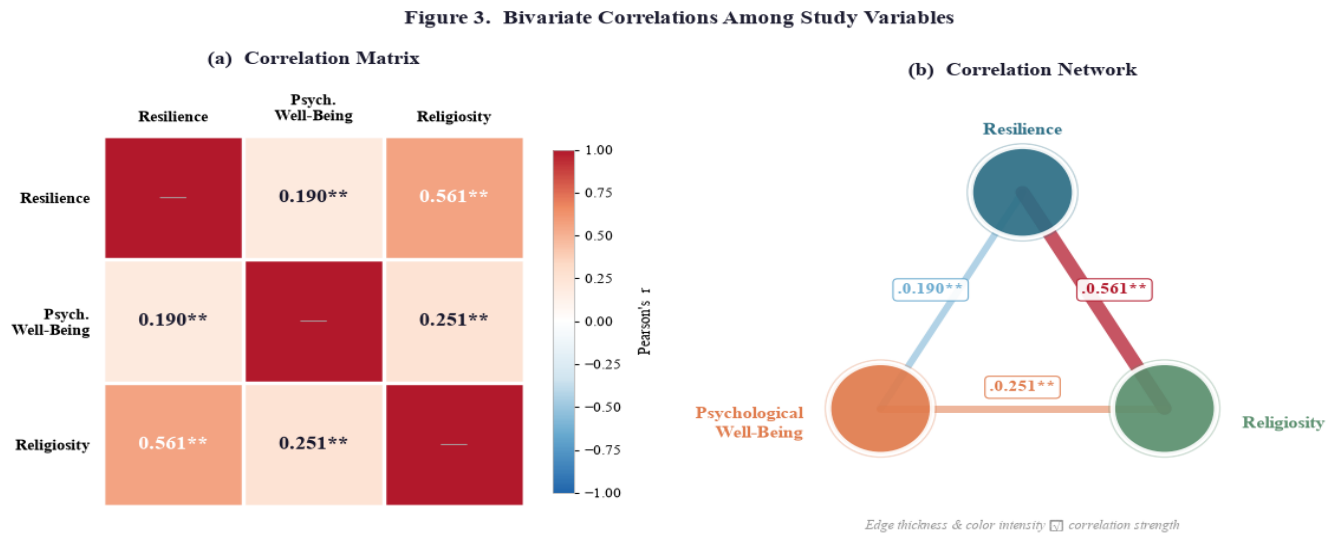
Figure 2: Psychometric Properties and Descriptive Statistics of Study Scales (N = 50)



Bivariate Correlations

Figure 3 shows the results of the Pearson relationship analysis. The examination shows the following important positive correlations: resilience with both psychological well-being ($r = .190$, $p < .01$) and religiosity ($r = .561$, $p < .01$); psychological well-being with religiosity ($r = .251$, $p < .01$). Based on these outcomes, the hypothesis 1 is supported because the results display positive correlations with the three variables of the research.

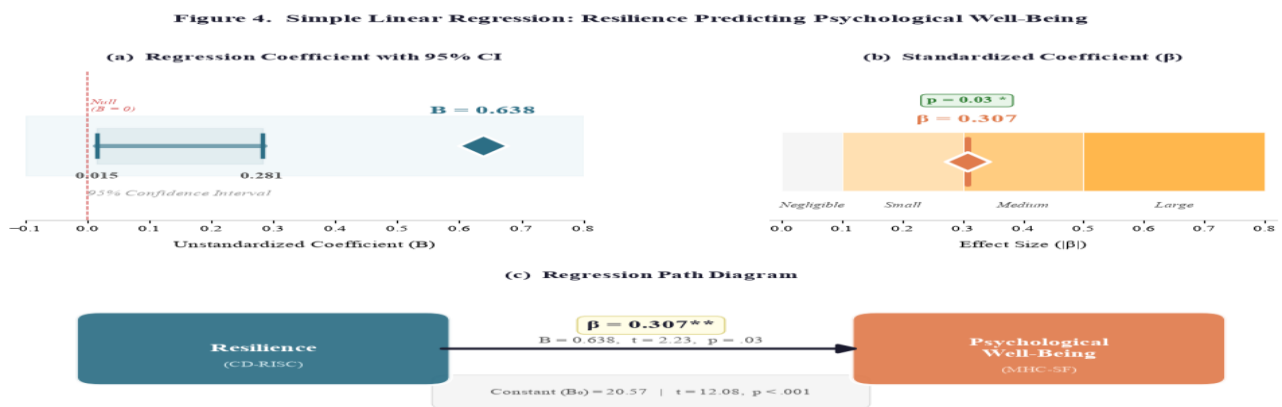
Figure 3: Bivariate Correlations Between Resilience, Psychological Well-Being, and Religiosity (N = 50)



Note. $N = 50$. ** $p < .01$ (two-tailed). CD-RISC = Connor–Davidson Resilience Scale; MHC-SF = Mental Health Continuum–Short Form.

Regression Analysis: Resilience Predicting Psychological Well-Being

To determine if resilience expected psychological well-being among individuals with SUD, a reversion analysis was used. Results are showed in Figure 4. Resilience was shown to predict psychological well-being positively and significantly ($\beta = .307$, $t = 2.23$, $p = .030$). The regression model evaluated the variance of psychological well-being, and the model fit was regarded as the total difference of well-being explained in the model ($R^2 = .094$, $F(1, 48) = 4.99$, $p = .030$) which was almost 9.4%. As hypothesized in Hypothesis 2, the relapse analysis suggested that individuals with SUD and greater levels of resilience had greater levels of psychological well-being.



Note. $N = 50$. * $p < .05$, ** $p < .01$. CD-RISC = Connor–Davidson Resilience Scale; MHC-SF = Mental Health Continuum–Short Form. Effect-size benchmarks follow Cohen (1988).

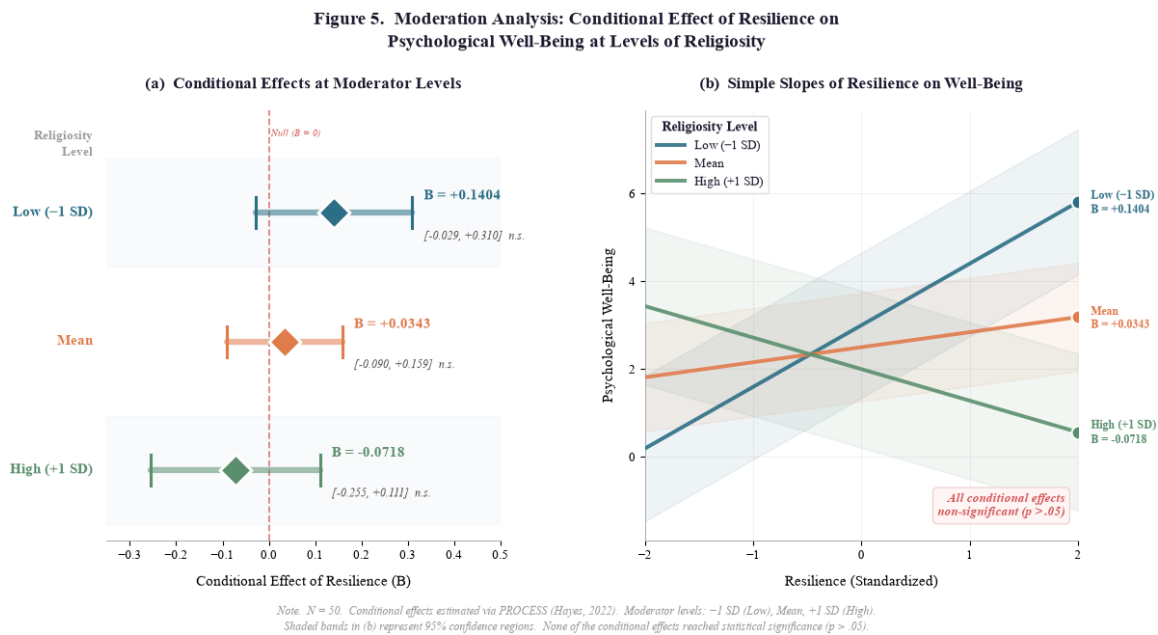
Figure 4: Regression Analysis: Resilience Predicting Psychological Well-Being (N = 50)

Note. $R^2 = .094$; $F(1, 48) = 4.99$, $p = .030$. B = unstandardized coefficient; β = standardized coefficient; CI = confidence interval.

Moderation Analysis: Religiosity as a Moderator

To see if resiliency and psychological well-being had a relationship that was regulated by religiosity, a moderation analysis was executed. The conditional effects are displayed in Figure 5 and show the effects of resilience on psychological well-being at the moderator's three levels (minimum, average, and maximum religiosity). Each of the conditional effects for the moderator was as follows: minimum religiosity (Effect = .1404, SE = .0844, $t = 1.66$, $p = .102$, 95% CI [-.029, .310]); average religiosity (Effect = .0343, SE = .0629, $t = .553$, $p = .582$, 95% CI [-.090, .159]); maximum religiosity (Effect = -.0718, SE = .0912, $t = -.786$, $p = .435$, 95% CI [-.255, .111]). None of these conditional effects were arithmetically significant. This means that the evidence does not support that religiosity does moderate the resilience and psychological well-being relationship and hence, Hypothesis 3 is not supported.

Figure 5: Conditional Effects of Resilience on Psychological Well-Being at Levels of Religiosity (N = 50)



Note. Effects represent the conditional effect of resilience on psychological well-being at specified levels of religiosity. CI = confidence interval.

Discussion

Summary of Findings

This research examined the relationships between resilience, psychological well-being, and religiosity. The study also looked at whether religiosity performed as a moderator between the resilience and well-being of heroin users in rehabilitation in Pakistan. Three hypotheses were put forth. Hypothesis 1 was supported. Resilience was positively related to both psychological well-being and religiosity. Hypothesis 2 was also supported. Resilience was an important predictor of psychological well-being, and in doing so, explained 9.4% of the variation of psychological well-being. Hypothesis 3 was not supported, and religiosity did not significantly act as a moderator of the resilience well-being relationship, anyway of the level of the moderator.

Interpretation and Comparison with Existing Literature

Resilience having a positive relationship with psychological well-being with those who have SUD is uniform with much prior study. Kharam et al. (2014) and Beraldo et al. (2019) noted comparable positive relationships between resilience and quality of life with SUD. Moreover, Yang et al. (2020) displayed that in their research, resilience acted as a mediator between religious engagement and the decrease of substance use, strengthening the argument of resilience being a key protective component. This finding, along with the study of Krentzman (2013) suggests that people with an elevated level of resilience are more efficient of maintaining psychological well-being with the disease of substance use disorder. This finding also fits into the enlarge -and-build theory (Fredrickson, 2004) in that resilient people have evolved positive emotional and cognitive resources that improve their coping abilities and psychological capital.

Having a higher stage of resilience associate positively with having a higher level of religiosity. This is also found in the study of Al Eid et al. (2020), who saw positive correlational research of religiosity and resilience of breast cancer patients in Saudi Arabia. Grant Weinandy and Grubbs (2021) also noted positive associated ties of resilience and SUD patients of a religious nature. The studies of Papanikolopoulos and Kaprinis (2022) and Kasen et al. (2012) offer other cross-cultural views of religiosity and resilience. In the present study, this relates to the strong influence of Islamic religiosity within the culture of Pakistan, as the conviction and practices of religion provide meaning, community, and coping system that promote resilience (Hill & Pargament, 2003; Paloutzian & Park, 2013).

Resilience predicts psychological well-being ($\beta = .307$, $p = .030$), which shows that resilience is an important focal point for therapy.

Klainin-Yobas et al. (2021) demonstrated that resilience mediated the stress well-being relationship using structural equation modeling. Padmanabhanunni et al. (2023) stated that resilience mediated the role stress well-being relationship during the COVID-19 pandemic. Even though the current research used an uncomplicated analytic approach, the findings' direction and significance associated with these advanced models. The R^2 of .094 can be accepted given the complex nature of psychological well-being and propose that resilience contributes meaningful, but not substantive, variation.

The deficiency of a significant moderating effect of religiosity was an engaging finding. There was a clear direct relationship between religiosity and well-being in other studies (Vuzic et al., 2022; Mehran et al., 2011), while the current research found no relationship between religiosity and the resilience well-being relationship. This can be ascribed to several reasons. The small sample size ($N = 50$) may have had an inadequate effect size to identify a moderating relationship. This is normally the case for minor samples. The current sample was homogenous with consider to religiosity because the sample consisted of Muslim males; furthermore, the sample was in a situation where religious participation was likely to be elevated, which may have limited the difference of the suggested moderator. A third possible reason is the religiosity, and well-being measures had a moderate interior consistency ($\alpha = .64$ and $.65$, respectively). The current research may have reduced the relationships due to the assess used.

Since religiosity is executed in different ways, it might act as a direct predictor or as a mediator as opposed to a moderating variable amid this population, and this should be considered in other forthcoming studies (Thanoi et al., 2023).

Clinical and Practical Implications

The conclusions have numerous clinical and practical results for substance abuse treatment in Pakistan and similar situation. First, because resilience has a sturdy predictive capacity for psychological well-being, the evolution of resilience should be a primary objective of rehabilitation involvement. This development can be realized through different interventions and therapy models, such as dialectical behavior therapy (DBT) and cognitive-behavioral therapy (CBT) with coping skills, and strengths-based therapeutic models, which have been proposed to increase psychological well-being for patients with substance use disorder (Krentzman, 2013; Poudel et al., 2016). Second, though this research found no moderating effect of religiosity on the resilience well-being relationship, the positive organized of religiosity with resilience and well-being shows that some spiritually focused rehabilitative tries, such as the Islamic version of 12-step programs, and the development of faith-based support groups, may help resilience building efforts. Third, the findings call for the involvement of psychological, social, and spiritual aspect of recovery in the treatment models (Beraldo et al., 2019).

Limitations

There are some essential considerations of this study. The direction of the relationships of resilience, psychological wellbeing and religiosity is unknown due to the cross-sectional study design. The minor sample size ($N = 50$) is a study limitation that decrease confidence in the results and the ability to identify moderation results. The sample contained of self-reported measures, which can initiate biases due to the self-report nature of the measures, which are exposed to socially desirable responding, specifically in reporting religiosity in a rehabilitation context. The use of convenience sampling is another restriction. The sample of men is from an individual substance, from a single substance (heroin) and is restricted to two cities in Pakistan, all of which restrict the study in terms of substance use, gender, and cultural context. The study also characterizes the short to moderate internal reliability of the MHC-SF ($\alpha = .65$) and the Index of piety ($\alpha = .64$), which also limit the study in terms of measurement of the assemble and may have decreased the effect size of the study. The lack of control of the duration of substance use, other psychiatric disorders, socioeconomic status, abstinence duration, and former rehabilitation attempts may affect the results and the validity of the constructs.

Future Research Directions

Multiple pathways for more study are suggested. Longitudinal and cross-lagged panel studies should be evolved for the SUD population to examine the temporal priority and causal directions of religiosity, resilience, and psychological well-being (Rutter, 2012; Masten, 2019). The generalizability and statistical power of future study findings will be enhanced by containing larger, more diverse (women, poly-drug users, different areas and countries, different cultures and religious affiliations) study populations (Poudel et al., 2016). Future researches will also benefit from using more than one process for assessment (Southwick et al., 2014). Future study should also examine different models (i.e. religiosity as a mediator), and the different categories (i.e. religious coping, intrinsic and extrinsic religiosity) of religiosity and how they affect the resilience and well-being pathway (Hill & Pargament, 2003; Emmons & Paloutzian, 2003). Further analysis is warranted to explore the effects of resilience and religiosity on psychological well-being of SUD clients using building resilience and spirit-based integration therapies (Krentzman, 2013; Beraldo et al., 2019). Future research should also study the impact of other significant variables on SUD clients, including the severity of other diagnoses, substance use severity, and the length and type of treatment, on the psychological well-being of SUD clients.

Conclusion

This research provides proof of a direct relationship of resilience with psychological well-being and religiosity of heroin users within rehabilitative settings in Pakistan. Resilience has appeared as an influential predictor of psychological well-being in the examined demographic, capturing the attention of researchers for its therapeutic potential for substance abuse. While religiosity did not act as a moderator of the resilience well-being relationship, the significant associations of both constructs of religiosity shows its impact and presence in the alternative recovery frameworks. Including the findings in the developing pool of literature on substance use disorder (SUD) considers the potential need for resilience-centered, socially appropriate care, and provides models of recovery raising both psychological and spiritual well-being. Future studies, employing a kind, of qualitative and quantitative research methods, and integrating longitudinal and cross-sectional designs and larger varied study populations, will strengthen evidence of the correlations of resilience and religiosity with well-being in the recovery of substance use disorder.

Declarations

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Conflict of Interest Statement

The authors declare that they have no conflicts of interest relevant to the content of this article.

Author Contributions

Muhammad Uzair Khan: Conceptualization, methodology, data collection, formal analysis, writing original draft, and project administration. Komal Yousafzai: Literature review, writing review and editing, and validation. Naji Ullah: Data curation, writing review and editing, and visualization.

All authors have read and approved the final version of the manuscript.

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Data Availability

The data supporting the findings of this study are available from the corresponding author upon reasonable request.

Ethics Statement

Ethical approval for this study was granted by the Department of Psychology, Faculty of Social Sciences, International Islamic University Islamabad. Informed consent was obtained from all individual participants prior to their inclusion in the study. All procedures performed in this study were in accordance with the ethical standards of the institutional research committee and with the 1964 Helsinki Declaration and its later amendments.

References

- Al Eid, N. A., Alqahtani, M. M., Marwa, K., Arnout, B. A., Alswailem, H. S., & Al Toaimi, A. A. (2020). Religiosity, psychological resilience, and mental health among breast cancer patients in Kingdom of Saudi Arabia. *Breast Cancer: Basic and Clinical Research*, 14, 1178223420903054. <https://doi.org/10.1177/1178223420903054>
- Bandura, A. (2012). Social cognitive theory. In *Handbook of theories of social psychology*, Vol. 1 (pp. 349-373). Sage Publications Ltd. <https://doi.org/10.4135/9781446249215.n18>
- Beraldo, L., Gil, F., Ventriglio, A., de Andrade, A. G., da Silva, A. G., Torales, J., Gonçalves, P. D., Bhugra, D., & Castaldelli-Maia, J. M. (2019). Spirituality, religiosity, and addiction recovery: Current perspectives. *Current Drug Research Reviews*, 11(1), 26–32. <https://doi.org/10.2174/1874473711666180612075954>
- Bonanno, G. A. (2004). Loss, trauma, and human resilience: Have we underestimated the human capacity to thrive after extremely aversive events? *American Psychologist*, 59(1), 20–28. <https://doi.org/10.1037/0003-066X.59.1.20>
- Bretherton, I. (1992). The origins of attachment theory: John Bowlby and Mary Ainsworth. *Developmental Psychology*, 28(5), 759–775. <https://doi.org/10.1037/0012-1649.28.5.759>
- Cook, K. S., Cheshire, C., Rice, E. R. W., & Nakagawa, S. (2013). Social exchange theory. In *Handbook of social psychology*, 2nd ed (pp. 61–88). Springer. https://doi.org/10.1007/978-94-007-6772-0_3
- Connor, K. M., & Davidson, J. R. T. (2003). Development of a new resilience scale: The Connor-Davidson Resilience Scale (CD-RISC). *Depression and Anxiety*, 18(2), 76–82.
- Diener, E. (1984). Subjective well-being. *Psychological Bulletin*, 95(3), 542–575. <https://doi.org/10.1037/0033-2909.95.3.542>
- Diener, E., Lucas, R., & Oishi, S. (2002). Subjective well-being: The science of happiness and life satisfaction. In C. R. Snyder & S. J. Lopez (Eds.), *Oxford handbook of positive psychology*. Oxford University Press. <https://doi.org/10.1093/oxfordhb/9780195187243.013.0017>
- Emmons, R. A., & Paloutzian, R. F. (2003). The psychology of religion. *Annual Review of Psychology*, 54, 377–402. <https://doi.org/10.1146/annurev.psych.54.101601.145024>
- Faran, S., et al. (2015). Urdu translation and validation of the Mental Health Continuum Short Form (MHC-SF).
- Fleming, J., & Ledogar, R. J. (2008). Resilience, an evolving concept: A review of literature relevant to Aboriginal research. *Pimatisiwin*, 6(2), 7–23.
- Fredrickson, B. L. (2004). The broaden-and-build theory of positive emotions. *Philosophical Transactions of the Royal Society B*, 359(1449), 1367–1378. <https://doi.org/10.1098/rstb.2004.1512>
- Grant Weinandy, J. T., & Grubbs, J. B. (2021). Religious and spiritual beliefs and attitudes towards addiction and addiction treatment: A scoping review. *Addictive Behaviors Reports*, 14, 100393. <https://doi.org/10.1016/j.abrep.2021.100393>
- Hill, P. C., & Pargament, K. I. (2003). Advances in the conceptualization and measurement of religion and spirituality: Implications for physical and mental health research. *American Psychologist*, 58(1), 64–74. <https://doi.org/10.1037/0003-066X.58.1.64>
- Hood Jr., R. W., Hill, P. C., & Spilka, B. (2009). *The psychology of religion: An empirical approach* (4th ed.). Guilford Press.
- Huppert, F. A., & So, T. T. C. (2013). Flourishing across Europe: Application of a new conceptual framework for defining well-being. *Social Indicators Research*, 110(3), 837–861. <https://doi.org/10.1007/s11205-011-9966-7>
- Kasen, S., Wickramaratne, P., Gamaroff, M. J., & Weissman, M. M. (2012). Religiosity and resilience in persons at high risk for major depression. *Psychological Medicine*, 42(3), 509–519. <https://doi.org/10.1017/S0033291711001516>
- Kern, M. L., Waters, L. E., Adler, A., & White, M. A. (2015). A multidimensional approach to measuring well-being in students: Application of the PERMA framework. *Journal of Positive Psychology*, 10(3), 262–271. <https://doi.org/10.1080/17439760.2014.936962>
- Keyes, C. L. M. (2005). Mental illness and/or mental health? Investigating axioms of the complete state model of health. *Journal of Consulting and Clinical Psychology*, 73(3), 539–548. <https://doi.org/10.1037/0022-006X.73.3.539>

- Kharame, Z. T., Zamanian, H., Foroozanfar, S., & Afsahi, S. (2014). Religious wellbeing as a predictor for quality of life in Iranian hemodialysis patients. *Global Journal of Health Science*, 6(4), 261–269. <https://doi.org/10.5539/gjhs.v6n4p261>
- Klainin-Yobas, P., Vongsirimas, N., Ramirez, D. Q., Sarmiento, J., & Fernandez, Z. (2021). Evaluating the relationships among stress, resilience, and psychological well-being among young adults: A structural equation modelling approach. *BMC Nursing*, 20(1), 119. <https://doi.org/10.1186/s12912-021-00645-9>
- Krentzman, A. R. (2013). Review of the application of positive psychology to substance use, addiction, and recovery research. *Psychology of Addictive Behaviors*, 27(1), 151–165. <https://doi.org/10.1037/a0029897>
- Masten, A. S. (2019). Resilience from a developmental systems perspective. *World Psychiatry*, 18(1), 101–102. <https://doi.org/10.1002/wps.20591>
- Nawi, A. M., Ismail, R., Ibrahim, F., Hassan, M. R., Manaf, M. R. A., Amit, N., Ibrahim, N., & Shafurdin, N. S. (2021). Risk and protective factors of drug abuse among adolescents: A systematic review. *BMC Public Health*, 21(1), 2088. <https://doi.org/10.1186/s12889-021-11906-2>
- Özdoğan, A. A. (2011). Bronfenbrenner's ecological theory. In S. Goldstein & J. A. Naglieri (Eds.), *Encyclopedia of child behavior and development* (pp. 300–301). Springer. https://doi.org/10.1007/978-0-387-79061-9_940
- Padmanabhanunni, A., Pretorius, T. B., & Khamisa, N. (2023). The role of resilience in the relationship between role stress and psychological well-being during the COVID-19 pandemic: A cross-sectional study. *BMC Psychology*, 11, 45. <https://doi.org/10.1186/s40359-023-01082-w>
- Paloutzian, R. F., & Park, C. L. (2013). *Handbook of the psychology of religion and spirituality* (2nd ed.). Guilford Press.
- Papanikolopoulos, P. N., & Kaprinis, S. G. (2022). Religiosity and mental health of adolescents and young adults: A review. *Psychiatrike*, 33(2), 157–165. <https://doi.org/10.22365/jpsych.2021.036>
- Poudel, A., Sharma, C., Gautam, S., & Poudel, A. (2016). Psychosocial problems among individuals with substance use disorders in drug rehabilitation centers, Nepal. *Substance Abuse Treatment, Prevention, and Policy*, 11, 28. <https://doi.org/10.1186/s13011-016-0072-3>
- Rutter, M. (2012). Resilience as a dynamic concept. *Development and Psychopathology*, 24(2), 335–344. <https://doi.org/10.1017/S0954579412000028>
- Ryan, R. M., & Deci, E. L. (2000). Self-determination theory and the facilitation of intrinsic motivation, social development, and well-being. *American Psychologist*, 55(1), 68–78.
- Ryff, C. D. (2014). Psychological well-being revisited: Advances in science and practice. *Psychotherapy and Psychosomatics*, 83(1), 10–28. <https://doi.org/10.1159/000353263>
- Ryff, C. D., & Singer, B. H. (2008). Know thyself and become what you are: A eudaimonic approach to psychological well-being. *Journal of Happiness Studies*, 9(1), 13–39. <https://doi.org/10.1007/s10902-006-9019-0>
- Seligman, M. E. P. (2011). *Flourish: A visionary new understanding of happiness and well-being*. Free Press.
- Southwick, S. M., Bonanno, G. A., Masten, A. S., Panter-Brick, C., & Yehuda, R. (2014). Resilience definitions, theory, and challenges: Interdisciplinary perspectives. *European Journal of Psychotraumatology*, 5, 25338. <https://doi.org/10.3402/ejpt.v5.25338>
- Thanoi, W., Vongsirimas, N., Sitthimongkol, Y., & Klainin-Yobas, P. (2023). Examining predictors of psychological well-being among university students: A descriptive comparative study across Thailand and Singapore. *International Journal of Environmental Research and Public Health*, 20(3), 1875. <https://doi.org/10.3390/ijerph20031875>
- Vuzic, X. D., Burkart, P. L., Wenzl, M., Fuchshuber, J., & Unterrainer, H.-F. (2022). The relationship between religious/spiritual well-being, psychiatric symptoms, and addictive behaviors among young adults during the COVID-19-pandemic. *Frontiers in Psychology*, 13, 942149. <https://doi.org/10.3389/fpsyg.2022.942149>
- Watson, J. C., & Schneider, K. (2016). Humanistic–existential theories. In *APA handbook of clinical psychology: Theory and research*, Vol. 2 (pp. 117–143). American Psychological Association. <https://doi.org/10.1037/14773-005>
- Wulff, D. M. (1997). *Psychology of religion: Classic and contemporary* (2nd ed.). John Wiley & Sons.

Yang, C., Zhou, Y., & Xia, M. (2020). How resilience promotes mental health of patients with DSM-5 substance use disorder? The mediation roles of positive affect, self-esteem, and perceived social support. *Frontiers in Psychiatry*, 11, 588968. <https://doi.org/10.3389/fpsyt.2020.588968>



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