

**Differences in Psychological Distress and Psychological Resilience among
Individuals Dependent on Psychoactive Substances According to
Residence, Years of Substance Use, and Relapse Frequency**

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Abstract:

The present study aimed to examine differences in psychological distress and psychological resilience among individuals dependent on psychoactive substances, in relation to their place of residence (rural vs. urban), duration of substance use, and relapse frequency. The sample comprised sixty (60) substance-dependent individuals aged between 21 and 43 years. Data collection instruments included the Psychological Resilience Scale (Abdelmonem, (2022)) and a newly developed Psychological Distress Scale (the Researcher, 2026). The findings revealed statistically significant differences in total psychological distress and its psychological domain based on the place of residence, consistently favoring rural participants who reported higher distress levels, whereas no significant differences were observed in psychological resilience. Regarding the duration of substance use, significant differences emerged exclusively in total psychological resilience, favoring individuals with a shorter history of substance use—while psychological distress remained statistically unchanged. Furthermore, relapse frequency did not yield any statistically significant differences in either psychological distress or psychological resilience. The study demonstrates that psychological distress is heavily influenced by environmental contexts (residence), whereas psychological resilience is an internal asset that progressively erodes with prolonged substance exposure than episodic relapse events.

Keywords : Psychological resilience, rather Psychological distress, Individuals dependent on Psychoactive substances.

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Introduction:

The phenomenon of psychoactive substance dependence stands as one of the most critical contemporary crises threatening adult populations. It poses a severe risk to both individual well-being and societal development due to its profound psychological, physiological, and cognitive ramifications (Wafqi, Hamed (2003)).

The gravity of this issue is exacerbated by its high prevalence among youth, who constitute a society's core human capital. Furthermore, contemporary trends indicate that substance abuse is no longer confined to single-agent consumption; instead, polysubstance dependence has become increasingly pervasive. Because youth represent a vital societal demographic, any systemic instability inevitably reverberates across this group with amplified intensity. Consequently, the socioeconomic and human losses are particularly devastating among young adults, upon whom national progress and societal development depend (Rania, Sami (2022)).

Relapse remains an imposing barrier within addiction therapeutics. It represents a fundamental challenge to the rehabilitation process and significantly impedes a patient's successful reintegration into functional daily life following primary treatment phases. Crucially, relapse susceptibility is closely intertwined with an individual's capacity for stress-coping, their experience of psychological distress, and their level of psychological resilience in the face of crisis. Epidemiological data indicate that approximately 70% of recovering individuals undergo relapse, a vulnerability primarily triggered by exposure to acute psychological pressures and pervasive distress, compounded by an inability to sustain psychological resilience when confronting internal and external stressors.

Psychological distress is a complex, multifaceted phenomenon experienced by individuals navigating adverse life circumstances. It arises from the cumulative series of challenging events encountered in daily life, undermining psychological well-being and manifesting in diverse symptomatic presentations (Manal Bin Rashid, (2022)). Empirical evidence (e.g., Ali Kazem, (2007); Jaafar Askari, (2013); Wafaa Mahmoud, (2018)) underlines the profound extent to which substance-dependent cohorts are afflicted by psychological distress, highlighting their compromised coping capacities and documenting the direct role that psychological distress plays in precipitating relapse events.

Concurrently, psychological resilience has emerged as a pivotal construct within contemporary psychological research. It encompasses a constellation of behavioral and psychological attributes, such as perseverance, cognitive flexibility, psychological hardiness, and positive future orientations, that mediate the dynamic

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interaction between an individual and stressful environmental stimulus including crises, systemic threats, and traumatic experiences (**Mohamed, El-Behairy (2011)**).

Furthermore, resilience operates as an intrinsic motivational force driving individuals toward self-actualization, altruism, and wisdom, enabling them to attain harmony and equilibrium with internal and spiritual sources of strength (**Richardson, (2002)**).

Accordingly, the present study seeks to elucidate the differential expressions of psychological distress and psychological resilience among individuals dependent on psychoactive substances. Specifically, it investigates how these psychological constructs vary as a function of clinical and demographic determinants, namely: the duration of substance use, the frequency of relapse episodes, and the place of residence. The insights gleaned from this investigation may inform targeted clinical interventions aimed at cultivating psychological resilience and mitigating distress within substance-dependent populations, while clarifying the underlying role of demographic variations.

1. Statement of the Problem:

Substance addiction represents an intricate, multi-dimensional global crisis encompassing intertwined political, security, healthcare, psychological, economic, and social challenges. Globally, the number of individuals utilizing illicit substances escalated to approximately 275 million in 2020, with nearly 36 million individuals meeting the clinical criteria for substance use disorders (**United Nations Office on Drugs and Crime (2021)**).

Domestically, Egypt has historically recognized the existential threat posed by substance abuse; it was a pioneer in institutional drug control, establishing the world's first specialized drug control office in 1929, followed by the Drug Control Administration in 1947, and subsequently the National Council for Drug Control and Addiction Treatment in 1968 (**Research Unit of the General Secretariat of Mental Health and Addiction Treatment (2015)**).

Extensive empirical literature emphasizes the vital role of psychological resilience in buffering against stress and facilitating adaptation to adverse conditions. Cultivating resilience equips individuals to navigate psychological distress more effectively and fortifies them against future hardships (**Mounira, Youssef (2021)**). The foundational importance of resilience stems from the reality that no individual is immune to distress within highly volatile environments; thus, developing resilience enhances coping capacities, improves daily stress

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management, enables realistic goal-setting, and promotes effective problem-solving and interpersonal communication (Goldstein & Brooks (2011)).

A baseline review of specialized literature reveals critical insights into these dynamics within clinical samples. "Ali Kazem" (2007) demonstrated that chronic pressure and psychological distress constitute a persistent, defining trait among substance users, which directly triggers relapse by undermining healthy coping mechanisms. Similarly, "Abou Bakr Mohamedien" (2018) observed that psychological distress remains chronically elevated and stable among dependent individuals due to the persistent nature of addiction-related stressors and their severe social repercussions. Regarding resilience, "Amira Yahya" (2017) documented a sharp decline in psychological resilience among dependent cohorts compared to healthy controls, a deficit that severely restricts their capacity to navigate crises. In international contexts, "Chunyu Yang" (2018) confirmed that psychological resilience serves as a core line of defense that directly attenuates psychological distress and enhances life satisfaction. "Moreover, Rudzinski" (2018) pointed out that a prolonged history of substance abuse causes a progressive, linear erosion of internal resilience assets, thereby elevating the risk of sudden relapse, whereas "Stinson" (2014) established that elevated resilience profiles are strongly predictive of lower relapse rates and long-term recovery maintenance.

Despite the wealth of literature addressing psychological resilience and psychological distress as separate entities, a noticeable gap remains regarding their concurrent manifestation within psychoactive substance-dependent populations. Crucially, insufficient research has been dedicated to analyzing how these internal psychological resources interact with clinical and demographic variables, such as place of residence (rural vs. urban), duration of substance use, and relapse frequency.

The problem of the current study emerged precisely from these unaddressed gaps in the literature. While prior research (Ali Kazem (2007); Stinson (2014); Rudzinski (2018)) establishes that distress and resilience do not operate in isolation from clinical profiles, there is an acute scarcity of Arab and regional studies examining the *combined interaction* of residence, duration of substance use, and relapse frequency on both distress and resilience simultaneously.

To address this empirical gap, the present study was designed to construct a comprehensive explanatory framework. This framework delineates how these vital psychological resources are altered by the specific clinical and demographic realities of substance-dependent individuals, ultimately assessing how variations in residence, usage history, and relapse frequency dictate fluctuations in psychological distress and resilience.

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▪ **Research Questions:**

1. Are there statistically significant differences in psychological distress and psychological resilience among individuals dependent on psychoactive substances based on their place of residence (rural vs. urban)?
2. Are there statistically significant differences in psychological distress and psychological resilience among individuals dependent on psychoactive substances based on the duration of substance use?
3. Are there statistically significant differences in psychological distress and psychological resilience among individuals dependent on psychoactive substances based on their relapse frequency?

2. Objectives of the Study:

The primary overarching purpose of this study is to analyze the variations in internal psychological mechanisms among substance-dependent individuals when subjected to different clinical and contextual factors. Specifically, the study aims to achieve the following objectives:

- 1) Investigating Contextual and Clinical Variations: To empirically examine the distinct effects and differences that place of residence (rural vs. urban), duration of substance use, and relapse frequency exert on both psychological distress and psychological resilience within the target population.
- 2) Integrating Clinical and Demographic Determinants: To transcend descriptive mappings of isolated psychological variables by systematically linking them to geographic boundaries and clinical history within a single, unified explanatory framework.
- 3) Delineating Patterns of Psychological Resource Depletion: To map out the critical trajectory of psychological deterioration in substance-dependent individuals, demonstrating whether internal assets (such as psychological resilience) remain stable or undergo linear erosion across time, thereby offering therapeutic practitioners a precise temporal indicator for early clinical intervention.
- 4) Validating a Contemporary Local Standardized Measure (2026): To develop, psychometrically evaluate, and standardize a context-specific Psychological Distress Scale tailored to the contemporary Egyptian socio-cultural and clinical environment.

3. Significance of the Study:

3.1. Theoretical Significance:

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1. Conceptual Integration: The study advances the positive psychology and clinical literature by examining the concurrent and interactive roles of psychological distress and psychological resilience specifically within a psychoactive substance-dependent cohort.

2. Empirical Addressing of Literature Scarcity: It directly addresses a prominent gap in regional and international literature by exploring how fixed environmental constraints (place of residence) and progressive clinical variables (duration of use and relapse frequency) jointly impact internal coping mechanisms.

3. Elucidating Resource Trajectories: It enriches the theoretical framework surrounding substance use disorders by moving beyond static measurements to conceptualize whether psychological resilience is a stable trait or an asset vulnerable to linear, chronological erosion.

4. Providing a Framework for Predictive Modeling: By documenting the exact patterns of systemic distress alongside resilience, this research provides a theoretical foundation for building predictive models that can assess relapse risk based on a patient's socio-demographic and clinical profile.

3.2. Practical Significance:

1. Spatio-Temporal Intervention Design: The empirical findings offer actionable insights for clinical psychologists and rehabilitation experts to design "differentiated intervention protocols." These protocols can be tailored spatially (addressing context-specific distress and social stigma in rural vs. urban settings) and temporally (targeting resource reconstruction for long-term users).

2. Relapse Prevention Strategy: By establishing the precise threshold where internal coping assets degrade, the study provides rehabilitation centers with a diagnostic indicator to identify highly vulnerable patients, thereby enhancing targeted relapse prevention strategies.

3. Clinical Psychometric Contribution: The development and psychometric validation of a contemporary local scale (2026) equips Egyptian and Arab clinicians with an objective, socio-culturally standardized instrument to measure and monitor psychological distress levels throughout the treatment lifecycle.

4. Informing Health Policy and Public Awareness: The outcomes serve as an empirical resource for public health policymakers to optimize resource allocation toward community-based psychiatric care and to foster public awareness concerning the protective power of psychological resilience in sustaining long-term recovery.

4. Theoretical Framework:

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A- Psychological Distress

Psychological distress represents an existential threat to an individual's holistic health and internal homeostasis, severely jeopardizing overall well-being. Its deleterious consequences manifest in compromised adaptability, diminished performance, functional impairment in activities of daily living, attenuated work motivation, and state of profound psychological exhaustion (Abdullah Al-Khatib, 2020).

-Theoretical Approaches to Psychological Distress:

• Behavioral Theory:

Grounded in classical and operant conditioning paradigms, behaviorism asserts that psychological responses are fundamentally linked to environmental stimuli through positive or negative reinforcement. Behavioral theorists argue that psychosomatic manifestations and distress result from a prior conditioning process connecting an emotionally stressful situation with a specific organ response. If an individual receives secondary reinforcement for this somatic or psychological response, and if the stressors recur with sufficient frequency and intensity, chronic functional disturbances emerge (Najiya, Dali (2013)). Furthermore, behaviorists posit that distress develops through learned information-processing pathways regarding dangerous or volatile environments; when these contemporary stressors become conditionally paired with prior adverse experiences, individuals perceive them as highly anxiety-provoking stimuli (Mahmoud Sherif & Nadia Abdel Salam (2016)).

• Cognitive Theory:

From a cognitive perspective, psychological distress is governed not merely by objective life events, but by the internal cognitive architecture through which those events are mediated. This framework emphasizes the automatic thoughts, schemas, and cognitive interpretations individuals construct regarding life phenomena. Stressors trigger distress because they are cognitively appraised as sources of direct threat, harm, or challenges that dwarf the individual's perceived coping capacities. Consequently, cognitive appraisal serves as the regulatory gateway determining the behavioral strategies employed to manage stress, establishing that the modification of dysfunctional thoughts is an indispensable mechanism for mitigating psychological distress (Manar Al-Shaer (2011)).

• Psychoanalytic Theory:

Proponents of psychoanalytic theory view psychological distress as the tangible manifestation of unresolved intrapsychic conflicts and contradictory instinctual desires, occurring either within the individual's psyche or between the self and the social environment. When baseline drive conflicts clash with internal ego controls (the Superego), ego defense mechanisms are automatically mobilized to alleviate the resulting anxiety. While these defense mechanisms actively shape personality development across the lifespan, severe or chronic external life challenges can destabilize this defensive equilibrium. This destabilization alters

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anticipated behavioral output and potentially induces psychological disorders that necessitate immediate clinical intervention (Shireen, Al-Shiyab (2017)).

B- Psychological Resilience:

Psychological resilience serves as a foundational protective buffer against crises and environmental stressors, acting as a structural safeguard against psychological morbidity. Individuals exhibiting low resilience thresholds often perceive themselves and their environment through a lens of meaninglessness, experiencing chronic vulnerability and perceived threat. Conversely, high psychological resilience preserves internal and external equilibrium, demonstrating strong positive correlations with hope, optimism, robust social support networks, and adaptive coping mechanisms (Mohamed, El-Behairy (2011)).

• Conceptualizations of Psychological Resilience:

Psychological resilience is defined as the capacity to navigate life challenges in an effective, positive manner and to adapt dynamically to shifting environmental demands. Highly resilient individuals display cognitive flexibility, dispositional optimism, and a stable sense of self-efficacy. They possess an intrinsic capacity to recover efficiently from traumatic exposures and to assimilate to crises with relative ease (Saher, Sami (2024)). Operationally, this study utilizes the definition formulated by Yosra Abdel Monem (2022), who conceptualized psychological resilience as an individual's capacity to effectively confront crises, pressures, and life hardships, enabling them to recover from their psychological impact, exhibit positive adaptation, and return to a baseline state of homeostasis.

Sustained scholarly interest in resilience dates back to the early 1960s, gaining momentum as cognitive and developmental psychologists began examining human behavior as a crucial mediator between affective states and cognitive operations. Early developmental research focused on how children adjust emotionally and behaviorally when exposed to acute stressors, finding that psychological resilience—often operationalized as emotional or affective regulation—directly attenuates stress levels, maladaptive behaviors, and negative affect (Landy (2002)).

In the Arab context, “Safaa El-Asser” (2010) analyzed the various linguistic translations of "resilience," highlighting the conceptual challenges of rendering the term into Arabic. She noted that while alternative concepts such as *resistance to breaking*, *hardiness*, *reconciliation*, *flexibility*, and *recovery* were proposed, each fell short of encapsulating the comprehensive scope of the construct, thereby justifying her preference for the term *psychological resilience* (المرونة النفسية).

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In mainstream literature, “**Ann Masten**” (2001) famously characterized resilience as “*ordinary magic*”, defining it as a positive psychological state marked by the capacity to “bounce back” from adversity, uncertainty, conflict, and failure toward positive transformation and personal responsibility. This process requires two critical pillars: the cognitive acknowledgment of present or past hardships and the demonstration of adaptive adequacy or effectiveness. Additionally, “**Kathleen Connor**” (2003) conceptualized resilience as a multidimensional matrix of personal characteristics that empower individuals to thrive amidst adversity, noting that its expression fluctuates across contexts, time, age, gender, and socio-cultural backgrounds. Similarly, “**George Bonanno**” (2004) defined resilience as the ability to maintain relatively stable, healthy levels of psychological and physical functioning despite negative emotional experiences. The wide variance in these definitions reflects the conceptual richness of resilience and the diverse theoretical paradigms applied across life domains.

- **The Trajectory of the Resilience Cycle:**

“**Terry Pearsall**” (2003) proposed a sequential framework outlining the stages individuals navigate when exposed to profound crises and adversity:

1. Deterioration Stage: Triggered by acute experiences of frustration, anger, and cognitive dissonance, individuals at this stage often externalize blame onto others or undergo a process of self-devaluation. The duration of this phase is heavily mediated by baseline personality traits and prior coping history.

2. Adaptation Stage: The individual begins to arrest the downward psychological trajectory by mobilizing coping strategies and proactive behaviors engineered to manage and mitigate the active sources of distress.

3. Recovery Stage: Representing a continuous extension of adaptation, the individual actively works to restore their previous level of psychological functioning, striving to return to their pre-crisis baseline.

4. Growth Stage: The definitive phase wherein the individual capitalizes on the adverse experience, deriving meaning and learning from the challenges to achieve an elevated state of psychological balance and personal development.

- **Profile and Principles of Resilient Individuals**

“**Reem Simoun**” (2015) identified several core behavioral and personality markers characteristic of highly resilient individuals, including high dispositional optimism and commitment, advanced problem-solving capacities, patience, emotional stability, a high capacity to generate positive outcomes from adversity, low impulsivity, and high persistence.

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Furthermore, this resilience is sustained by core principles: *activity and effectiveness* (taking internal locus of control over actions), *proactive self-awareness* (clarifying core values and priorities prior to goal setting), *rational optimization* (utilizing logical, mutual-benefit thinking to achieve outcomes), and *empathetic processing* (seeking to understand alternative perspectives before demanding to be understood).

-Theoretical Models of Psychological Resilience

- **Michael Rutter’s Protective Mechanisms Model:** Rutter emphasized evaluating resilience as a dynamic process rather than a static personality trait. His model focuses on the activation of protective mechanisms that shield individuals from the psychological risks associated with stress. These mechanisms operate through three primary processes: (1) reducing risk exposure by assessing and altering the impact of stressors, (2) changing the cognitive meaning of the risk through adaptive reframing, and (3) neutralizing negative behavioral or psychological response chains following stress exposure. These processes are reinforced by interactive protective factors such as self-esteem, self-efficacy, stable personality traits, and supportive family and social networks (Rutter, (2012)).

- **George Vaillant’s Ego Defense Framework:** Vaillant proposed a hierarchical model of ego defense mechanisms as the engine of human resilience. He argued that adaptive self-deception and unconscious defense mechanisms allow individuals to cope effectively with traumatic life events. Vaillant identified five mature defense mechanisms that directly correlate with high resilience profiles: (1) *altruism* (channeling energy into meeting others' needs to build self-efficacy), (2) *sublimation* (transforming maladaptive or unacceptable impulses into socially constructive behaviors), (3) *repression/suppression* (the conscious, deliberate postponement of distressing thoughts), (4) *anticipation* (cognitive planning and affective rehearsal for future challenges), and (5) *humor* (expressing painful emotions in a socially acceptable, positive, and adaptive manner) (Wicks, (2005)).

- **Glenn Richardson’s Metatheory of Resilience:** Richardson presented a pioneering model that views resilience as an intrinsic motivational force driving individuals toward self-actualization, altruism, wisdom, and spiritual harmony. His theory is anchored in the concept of **biopsychospiritual equilibrium**—a state of dynamic balance across the body, mind, and spirit that allows individuals to adapt to environmental conditions. Life stressors and psychological distress disrupt this equilibrium; resilience functions as the vital reintegration process that restores balance through the complex interaction between environmental disruptions and internal/external protective factors (Richardson, (2002)).

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5. Methodology and Procedures:

5.1. Research Design:

The present study adopted a comparative and correlational ex-post-facto research design. This approach was utilized to systematically examine the differences, associations, and internal interactions among the study variables within their natural clinical context without direct experimental manipulation.

5.2. Participants and Sample Characteristics:

The study sample comprised sixty (60) individuals dependent on psychoactive substances, recruited via purposive sampling from rehabilitation centers and psychiatric addiction treatment hospitals in Qena Governorate, Egypt. The demographic and clinical characteristics of the sample are detailed below:

-Age: Participants ranged in age from 21 to 43 years, with a mean age of 29.73 years (SD = 5.41\$).

-Duration of Substance Use: The chronicity of active substance use ranged from 1 to 25 years, with a mean of 6.28 years (SD = 5.09), reflecting substantial variability in the duration of exposure.

Relapse History: The frequency of documented relapse episodes ranged from 1 to 11 occurrences, with a mean of 2.45 relapses (SD = 2.26).

Geographic Residence: The sample displayed geographic diversity, consisting of 39 participants (65%) from rural regions and 21 participants (35%) from urban areas.

Educational Attainment: Regarding education, 22 participants completed primary education, 30 achieved an intermediate level of education, and 8 held university degrees.

Substance Profile: In terms of primary substance typology, \$4\$ participants reported dependency on opium, 12 on hashish, 13 on methamphetamine (Shabu), and 3 on tramadol, while 28 participants met the clinical criteria for polysubstance dependence, indicating a high prevalence of multiple concurrent substance use within the cohort.

5.3. Data Collection Instruments:

5.3.1. Psychological Distress Scale (Researcher, 2026)

To evaluate the severity of psychological distress among individuals experiencing psychoactive substance dependence, a context-specific instrument was engineered by the researcher (2026). The scale is structured around three core empirical dimensions: the psychological domain, the Physical domain, and the social domain. Items are rated on a Likert-type response format, where higher cumulative scores correspond to elevated levels of perceived psychological distress.

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-Validity: Construct validity was established using internal consistency analysis. Pearson product-moment correlation coefficients demonstrated that each individual item correlated significantly with the total score of its respective domain, and each sub-dimension correlated significantly with the global scale score.

-Reliability: The instrument's reliability was rigorously evaluated using Cronbach's alpha coefficient, which revealed high internal consistency across all sub-dimensions and the total scale. Additionally, split-half reliability coefficients were computed and adjusted using the Spearman–Brown prophecy formula, yielding satisfactory coefficients that confirm the temporal stability and internal coherence of the instrument.

5.3.2. Psychological Resilience Scale (Abdelmonem, Y (2022))

Psychological resilience was measured using the Psychological Resilience Scale originally developed by “Yousry Abdelmonem” (2022). The instrument captures six foundational dimensions of resilience: self-efficacy, flexibility, emotional regulation, social competence, problem-solving, and optimism.

Validity: Prior to deployment, the items were reviewed by a panel of expert psychometrists and clinical psychologists to ensure socio-cultural and clinical appropriateness. Construct validity was confirmed via internal consistency analysis, where item-to-subscale and subscale-to-total correlation coefficients emerged as statistically significant, validating the instrument's structural integrity.

Reliability: The scale demonstrated robust reliability profiles. Cronbach's alpha coefficients indicated strong internal consistency for both individual subscales and the global score. Furthermore, split-half reliability bounds, corrected via the Spearman–Brown formula, yielded high coefficients confirming the instrument's measurement reliability within the target clinical sample.

5.4. Statistical Analysis:

Quantitative data were processed and analyzed using IBM SPSS (Version 26.0). The following statistical techniques were employed to address the research hypotheses:

Descriptive Statistics: Frequencies, percentages, arithmetic means, and standard deviations (\$SD\$) were computed to summarize demographic data and clinical baseline profiles.

Independent Samples t-test: Applied to examine the differential expressions of distress and resilience based on the binary independent variable of residence (rural vs. urban).

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One-Way Analysis of Variance (ANOVA): Utilized to evaluate statistically significant differences across multi-group clinical parameters, specifically duration of use and relapse frequency.

Post-Hoc Pairwise Comparisons: Conducted using appropriate post-hoc tests (e.g., Tukey's HSD or Scheffé) to locate the exact direction of differences following significant ANOVA outcomes.

Pearson Product-Moment Correlation (\$r\$): Employed to estimate the strength and direction of the linear relationship between psychological distress and psychological resilience.

5.5. Methodological Limitations:

Inclusion Bounds (Sample): The empirical boundaries of this study are restricted to male and female individuals clinically diagnosed with psychoactive substance dependence, aged between **21** and **43** years, who voluntarily provided consent.

Spatial Scope: Data collection was strictly confined to specialized addiction treatment and rehabilitation facilities situated within Qena Governorate, Egypt—specifically including the Azima Addiction Treatment Center, the Erada Center, and the Al-Amal Center—thereby ensuring homogeneity in the socio-environmental and institutional setting.

Temporal Window: The empirical data collection phase was executed over a three-month duration spanning from February to April 2026, capturing the participants' psychological profiles during their active institutionalized rehabilitation cycle.

6. Research Hypotheses, Results, and Discussion:

▪ The First Hypothesis states that:

-There are statistically significant differences between rural and urban residents in both psychological distress and psychological resilience among individuals dependent on psychoactive substances, at both the sub-dimension level and the global score level.

To evaluate this hypothesis, an Independent Samples *t*-test was executed. The statistical outputs are systematically structured in Table 1.

Table 1: Differential Analysis of Psychological Distress and Psychological Resilience Between Rural and Urban Participants

Study Variables	Rural Group (n=39) Mean	SD	Urban Group (n=21) Mean	SD	t-value	Significance
Psychological domain	38.13	4.580	34.71	5.78	2.49	0.05 (Significant)

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Study Variables	Rural Group (n=39) Mean	SD	Urban Group (n=21) Mean	SD	t-value	Significance
Physical domain	24.10	3.925	22.42	4.34	1.51	Not significant
Social domain	26.15	3.15	24.85	5.57	1.14	Not significant
Total Psychological Distress	87.97	10.15	81.90	14.54	1.97	0.05 (Significant)
Self-efficacy	22.84	7.90	24.00	6.22	-0.57	Not significant
Flexibility	20.41	6.31	22.42	5.29	-1.24	Not significant
Emotional regulation	24.51	8.13	25.76	6.23	-0.61	Not significant
Social competence	23.30	7.27	25.33	7.16	-1.03	Not significant
Problem solving	22.68	6.92	25.57	10.40	-1.27	Not significant
Optimism	24.69	8.15	27.85	11.38	-1.24	Not significant
Total Psychological Resilience	136.92	41.40	150.95	41.14	-1.24	Not significant

Based on the empirical evidence summarized in Table1, the alternative directional hypothesis is accepted exclusively regarding psychological distress. The results reveal significant differences favoring rural residents, who exhibited higher mean distress scores. Conversely, the alternative hypothesis is entirely rejected regarding psychological resilience, as no statistically significant differences were established across any sub-dimensions or the global score.

The significantly elevated levels of psychological distress observed among rural participants—particularly within the psychological domain and the global distress score—can be profoundly interpreted through the lens of Cognitive Theory. In rural societies, social networks are tightly knit, collectivistic, and characterized by low anonymity. Consequently, the cognitive architecture of a recovering individual in a rural area is subjected to a highly amplified, omnipresent layer of localized social stigma and communal scrutiny. This intense environmental pressure creates a severe, continuous cognitive load. According to Aaron Beck's cognitive formulation, the individual continuously processes their immediate surroundings through negative cognitive schemas, perceiving the community as a source of social threat, rejection, and moral condemnation. This severe cognitive monitoring translates into elevated affective tension, driving up global psychological distress indices.

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This finding aligns with earlier foundational research (e.g., Ali Kazem, (2007); Wansen Yan (2014)), which underscores that distinct environmental conditions and highly critical social contexts heavily modulate systemic psychological distress.

Furthermore, this residential disparity is aggravated by macro-systemic and socio-economic realities. Rural environments are frequently characterized by geographical disparities, including highly restricted access to comprehensive psychiatric services, fewer specialized addiction rehabilitation facilities, and a marked scarcity of institutionalized psychosocial support groups. These systemic limitations leave rural patients highly vulnerable to daily life stressors, magnifying their subjective feelings of isolation, vulnerability, and helplessness.

Conversely, the statistical uniformity observed across the physical and social domains of distress indicates that the somatic withdrawals, physiological disruptions, and baseline transactional impairments associated with chemical dependence are experienced universally by individuals under the influence of psychoactive substances, irrespective of their wider geographical setting.

Regarding psychological resilience, the t-test yielded no statistically significant variations between rural and urban cohorts across all six subscales and the global index. This empirical stability aligns seamlessly with Richardson's Metatheory of Resilience (2002). Richardson conceptualizes resilience as originating from a "biopsychospiritual equilibrium"—an internal, latent reserve capacity and an innate psychological hardiness. Because resilience operates as a deeply rooted, intrinsic protective force engineered to preserve psychological homeostasis, it functions independently of immediate external geography or physical residence. This finding is further supported by the assertions of Stinson (2014) and Rudzinski (2018), who noted that psychological resilience is governed by stable internal assets—such as self-awareness, active emotional regulation, and cognitive reframing strategies—rather than fluctuating socio-demographic indicators. Therefore, while environmental constraints amplify distress, they do not automatically alter the internal structural architecture of resilience.

▪ **The Second Hypothesis states that:**

-There are statistically significant differences in the mean scores of both psychological distress and psychological resilience among individuals dependent on psychoactive substances according to their years of substance use.

To empirically evaluate this assumption, a One-Way Analysis of Variance (ANOVA) was executed across three chronicity cohorts based on the duration of

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active substance exposure: (1) less than 3 years, (2) 4 to 7 years, and (3) 8 years or more. The statistical outputs are presented in Table 2.

Table 2: One-Way ANOVA Results for Differences in Psychological Distress and Psychological Resilience Across Substance Use Duration Groups

Study Variables	Sum of Squares	df	Mean Square	F-value	Significance
Psychological domain	3.62	2	1.81	0.64	Not significant
Physical domain	12.88	2	6.448	0.37	Not significant
Social domain	3.048	2	1.528	0.68	Not significant
Total Psychological Distress	4.36	2	2.00	0.41	Not significant
Self-efficacy	4.39	2	2.18	0.32	Not significant
Flexibility	2.04	2	1.02	0.16	Not significant
Emotional regulation	3.13	2	1.06	0.67	Not significant
Social competence	2.01	2	1.01	0.98	Not significant
Problem solving	4.82	2	2.41	0.58	Not significant
Optimism	16.43	2	8.21	0.05	Not significant
Total Psychological Resilience	11506.93	2	5753.46	3.64	0.05 (Significant)

The inferential outputs summarized in Table 2 indicate an absolute rejection of the alternative hypothesis regarding psychological distress, as no variation reached statistical significance. Conversely, the alternative hypothesis is accepted regarding the global score of psychological resilience, establishing a statistically significant difference at the .05 level. Because the global resilience index yielded significant multi-group variations, a Scheffé post-hoc pairwise comparison matrix was calculated. The post-hoc matrix revealed that individuals with a brief history of substance exposure (less than 3 years) exhibited significantly higher global psychological resilience scores compared to those with chronic exposure (8 years or more), directly proving that internal resilience resources undergo a linear, chronological deterioration as the years of substance dependence accumulate.

The relative stability and homogeneity of psychological distress across all three duration cohorts find strong validation in Behavioral Theory. From a behavioral paradigm, psychological distress functions as a deeply ingrained, "conditioned response" to the physiological and psychological cycles of dependency. Through persistent, repetitive exposure to multi-layered addictive

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stressors (withdrawal, financial ruin, legal crises, and marital dissolution), this distress transitions into a chronic, stable symptomatic state. It ceases to scale up over time because it has already reached its symptomatic ceiling during the acute phases of addiction development. This result converges with the findings of "Ali Kazem" (2007) and "Abou Bakr Mohamedien" (2018), who documented that psychological distress acts as a persistent, stable trait among substance-dependent individuals, remaining consistently elevated due to the chronic and unremitting nature of addiction-associated stressors. It is a baseline reality that establishes itself early and persists regardless of the passage of chronological time.

In contrast, the progressive, linear erosion identified in global psychological resilience—culminating in a sharp decline among individuals with over 8 years of active substance exposure—is robustly explained by George Vaillant’s Ego Defense Framework. Long-term, chronic psychoactive substance abuse progressively deconstructs mature ego defense mechanisms (such as altruism, sublimation, anticipation, and humor). As these higher-order regulatory strategies disintegrate under the neurocognitive toxicity and cumulative social impact of prolonged dependency, they are systematically replaced by primitive, neurotic, and immature defenses (such as denial, projection, and acting out).

Consequently, this psychological regression profoundly impairs the patient's capacity to active internal coping resources and "bounce back" from environmental trauma, a critical failure of adaptive recovery as defined by Ann Masten's Adaptive Capacity Model (2001). This erosion pattern is consistent with the empirical evidence presented by Rudzinski (2018) and Stinson (2014), which demonstrates that internal resilience is negatively impacted by long-term addiction, showing a clear trajectory of degradation as exposure length increases. Similarly, this supports the perspective of Chunyu Yang (2018) that psychological resilience is an active protective asset; patients with shorter addiction histories retain significantly stronger coping resources because their structural ego defenses have not yet been fully depleted by chronic chemical exposure.

-Test and Extended Discussion of Hypothesis Three:

▪ The third Hypothesis states that:

-There are statistically significant differences in the mean scores of both psychological distress and psychological resilience among individuals dependent on psychoactive substances according to the number of relapse episodes, at both the sub-dimension level and the global score level.

To evaluate this assumption, a One-Way ANOVA was conducted across three distinct clinical groups: (1) one relapse episode, (2) 2 to 3 relapse episodes, and (3) 4 or more relapse episodes. The statistical data are presented in Table 3.

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Table 3: One-Way ANOVA Results for Differences in Psychological Distress and Psychological Resilience Across Relapse Frequency Groups

Study Variables	Sum of Squares	df	Mean Square	F-value	Significance
Psychological domain	16.64	2	8.32	0.29	Not significant
Physical domain	44.60	2	22.30	1.32	Not significant
Social domain	30.74	2	15.37	0.58	Not significant
Total Psychological Distress	214.12	2	107.05	0.73	Not significant
Self-efficacy	22.86	2	11.43	0.21	Not significant
Flexibility	3.99	2	1.99	0.53	Not significant
Emotional regulation	75.92	2	37.96	0.86	Not significant
Social competence	34.20	2	17.10	0.31	Not significant
Problem solving	90.64	2	45.32	0.64	Not significant
Optimism	78.17	2	39.08	0.43	Not significant
Total Psychological Resilience	1750.36	2	875.18	0.49	Not significant

The inferential values documented in Table 3 indicate an absolute rejection of the alternative hypothesis for both primary variables. No statistically significant differences were observed across the relapse frequency categories for either psychological distress or psychological resilience, at both the specific sub-dimension and global index levels.

The statistical uniformity across the relapse cohorts indicates that the frequency of relapse events does not fundamentally differentiate the internal psychological profiles of substance-dependent individuals. This reveals a striking homogeneity within the clinical sample, which can be interpreted through Michael Rutter's Protective Mechanisms Model.

According to Rutter's conceptualization, a relapse event is not an independent generator of psychological restructuring; rather, it is the behavioral manifestation of a prior breakdown in internal protective mechanisms and coping strategies. Because the entire clinical sample shares the unifying status of active chemical dependence and subsequent hospitalization, the initial failure of their coping architecture has

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already occurred. Therefore, incremental increases in the frequency of relapse episodes do not introduce a qualitative shift in their psychological resilience or distress profiles.

From a psychoanalytic perspective, this finding can also be attributed to a phenomenon of "traumatic fixation." The intense trauma, environmental stigma, and psychological shock tied to the very first relapse establish a deep psychological baseline. Subsequent relapses, while severe, operate within this pre-established traumatic framework, rendering them statistically equivalent in their immediate psychological impact.

This position aligns with the findings of Ali Kazem (2007) and Abu Bakr Mohamedin (2018), who confirmed that psychological distress represents a pervasive, structural baseline condition among substance users that remains continuously elevated due to the chronic nature of addiction, rather than fluctuating in response to specific behavioral episodes like relapse.

Similarly, regarding resilience, the lack of statistical variance supports the empirical conclusions of Stinson (2014) and Rudzinski (2018), who posited that resilience is anchored in relatively stable, long-term internal psychological assets and structural coping systems. While resilience acts as an active predictor of recovery outcomes, its internal structure does not fluctuate in a linear relationship with episodic relapse counts. As Chunyu Yang (2018) highlighted, these core constructs are deeply embedded within broader, stable macro-systems, such as foundational social support and long-term coping history. Consequently, relapse frequency alone does not serve as a powerful determinant of psychological functioning. Instead, psychological distress remains a persistent condition across all relapse levels, while psychological resilience is shaped by long-term clinical trajectories rather than short-term relapse history.

The synthesis of the empirical findings demonstrates a clear divergence in how environmental, chronological, and clinical-behavioral variables interact with the psychological landscapes of substance-dependent individuals.

7. Place of Residence (Rural vs. Urban Dynamics):

The statistical verification of higher psychological distress among rural residents emphasizes the role of the macro-environment in modulating affective suffering. Rural environments, particularly within conservative regional frameworks like the Qena Governorate, impose a unique set of psychosocial pressures. The lack of cultural anonymity turns the clinical condition of substance dependence into a highly stigmatized communal focal point. This localized social stigma acts as an ongoing environmental stressor, generating elevated scores in the psychological domain of distress.

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Conversely, the stability of psychological resilience across geographical boundaries confirms that resilience functions primarily as an internal personality asset. As highlighted by Rudzinski (2018), resilience resources are driven by internal psychological factors—such as emotional hardiness and cognitive processing style—which operate independently of immediate geographical conditions.

7.1. Years of Substance Use (Chronicity vs. Erosion Framework):

The data present an important conceptual insight: psychological distress remains consistently high across all duration groups, whereas global psychological resilience undergoes a clear chronological erosion. This supports the conceptualization of psychological distress as a chronic trait that is established early in the etiology of substance use disorders. Once dependence is reached, distress remains elevated due to the continuous cycle of addiction.

In contrast, internal resilience assets undergo progressive degradation. Prolonged exposure to psychoactive substances acts as a chronic neurocognitive and emotional drain, gradually depleting the mature ego defenses required for adaptive coping (Vaillant, 1992). Individuals with a short duration of use (less than 3 years) retain their baseline coping reserves, whereas long-term users (8 years or more) exhibit a severe breakdown in global resilience.

7.2. Relapse Frequency (Episodic Invariance)

The complete absence of statistical variance across relapse frequency cohorts suggests a psychological homogeneity within hospitalized substance-dependent populations. Whether a patient has experienced a single relapse or multiple episodes, the underlying levels of distress and resilience remain statistically equivalent. This indicates that the defining clinical reality is the state of active dependence and re-hospitalization itself, rather than the numerical count of relapses. The initial collapse of coping strategies establishing the first relapse sets a baseline psychological ceiling, and subsequent relapses operate within this pre-existing clinical framework.

- Practical Suggestions:

1. Develop specialized intervention programs for individuals with substance dependence in rural areas, focusing on reducing psychological distress associated with social stigma, community scrutiny, and limited access to mental health services. These programs should incorporate Cognitive Behavioral Therapy (CBT) techniques aimed at modifying negative beliefs and enhancing adaptive coping strategies.

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2. Strengthen community-based psychosocial support systems, particularly in rural communities, through awareness campaigns, family involvement, and collaboration with local community leaders to reduce stigma and facilitate the social reintegration of individuals in recovery.
3. Implement preventive and resilience-enhancement programs for individuals in the early stages of substance use (less than three years), focusing on preserving existing resilience resources through mindfulness training, emotional regulation skills, problem-solving strategies, and self-efficacy enhancement.
4. Design intensive rehabilitation programs for individuals with prolonged substance use histories (eight years or more), emphasizing resilience reconstruction, rebuilding self-efficacy, strengthening adaptive coping mechanisms, and addressing the cumulative psychological effects of long-term substance dependence.
5. Expand and improve access to addiction treatment and psychological support services in underserved areas through integrated mental health programs, community outreach initiatives, and the provision of specialized rehabilitation services tailored to local needs.
6. Encourage future longitudinal and comparative research to further investigate the dynamic relationship between psychological distress, psychological resilience, duration of substance use, and environmental factors, as well as to identify additional protective factors that may contribute to successful recovery and long-term rehabilitation outcomes.

These recommendations support the development of context-sensitive therapeutic and preventive models that address both the environmental factors contributing to psychological distress and the temporal factors influencing psychological resilience, thereby enhancing the effectiveness of addiction treatment programs within Egyptian and Arab clinical settings.

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