On the Comparison of Public Health and Social Support in Addicts and Non-Addicts

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Abstract

Objective: This study aimed at comparing the degree of public health and social support in addicted and non-addicted people. **Method:** This study was causative-comparative and all the addicts who had referred to addiction treatment centers in Khoy city in 2012 constituted its population. From among this population, 60 addicts through convenience sampling method were selected and then were matched with 60 normal subjects by age, gender, and education. The measurement tools were Goldberg Public Health (Ghq-28) and Social Support (Fleming) questionnaires. **Results:** The results showed that addicts enjoy a lower degree of mental health and social support. **Conclusion:** Providing social support for the addicts under treatment programs is one of the important factors in abstinence from drug use.

Keywords: Mental Health; Social Support; Drug Dependence

Introduction

Addiction may be viewed as a shelter in which failed people take refuge as a result of desiderata, uncertainties, and mental disorders. Addiction is a condition through which a person both physically and mentally becomes dependent on substance, strongly needs to take substance, and is not able to stop it whenever he/she wants, and his/her tolerance towards drug use wanes (Narimani, 1999, cited in Javanmard, 2001). It is noteworthy that, recently, the issue of drug addiction has expanded from small private neighborhoods of adults to public institutions and the average age of drug users has decreased.

In addition to the physical and psychological damages to addicts, addiction imposes a heavy burden on society. In this regard, the estimates of direct and indirect annual economic losses resulting from narcotic drugs amount to 200 million dollars (Sadeghi, 2003; cited in Bagheri, Nabavi, Moltafet & Taghipour, 2010). Research has shown that people usually fall victim by addiction in their teens and youth. In a study in America, it was found that 78 percent of addicts were less than 25 years old and 50 percent of them were less than 21 years old. Similarly, the results of a study in Iran showed that the critical and sensitive age of addiction ranges from 16 to 25 years (Narimani, 1999, cited in Javanmard, 2001).

Health and welfare, in its broadest sense, is the phenomenon of interest to human beings, social groups and communities. So far, various definitions of "mental health" have been proposed that all emphasize the importance and integrity of personality. The World Health Organization defines mental health as capability of establishing harmonious relations with others, modifying the personal and social environment, conflict resolution, and directing personal desires reasonably. This organization states that mental health is not merely the absence of mental illness, but it is the ability of responding to different types of life experiences flexibly and meaningfully (Salehi, Soleimanizadeh, Bagheri Yazdi & Abaszadeh, 2007). Dimatteo (2004) argues that health is not merely the absence of disease, one might not pathologically suffer from any physical problems, but such a person might not be healthy, either. In other words, any unnatural deviation in the person's emotional or active state suggests that the person is not healthy.

Chauhan (1991) interpreted mental health as a status of psychological maturity that entails the maximum effectiveness and satisfaction with personal and social interaction, that is, positive emotions and attitudes towards themselves and others. Less attention has been paid to the mental dimension of health in many countries (especially developing countries) since the main concern has been other health priorities, such as communicable diseases in the past and/or, chronic diseases at present. Thus, the published statistics and figures on the prevalence of mental disorders in different countries suggest that mental health status is critical. According to the World Health Organization estimates, more

than 500 million people in the world suffer from one of the mental disorders, among whom 50 million people suffer from severe mental disorders, 250 million people suffer from mild mental disorders, 120 million people suffer from mental retardation, 50 million people suffer from epilepsy, and 30 million people suffer from dementia (cited in Mehrabani, 2006). The studies conducted in Iranian contexts show that the prevalence of mental disorders in Iran is no less than that in other countries (Khosravi, 2002). Jafari & Shahidi (2009) conducted a study on three groups (opiate dependent group seeking treatment, opiate dependent group in prison, and healthy subjects) and found that both groups of addicts enjoy lower levels of assertiveness and mental health in comparison with the healthy group. Sohrabi (2004) concluded that drug dependent people benefit from the least degree of mental health compared to ordinary people. Alimoradi (2011) also found that addicts have lower mental health compared to healthy people. Hosseinifar (2011) conducted a study on 520 men and found that addicts and healthy individuals are significantly different from each other in terms of quality of life and mental health variables. In other words, addicts had lower levels of metal health compared to their healthy counterparts. Moalemi, Raghibi & Salari (2010) concluded that substance abusers were in a worse situation in all subscales of mental health than their counterparts in control group. Khosravi Kabir, Mousavi & Agha Yousefi (2008) found a significant difference in rates of mental health between drug abusers and healthy people which is indicative of the lower levels of mental health in addicts compared to healthy subjects.

Social support is a multidimensional concept that has been defined in various ways and forms. For example, it can be defined as a source provided by others, as resources for coping with stress, or as an exchange of resources (Schulz & Schwartzberg, 2004). Some researchers have defined social support as the rate of enjoyment of affection, companionship, care, respect, attention, and support received by individuals from other groups or individuals, including family members, friends, and important persons (Sarafino, 1998). Sarason describes social support as a multidimensional concept that entails both real and imaginary dimensions (cited in Alipour, 2006). Social support refers to the feeling that a person is cared and valued by others and that he/she belongs to a social network. Wasserman, Stewart & Delucchi (2001) came to the conclusion that high social support is associated with abstinence from cocaine use in the patients under opioid maintenance treatment. Kandel & Andrews (1987) and Wills & Cleary (1996) suggested that social support acts as a protective factor against the development of substance abuse problems, especially for people with a family history of alcohol dependence. Family support communications are associated with low alcohol and drug use. In a longitudinal study on adolescents, Brook, Brook, Gardon, Whiteman & Cohen (1990) reported that the mutual attachment between parents and children is correlated with less substance abuse in children. Barerra, Chassin & Rogosh (1993) suggest that high social support and high parental support are associated with better mental health and the low possibility

of substance abuse in adolescents. Averna & Hesselbrock (2001) reached the conclusion that high social support especially high support of family members is related with less smoking, less use of marijuana, and later initiation of marijuana use; therefore, high family support may delay the start of drug and alcohol consumption. Lin, Wu & Detels (2011) demonstrated that there was a positive correlation between family support and a better quality of life in addicts; and family support has preventive effects on substance abuse relapse of the patients under methadone treatment. Groh, Jason & Keys (2008) found that social support is a variable that positively intervenes in the stress resulting from alcohol use abstinence in anonymous alcoholics. Accordingly, they defined social support as a mechanism that is effective in the cultivation and betterment of anonymous alcoholics' lifestyles. Tayebi, Abolghasemi & Mahmoud Alilou (2012) concluded that addicts have less support of others compared to normal people and also suffer multiple social deprivations. Several studies have shown that drug addicts benefit from less social support than healthy persons (Pourmohamadreza & Mirzamani, 2008; Hashemi, Fotoohi, Karimi & Beyrami, 2009). Providing adequate social support has substantial direct effects on mental health so that levels of social support are followed by a lower rate of mental disorders (George, 1989; cited in Peiravi, Hajebi & Panaghi, 2010). Most of the studies conducted in this area have confirmed the strong effectiveness of perceived social support in mental health and comfort (Cornman, Goldman, Glei, Weinstein & Chang, 2003). A large number of related research projects have placed their focus on the assumption that lower levels of social support increase the risk of depressive symptoms. Despite the application of different scales to measure social support and depression, almost all the studies demonstrate same results about the effects of social support on reducing depression (Turner & Turner, 1999). In the same way, the related studies suggest the availability of a significant correlation between high levels of anxiety and low levels of social support (Landman, et al., 2005; Hughes et al., 2004). Thus, the main question in the present study was formulated as: is there any significant difference between substance dependent patients and healthy people in terms of social support and public health?

Method

A causative-comparative research method was employed for this study and all the addicts who had referred to addiction treatment centers in Khoy city in 2012 constituted its population. From among this population, 60 addicts were selected as the experimental group through convenience sampling method and, then, 60 ordinary participants who had been matched with the experimental group in terms of education, age and gender were selected as the control group via purposive sampling. Using the independent t test, it was determined that the two groups were matched for age ($t=1.62$, $P>.05$); and also using chi square test,

it was shown that the two groups were matched for education level and gender (x^2=2.435, P>.05).

Instrument

General Health Questionnaire (GHQ): this scale was developed by Goldberg & Hillier (1979) and its 28-item version was used for this study. The 28-item version contains four 7-item subscales, namely somatic symptoms, anxiety and insomnia, social dysfunction and severe depression which are scored via a 4-point Likert scale from zero to three. The resulting score of this scale for one person ranges from zero to 84. The items numbered 1 to 7 tap into somatic symptoms, items numbered 8 to 14 tap into anxiety, items numbered 15 to 21 tap into social dysfunction, and items numbered 22 to 28 tap into depression (Abolghasemi, 2006). A study entitled reliability of GHQ was conducted on 571 female and male bachelor's program students of Teacher Training College in 1996. The Cronbach's alpha reliability coefficients of the subscales of somatic symptoms and depression were reported about .79 and .91, respectively (Hooman, 1998). Social Support Inventory: this scale was developed by Fleming et al in 1982 (cited in 1996). It consists of 25 items and 5 subscales, namely general perceived support, perceived support by family, perceived support by friends, perceived support by peers, and notion or opinion about the importance of social support. The subscale of perceived support by friends was merged with perceived support by neighbors and stood as a unitary subscale. The final version consists of four subscales as perceived support by family containing 7 items (1 to 7), perceived support by friends consisting of 7 items (8 to 14), notion or opinion about social support including 5 items (15 to 20), and general or total support consisting of 6 items (items numbered 20, 21, 22, 23, 24, and 25). The scoring of this scale is done by assigning zero to each incorrect response and 1 to correct responses, but the items numbered 7, 15, 16, 17, 18, 20, 21, and 24 are scored in reverse, that is, zero is considered for each correct answer and 1 for incorrect ones (Abolghasemi, 2006).

Results

Descriptive statistics of the variables of the study for each group are presented in the following table.

Table 1: Descriptive statistics of the variables of the study for each group

Variables	*Groups*	*Mean*	*SD*	*N*
General health	Addicted	42.86	19.72	60
	Healthy	24.70	11.32	60
Somatic symptoms	Addicted	9.56	6.08	60
	Healthy	6.21	4.58	60
Anxiety	Addicted	10.26	5.35	60
	Healthy	7.90	3.75	60

Variables	*Groups*	*Mean*	*SD*	*N*
Social dysfunction	Addicted	8.98	4.48	60
	Healthy	6.91	2.72	60
Depression	Addicted	8.95	6.85	60
	Healthy	5.25	4.94	60
Total support	Addicted	12.41	3.70	60
	Healthy	16.16	4.13	60
Perceived support by family	Addicted	3.91	2.22	60
	Healthy	5.98	1.78	60
Perceived support by friends	Addicted	2.88	1.85	60
	Healthy	4.23	1.72	60
Notion about social support	Addicted	2.35	1.14	60
	Healthy	3.36	1.36	60
General support	Addicted	2.46	1.89	60
	Healthy	3.43	1.06	60

Multivariate analysis of variance should be used to evaluate the differences in the components of social support and mental health between the two groups. One of the assumptions for the legitimacy of using this test was the equality of error variances. To this end, Levene's test was run and results indicated that this assumption has been met for all the components (P>.05). Another assumption was the equality of covariance matrices. Box's Test results indicated that this assumption has been met (Box's M=8.45, F=2.34, P>.05). Therefore, multivariate analysis of variance was performed and the results suggested the availability of a significant difference in the linear combination of variables between the two groups (Wilks' Lambda=.494, F=11.152, P<.001). Thereafter the univariate analysis of variance was used to examine differences in patterns as follows.

Table 2: **Results of univariate analysis of variance representing differences in patterns**

Variables	*Mean square*	*F*	*Sig.*
Somatic symptoms	336.67	11.59	.001
Anxiety	168.03	7.85	.006
Social dysfunction	128.13	9.31	.003
Depression	410.70	11.49	.001
Perceived support by family	128.13	31.52	.0005
Perceived support by friends	54.67	17.117	.0005
Notion about social support	31.00	19.50	.0005
General support	28.03	29.10	.0005

As it is observed in the table above, there is a significant difference between the two groups in all the components. Considering descriptive statistics, the participants in the addicted group gained higher scores in all the components of mental health (i.e., more inappropriate mental health) and they obtained lower scores in all the components of social support (i.e., lower levels of support).

Discussion and Conclusion

The purpose of this study was to compare the general health and social support between substance dependent patients and healthy individuals. According to the results obtained from the study, there was a significant difference between the two groups in terms of general health and its components (somatic symptoms, anxiety, social dysfunction, depression). This finding is consistent with that of Jafari & Shahidi (2009), Sohrabi (2004), Alimoradi (2011), Hosseinifar (2011), Moalemi et al (2010), Kidorf et al (2004), Zimmerman, Sheeran, Chelminski & Young (2004), Calsyn, Fleming, Wells & Saxon (1996), Brooner, King, Kidorf, Schmidt & Bigelow (1997), and Khosravi Kabir et al (2008). The results of these studies indicate that addicts have poor mental health. To interpret this finding, one can refer to factors such as higher degrees of substance use, decrease of the individual's skill in dealing with drug use because of the subsequent mental disorder, and, thereby, the ease of turning to drug abuse. This is so because substance abuse, apart from financial costs, has many negative consequences (including cerebral and psychiatric aspects) whose control is difficult for addicts. Substance use can engender common psycho-neurological symptoms and psychiatric disorders, such as schizophrenia and mood disorders. Therefore, the negative effects of substance abuse and first psychiatric disorders may be associated with each other. Mental disorders can reduce individuals' skill in dealing with substance abuse and cause them to easily take refuge in narcotic drugs as a shelter. In other words, they use drugs as a means of interacting with people and situations to regulate their mood (Kaplan & Sadouk, 2004).

The findings obtained from this study also indicated that there was a significant difference between substance dependent patients and healthy people in terms of social support and its components (i.e., perceived support by family, perceived support by friends, notion or opinion about social support, and general support). This finding is consistent with that of Wasserman et al (2001), Kandel & Andrews (1987), Wills & Cleary (1996), Brook et al (1990), Barerra et al (1993), Averna & Hesselbrock (2001), Lin et al (2011), Groh et al (2008), Tayebi et al (2012), Pourmohamadreza, & Mirzamani (2008), Karimi et al (2009). This finding suggests that social support is lower in substance abusers than that in ordinary people. The results of the research conducted by Cole, Logan & Walker (2011) demonstrated that the majority of acquaintances reject substance abusers and, thereby, such addicts receive little support from their families and have low quality of life. It can be claimed that family as a small but important component of support network has a key role and addiction has been named "family disease" because it affects the whole family. The family system that has undergone changes and distortions by drug addiction strengthens the persistence of addictive behavior in addicts. In many cases, family members think that they can force the addicted member to stop self-destructing behaviors and drug use.

Clinical experience has shown that family involvement in treatment process leads to the greater participation of communities in treatment and, thereby, recovery accelerates. Therapists must carefully evaluate the support system of clients and move towards the supportive direction of treatment. If a family member requires a long-term treatment intervention, this is the therapist's task to guide him/her to the right treatment. If a family is not supportive, their attitude and behavior should be altered by training and observation. Wrong attitudes and maladaptive behavior make it difficult for clients to recover. The clients benefiting from family support keep on their recovery with higher speed and determination. Family system, with a strong focus on the addicted member loses its natural function. This dysfunction in the family deters the way for any change. In fact, such families live in a backwater that resort to anything to maintain family stability and this intensifies addictive behaviors in the addicted person (Parkinson, 2000). The results of this study and the related ones implicate that addicts are primarily psychological patients and need counselling, support, and treatment. Imprisonment and punishment are not considered as treatment for an addict because these methods not only heal up his/her problems and pains but also lead to the spread of abnormalities and mental disorders and certainly increase addiction relapse. Addiction is a social disease with physical and mental issues; and physical and psychological treatment will be effective only for a short time and addicts will relapse into addiction unless the causes of addiction are taken into account. In addition, as per the results of this study and previous ones, it is suggested that other studies get conducted to evaluate the causes and factors effective in low levels of social support among substance abusers so that social support can be enhanced among them with the identification of such factors, ultimately; mental health will be improved, as well.

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