The Terminal Uniqueness Scale: Psychometric Validation and Factorial Structure in Addiction Recovery

Shivani Rani[1], Dr Balbinder Singh[2]

[1]Research Scholar, Department of Psychology, Guru Nanak Dev University, Amritsar.
[2]Assistant Professor, Department of Psychology, Guru Nanak Dev University, Amritsar.

Corresponding Author: Dr. Balbinder Singh

ABSTRACT

Terminal uniqueness, the belief that one's issues are fundamentally different from those of others, has been identified for a long time as an obstacle to participating in treatment for addiction recovery. Even though it is clinically important, there has been a lack of empirical measurement of this concept. This study created and verified the Terminal Uniqueness Scale (TUS), which is a binary measure that evaluates cognitive, emotional, interpersonal, and physical aspects of resistance based on a sense of uniqueness. Data from 202 treatment-seeking adults in Punjab, India, were analysed using tetrachoric Exploratory Factor Analysis (EFA). A three-factor, 24-item structure emerged, accounting for 61.7% of the total variance. The factors—*Cognitive Resistance and Self-Exception*, *Interpersonal Detachment and Isolation*, and *Affective-Somatic Dysregulation*—demonstrated strong internal consistency (KR-20 = .88; α = .76–.84). The findings reinforce the idea that terminal uniqueness acts as a complex defense mechanism that hinders participation in recovery efforts. The validated TUS provides clinicians with a dependable and theoretically sound instrument for evaluating resistance linked to a sense of uniqueness in addiction treatment.

INTRODUCTION

One of the major obstacles to accessing alcohol and drug treatment for individuals with substance use disorders (SUD) is their lack of awareness about the existence of a problem. Many individuals suffering from SUDs fail to recognize their substance use as an issue, even when they fulfill the diagnostic criteria for these disorders [2,18]. Awareness of one's issues is a crucial factor in determining the use of treatment, the likelihood of completing it, and the ability to maintain recovery afterward [3,4,7]. Cognitive-behavioral perspectives frame it as a maladaptive belief system that maintains denial and relapse vulnerability [1]. Clinically, terminal uniqueness functions as an ego defense mechanism—a strategy to protect self-esteem and autonomy in the face of dependency and shame [8]. Empirical work on resistance patterns demonstrates that denial-based defensiveness predicts lower motivation for change, weaker group cohesion, and higher relapse risk. Individuals with substance use disorders (SUDs) who fail to see their substance use as a concern are less likely to believe they need treatment and are less inclined to pursue assistance [15]. It is often the case that individuals who find it

hard to recognize their own problems are also less likely to admit they need help. This lack of insight can diminish their drive to seek professional guidance or therapy. When people are not fully aware of their challenges, they might overlook the significance of seeking support, which can impede their personal development and recovery journey. [10,12]

Successful addiction recovery requires acceptance of shared vulnerability and engagement in collective healing processes. Yet, many individuals' entering treatment perceives their experiences as uniquely different—believing that "others don't understand" or that "my addiction is not like theirs." This pattern, known as terminal uniqueness, reflects a cognitive and emotional stance that undermines group identification and adherence to therapeutic principles [16].

Despite its conceptual prominence, terminal uniqueness has not been operationalised through validated measurement.

The present study addressed this gap by developing and psychometrically validating the Terminal Uniqueness Scale (TUS), intended to measure the cognitive, affective, and interpersonal components of uniqueness-based resistance among individuals in addiction recovery. Specifically, the study sought to:

Identify the latent structure of the TUS using tetrachoric Exploratory Factor Analysis (EFA).

Evaluate internal consistency and factor reliability.

Interpret the resulting factors within clinical frameworks of resistance, denial, and recovery engagement.

METHOD
Participants
The sample comprised 202 adults (178 men, 24 women) enrolled in residential or outpatient rehabilitation centers across Punjab, India. Participants ranged in age from 21 to 48 years (M = 32.3, SD = 6.9). All met DSM-5 criteria for substance use disorder and had been in treatment for at least two weeks. Participation was voluntary, confidential, and approved by the institutional ethics committee.

Measure
The *Terminal Uniqueness Scale* (TUS) initially included 28 dichotomous items (1 = True, 0 = False). Items were derived from qualitative interviews with counselors and recovering clients describing experiences of perceived exceptionality, isolation, and resistance. Five clinical psychologists rated items for content validity (CVI = .91). Sample items included:

"My problems are too different for others to understand."

"I can recover in my own way without following standard programs."

"Advice from others rarely applies to me."

Items were designed to represent emotional, cognitive, interpersonal, and somatic expressions of uniqueness-based defensiveness.

PROCEDURE
Participants completed the TUS during structured psychosocial assessments administered by trained rehabilitation counselors. Completion time averaged 10–15 minutes. Missing data were minimal (<2%) and handled via listwise deletion.

Analytical Strategy
Given the dichotomous response format, a tetrachoric correlation matrix was computed to estimate the relationships among latent continuous traits underlying item responses. This method provides more accurate associations than Pearson correlations for binary data (Brown, 2015; Flora & Curran, 2004).

A principal axis factor analysis with Promax ($\kappa = 4$) rotation was applied to the tetrachoric matrix. Factor retention was guided by parallel analysis, eigenvalues greater than 1, and scree-plot inspection. Items with loadings ≥ .40 and cross-loadings ≤ .25 were retained. Reliability was estimated using KR-20 for the full scale and Cronbach's α for subscales.

RESULTS
Preliminary Analyses
The data were factorable (KMO = .87; Bartlett's χ^2 = 2145.33, $p < .001$). Inter-item tetrachoric correlations ranged from .18 to .68, suggesting moderate associations without redundancy.

A principal axis EFA yielded a three-factor, 24-item structure, explaining 61.7% of total variance. The pattern matrix indicated distinct but related clusters corresponding to cognitive defensiveness, interpersonal detachment, and affective-somatic manifestations of distress. All retained items demonstrated primary loadings ≥ .40 and minimal cross-loadings (< .25).

A brief excerpt of the tetrachoric correlation matrix is shown below (full matrix available upon request):

Item Pair	Tetrachoric r
Item 1 – Item 6	0.52
Item 2 – Item 14	0.56
Item 8 – Item 19	0.47
Item 13 – Item 20	0.59

Internal consistency was strong (KR-20 = .88), with subscale reliabilities ranging from α = .76 to .84, indicating robust homogeneity across domains.

Eight of the original 28 items were excluded due to low communalities (< .30) or conceptual overlap, resulting in a three-factor, 24-item solution explaining 57.4% of total variance.

Factor Structure
The EFA revealed a coherent three-factor structure, with minimal cross-loadings and strong internal consistency. The factors were interpreted as:

Core Psychological Distress (F1) – Emotional dysregulation, hopelessness, and self-directed frustration underlying resistance.

Social and Interpersonal Detachment (F2) – Relational withdrawal, comparative self-appraisal, and reduced receptivity to communal recovery.

Cognitive Denial and Self-Exception (F3) – Cognitive rigidity and self-exempting beliefs reflecting denial and uniqueness-based defensiveness.

Factor Structure
Three factors emerged, reflecting distinct but interrelated dimensions of terminal uniqueness: Core Psychological Distress, Social and Interpersonal Detachment, and Cognitive Denial and Self-Exception. Factor Labelling and Structure

Factor and label	Conceptual Description	Sample Items
F1 – Core Psychological Distress	Captures hopelessness, emotional disconnection, and self-sufficient defensiveness underlying feelings of uniqueness.	"I believe my issues are more burdensome than everyone else's."; "I am self-sufficient and can handle my problems independently."
F2 – Social and Interpersonal Detachment	Reflects withdrawal, poor relational reciprocity, and the belief that others cannot understand or help.	"I often struggle to communicate with others."; "I have no support system or community."
F3 – Cognitive Denial and Self-Exception	Represents cognitive distortion and rationalisation that recovery principles don't apply.	"I feel I can quit anytime."; "I believe I can overcome addiction without addressing deeper issues."

Table 1: *Rotated Tetrachoric Factor Loadings for the 24-Item Terminal Uniqueness Scale (N = 202)*

Item No.	Factor Label	Factor Loading	Communality	Decision
Item 1.	Core Psychological Distress	0.6	0.41	Retain
Item 2.	Core Psychological Distress	0.53	0.4	Retain
Item 3	Core Psychological Distress	0.55	0.44	Retain
Item 4	Core Psychological Distress	0.5	0.46	Retain
Item 5	Core Psychological Distress	0.54	0.53	Retain
Item 6	Core Psychological Distress	0.58	0.54	Retain
Item 7	Social and Interpersonal Detachment	0.51	0.41	Retain

Item 8	Social and Interpersonal Detachment	0.59	0.37	Retain
Item 9	Social and Interpersonal Detachment	0.54	0.47	Retain
Item 10	Cognitive Denial and Self-Exception	0.48	0.47	Retain
Item 11	Cognitive Denial and Self-Exception	0.47	0.42	Retain
Item 12	Cognitive Denial and Self-Exception	0.73	0.65	Retain
Item 13	Cognitive Denial and Self-Exception	0.68	0.65	Retain
Item 14	Cognitive Denial and Self-Exception	0.49	0.5	Retain
Item 15	Social and Interpersonal Detachment	0.64	0.51	Retain
Item 16	Cognitive Denial and Self-Exception	0.57	0.55	Retain
Item 17	Social and Interpersonal Detachment	0.72	0.6	Retain
Item 18	Cognitive Denial and Self-Exception	0.73	0.56	Retain
Item 19	Cognitive Denial and Self-Exception	0.65	0.65	Retain
Item 20	Social and Interpersonal Detachment	0.72	0.81	Retain
Item 21	Social and Interpersonal Detachment	0.78	0.74	Retain
Item 22	Social and Interpersonal Detachment	0.73	0.67	Retain
Item 23	Core Psychological Distress	0.86	0.83	Retain
Item 24	Social and Interpersonal Detachment	0.65	0.62	Retain

Note. **Loadings ≥ .40 are reported. Extraction = Principal Axis Factoring; Rotation = Promax (κ = 4).**

Internal Consistency

The Kuder–Richardson 20 coefficient (KR-20) for the total 24-item scale was .89, demonstrating excellent reliability for dichotomous data. Subscale reliabilities were strong and acceptable:

- Social and Interpersonal Detachment = .80
- Core Psychological Distress = .82
- Cognitive Denial and Self-Exception = .78

Item-total correlations ranged from .31 to .68, supporting adequate homogeneity and non-redundancy.

DISCUSSION

The 24-item Terminal Uniqueness Scale (TUS) revealed a theoretically coherent three-factor structure, offering the first psychometric validation of this long-theorised construct. Terminal uniqueness emerged as a multidimensional resistance process encompassing emotional vulnerability, cognitive defensiveness, and relational detachment.

Cognitive-behavioral theories indicate that a mindset centered on personal uniqueness may correlate with an increased likelihood of denying issues and a heightened risk of relapse. This implies that individuals who prioritize their individuality could be more prone to minimizing their difficulties and returning to old habits after trying to change.

[1]. Robust and positive social connections contribute to longer and healthier lives compared to those who are more socially isolated. Individuals with opioid use disorder often experience feelings of social seclusion, which can lead to a higher risk of suicide and, on a community scale, diminished social capital [5].

The addiction literature often emphasizes a "redemption" narrative, focusing on the transition from "substance users" to "recovering" individuals. This study highlights that some regain lost identities during recovery, while socially isolated individuals may forge new identities at the onset of addiction. Those seeking to restore their former selves aim to return to pre-addiction identities, while others pursue new roles in education, work, or family. These findings illustrate how social factors can influence recovery, acting as either motivators or barriers. [6] The results are consistent with psychodynamic theories that describe terminal uniqueness as a defense mechanism. This mechanism serves to evade feelings of dependence and shame. Essentially, individuals may adopt a belief in their exceptionalism—seeing themselves as fundamentally different from others—partly as a way to shield themselves from the vulnerability that comes with relying on others and the discomfort associated with shame. This perspective suggests that the

need to maintain a sense of individuality can be a psychological strategy to avoid confronting deeper emotional issues and the inherent interconnectedness of human relationships [8,17].

Clinically, high TUS scores may indicate difficulty engaging in group-based recovery programs, distrust of shared therapeutic models, and overreliance on self-control narratives. Interventions such as motivational interviewing, group therapy, and cognitive restructuring can be tailored to challenge these beliefs and enhance openness to collective support [9]. Many drug addicts lack motivation to quit using substances. To address this, the treatment program uses a four-phase approach: (1) confronting the patient about their addiction, (2) helping them understand why they use drugs, (3) fostering a belief in the harmful effects of drugs, and (4) raising awareness of the emotional factors in their addiction. This structured method has successfully rehabilitated several individuals [11].

The approach taken to treat heroin addiction within the communities emphasizes the role of interpersonal connections in facilitating psychosocial change. Findings indicate a rise in positive feelings, along with enhanced perceptions of personal strength and freedom. Additionally, participants have reported improved self-esteem and a decrease in fatalistic beliefs. This is viewed as a sign of successful transitions, reflecting greater autonomy, a broader perspective on life, and higher levels of realism [13].

Extended durations of isolation and loneliness have been recognized in various addiction studies as being detrimental to individuals' recovery processes. Moreover, these issues can also adversely affect those who are currently using substances. Many individuals rely on their social networks not just for obtaining drugs but also for emotional and practical support. In the absence of these connections, they may face greater difficulties in managing their substance use and overcoming the hurdles associated with recovery. [14].

The refined 24-item TUS presents a psychometrically sound, multidimensional structure that reflects the complex interplay between emotional, cognitive, and interpersonal barriers in addiction recovery. The three identified factors align with both clinical theory and empirical findings in addiction psychology.

Interpretation of Factors
1. **Core Psychological Distress** represents affective vulnerability—feelings of frustration, self-sufficiency, and alienation. These emotional states reflect the defensive withdrawal typical of early recovery, consistent with the "denial–defensiveness" axis proposed in cognitive models of addiction [1,8].
2. **Social and Interpersonal Detachment** captures relational disconnection, distrust, and diminished identification with others in recovery. These traits parallel findings on social isolation as a relapse risk factor, highlighting the role of interpersonal empathy and group identification in sustaining recovery.
3. **Cognitive Denial and Self-Exception** encompass distorted beliefs about control, personal immunity, and self-exemption from recovery norms—hallmarks of terminal uniqueness described in clinical literature [16,17]. This factor supports the theoretical premise that recovery resistance often emerges from self-enhancing cognitions that protect ego integrity while perpetuating addictive patterns.

Clinical and Research Implications
The validated 24-item TUS provides clinicians and researchers with a brief, reliable assessment tool for identifying maladaptive uniqueness in individuals undergoing addiction treatment. Its subscales can inform individualised interventions by pinpointing whether a client's resistance is primarily emotional (distress), interpersonal (detachment), or cognitive (denial).

Clinically, high TUS scores may warrant motivational interviewing or cognitive

restructuring interventions targeting resistance beliefs [9]. The scale can also serve as a progress monitoring tool, tracking reductions in uniqueness-based defensiveness during therapy or group participation.

Limitations and Future Directions

Despite strong psychometric support, several limitations merit consideration. The sample was region-specific (Punjab) and predominantly male, limiting generalizability. The dichotomous format may constrain sensitivity to subtle changes in belief intensity. Future studies should consider:

- Using Likert-type scaling for enhanced variance;
- Conducting Confirmatory Factor Analysis (CFA) with WLSMV estimation to validate the three-factor model;
- Testing measurement invariance across gender, treatment stages, and cultural groups.

Longitudinal research could also examine whether decreases in TUS scores predict improved treatment adherence, reduced relapse, or enhanced group engagement—thereby validating terminal uniqueness as a clinically modifiable construct.

CONCLUSION

The 24-item Terminal Uniqueness Scale demonstrates strong psychometric validity and theoretical coherence. The three identified domains—Core Psychological Distress, Social and Interpersonal Detachment, and Cognitive Denial and Self-Exception—offer an empirically grounded framework for understanding resistance and self-exceptionality in addiction recovery. By operationalising a construct historically discussed but rarely measured, the TUS advances both research and clinical practice, providing a nuanced lens to assess and address one of recovery's most enduring psychological barriers.

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