

Comparing the Spiritual Health and Quality of Life in Addicted and Non-Addicted Patients in the City of Birjand, Iran

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Abstract

Background: Substance abuse is a chronic phenomenon that affects many physical, psychological, social, familial and economic elements. Abusers are left with severely reduced interaction both with other individuals and society.

Objectives: The aim of this study was to compare the spiritual health of addicts and people with a normal quality of life in the city of Birjand, Iran.

Patients and Methods: The sample consisted of 100 non-addicted subjects and 100 patients who were drug addicts in treatment centers and rehabilitation facilities both public and private in Birjand. Normal sampling measures were used to find subjects of the same age and gender. The subjects completed a spiritual health questionnaire and the short form of the world health organization's (WHO) Quality of life questionnaire, and the data were analyzed using multivariate ANOVA.

Results: The results of ANOVA showed significant differences between addicted and non addicted individual on spiritual well-being subscales.

Conclusions: The strengthening of spiritual and religious attitudes among drug users encourages them to engage in and justify actions that are relevant to their health. When this happens, their quality of life increases significantly.

Keywords: Behavior, Addictive, Quality of Life, Spiritual

1. Background

Drugs abuse is one of the important and serious problems at the international level that can affect various aspects of economic, social, physiological and psychological wellbeing. One of the major problems in the present era is that most countries, both developed and undeveloped, are facing increasing rates of drug abuse, which is both a dilemma and a traumatic social phenomenon. The issue has attracted many psychologists, counselors and social workers' consideration.

Addiction literally means erroneously being devoted to oneself; in other words, having a slavish habit of using of drugs to a point that they are detrimental physically and socially is called addiction. An addict is someone who falls into the habit of using narcotics or other drugs as the result of repeated use (1). In fact, addiction is a chronic condition that is caused by repeated drug abuse. Addiction is psychological problem, this problem encourages a person to use drugs overtime. When an addicted person tries to stop using the drug, withdrawal syndrome

occurs, causing more problems such as aggression, distress, anxiety, etc. However, the addiction is harmful to both individuals and society (2).

Addiction is the most important social pathology that originates from psychosocial factors. It affects the mental health of both individuals and communities (3). Statistics show that about 16% of Iranian addicts are under the age of 19, and about 28% begin using drugs between the ages of 20 and 24. According to United Nations Population statistics, the number of drug users between 15 and 24-year-old worldwide is 200 billion people, or 5% of the world's population. Among them, 16 billion people, or 4% of the world's population, use opiates. Drug abuse disorders have a poor prognosis and directly and indirectly impose the high cost of health care on families and communities. At least half of those receiving treatment relapse within six months, and the number of those who relapse within a year of treatment is 75% (4). These findings emphasize the importance of preventing and identifying risk factors

and protection methods. Addiction, as a social problem in society, is especially common among young people; it can cause a variety of health and social harms, such as the destruction of private property, violence, AIDS, crime, unemployment, mental disorders, and suicide (5).

Today, nations' quality of life is used as a framework for providing services appropriately according to the allocation of resources and various aspects of life. The evaluation of quality of life is very important to the extent that some claim that improving quality of life is the most important goal of treatment interventions (6). According to the world health organization, quality of life refers to people's perception of life in the field of culture and the value systems in which they live. It is related to their life objectives, expectations, standards and other matters (7). One of the issues affecting quality of life, especially in addicts, is health status. Spiritual health is one of the aspects of health that some experts believe it is essential to pay attention (6).

Douaihy et al. define spiritual health as a kind of special state, a reaction of positive emotions, behaviors, and cognitions associated with the self, others and a supernatural force and nature. A person is persuaded to the perception of identity, integrity, satisfaction, pleasure, joy, beauty, love and respect, positive attitude, relaxation, inner balance and goal and way of life as a result of his or her spiritual health (6).

Spiritual health includes two dimensions, religious health and existential health. Religious health reflects a person's relationship with God or an infinite power, while existential health suggests our relationship with others, the environment, and our inner relationships that give us the capability to integrate different dimensions and make different choices (8).

Various studies have found that addicts have a lower level of mental health than non-addicts (2, 9). Hawks et al. (10) found that addicts have a lower quality of life compared to non-addicts. On the other hand, Jadidi et al. (8) demonstrated that there is a significant relationship between spiritual health, in its religious dimension, and quality of life, in the mental dimension (7). Extensive studies have been done about this subject, and a literature review shows that very little research has been done in this respect in Iran.

2. Objectives

Given the importance of the role of spirituality in people's quality of life, and the role of spiritual health in addicts' lives, the aim of this study is to compare the spiritual health and quality of life in addicted and non-addicted patients.

3. Patients and Methods

This research uses the scientific comparative plan. The population under study consisted of all addicts and non-addicts in the city of Birjand, Iran. The sample con-

sisted of 100 drug addicts and 100 non-addicts. Addicts were chosen through a sampling method available to the public and private treatment and rehabilitation centers in Birjand. Non-addicted subjects were chosen through sampling that matches them to addicts by age and gender. Data were analyzed using SPSS software and descriptive and inferential statistics, including frequency, mean, variance, standard deviation, and a multivariate analysis of variance.

3.1. Research Tools

3.1.1. Spiritual Well-Being Survey (SWBS)

This questionnaire includes 20 items, of which 10 are related to religious health and 10 measure existential health. The spiritual health score is the sum of these two sub-scales, and is expected to be in the range 20 - 120. The range of questions was classified in six options on a Likert scale, with responses ranging from "completely disagree" to "strongly agree." For negative questions, scoring was done in reverse. In the end, the spiritual health was divided in three levels: lower 20 - 40, moderate 41 - 99, and high 100 - 120. Several studies with validity and reliability assessments of the questionnaire and the Iranian context have revealed that, with Cronbach's alpha coefficient 0.82, it can be used in other subsequent researches (11). In this study, the Cronbach's alpha was 0.76.

3.1.2. Quality of Life Questionnaire

This is a short form of the personal Welfare questionnaire by the WHO that includes nine items with score varying between 0 and 10. In each item, a score of less than 5 indicates poor quality of life, a score of 5 shows average quality of life, and scores closer to 10 indicate a more desirable quality of life. The Adult Well-Being Index is the basis of the Comprehensive Quality of Life Scale. This index is provided by the order of international team of a health and welfare organization (12). The adult personal welfare index includes nine items that measure quality of life in terms of eight dimensions. To verify the validity of this scale, the Satisfaction with Life Scale (12) was used. The alpha for this scale was reported in Australia and other countries as being between 0.70 and 0.80 (13). Vaarwerk and Gaal (14) reported 0.74 for the test-retest reliability scale and 0.78 for the Cronbach's alpha. In this study, the Cronbach's alpha was 0.87.

4. Results

In terms of demographic characteristics, 16.5% of the study population was in the age group between 20 and 30-year-old, 41.9% were between 31 and 40-year-old, 22.4% were between 41 and 50-year-old, and 19.2% were more than 50-year-old. In terms of education, 9.1% had only a low literate education, 24.8% a high school diploma,

22.8% an Associate's degree, 39.3% an undergraduate degree, and 4% had a graduate degree. As can be seen, most subjects held a BA degree and were between the ages of 20 and 30-year-old. The following continues the investigation of the descriptive statistics present in the two groups (addicts and non-addicts) (Table 1).

Comparing the spiritual health subscales reveals that non-drug-dependent subjects have a higher mean compared to drug addicts across the subscales of this variable. Also, non-addicts report a higher quality of life than addicts do.

To test the study's hypothesis, a multivariate analysis of variance test was used; hence a multivariate test was performed first. According to -0.85 Wilks' Lambda, $P < 0.05$, $F_{(2,57)} = 3.43$ it was revealed that there is a significant effect for the drug dependence factor. This effect shows that there is a difference between at least one of the spiritual health scales and quality of life among people dependent on and independent of drugs.

The results of Table 2 show that the hypothesis that there is a significant difference in the scale of spiritual well-being and quality of life among drug-dependent and non-dependent people is confirmed. As the table indicates, the obtained significance level for all three scales is less than to the significance level of 0.016 obtained by Bonferoni edition (significance level 3 divided by research scale 0.05). The magnitude of drug dependence as a "significant action" for scales of religious health, existential health, and quality of life are, respectively, 0.12, 0.11, and 0.13. This means, respectively, that 12, 11, and 13 percent of the total variances or individual differences in the subscales of religious health, well-being, and quality of life among drug addicts and non-addicts in Birjand were related to drug dependence. In addition, the statistical analyses in this study suggest that at least a 78 percent probability of the null hypothesis being rejected correctly.

Table 1. Descriptive Characteristics of the Study Variables in the Addict and Non-Addict Groups (N=100)

Group	Mean \pm SD	Standard Mean Error
Religious health		
Addicts	30.78 \pm 1.98	2.45
Non-addicts	35.51 \pm 1.69	2.24
Existential health		
Addicts	29.14 \pm 1.78	2.87
Non-addicts	34.06 \pm 1.68	2.3
Quality of life		
Addicts	21.47 \pm 1.48	1.42
Non-addicts	26.45 \pm 1.47	2.25

Table 2. Analysis and Variance Test, Multivariate Analysis, and Variance^a

Statistical Indicators Variables	SS	df	F	Significance Level	The Effect	The Test
Religious health	25.16	1	8.68	0.005	0.12	0.82
Existential health	18.35	1	7.59	0.007	0.11	0.78
Quality of life	15.87	1	7.57	0.004	0.13	0.83

^aSource of change: group.

5. Discussion

The aim of this study was to compare the spiritual health and quality of life in the city of Birjand, Iran among drug addicts and non-addicted people. The sample consisted of 100 non-addicted subjects and 100 drug addicts, in which the addicts were selected through a sampling method available to public and private treatment and rehabilitation centers in Birjand. Non-addict subjects were selected by available sampling in which they were matched to the addicts' age and gender status. Quality of life was defined as someone's satisfaction with his or her life and surroundings; this includes the meeting of needs and other tangible and intangible factors that affect all aspects of a person's wellbeing (15).

The first finding of this study was that there is a significant difference between the quality of life of addicts and non-addicted people; these results were consistent with the results of other studies (14, 16, 17). In explaining this hypothesis, it can be said these differences can be caused by various factors, such as family relationships, child rearing, interpersonal relationships and individual interaction, peer groups, poor life circumstances, having another addict in the family, poor nutrition, and so on. Drug abuse leads to unpleasant consequences, such as physical, mental, and social problems (13). These consequences include physical pain, a lack of social communication, aggression, depression, anxiety, poor quality of life and life satisfaction, and more. Addiction causes changes in behavior, self-esteem, nutrition, work, and life in general and leads to the reduction of a person's quality of life (3).

Another finding of the present study is that there is a significant difference between the religious health of non-addicted people and addicts; this result is consistent with the study by Babaie and Razeghi (18) who found that engaging in religious activities and participating in religious ceremonies affects people's relationships with others, and can affect people's physical health and mental wellbeing. From these results, it can be inferred that religious and spiritual beliefs and practices can be assumed as supporting actors that through bring hope and strength and give meaning to life. This, in turn, leads to a reduction in stress levels and improvements in people's quality of life.

In explaining the above hypothesis, it can be stated that,

when developing in addiction, addicts do not have the chance to participate in various activities, like sports, religious and spiritual events, all of which improve people's wellbeing and health. The result is a decrease in the religious health of these people, so the results of the present study are not unexpected.

Finally, this research also reveals a significant difference between addicts and non-addicted people in terms of existential health variables. One justification for this topic of study is that that addicts probably suffer from stressful psychological and social changes, such as conflicts associated with their lives' meaning and purpose. The suffering and pain of addiction often leads to challenges to addicts' meaning and purpose of life (19). The most frequent disorders co-occurring among addicts were: hepatitis C (92%), HIV (77%), benzodiazepine abuse (56%), and anxiety disorders (32%). A higher severity of psychiatric and physical problems was associated with poorer quality of life (20). The present study also revealed that some disorders in family function dimensions were more common among addicts, compared to non-addicts. Addicts have a quality of life lower than non-addicts ($P < 0.05$). There is a relationship between the different dimensions of family function and the quality of life in both addicts and non-addicts (20).

In fact, strengthening the sense of one's own importance and inner peace, especially in addicts, seems to be very important, because addicts have many personal challenges, including assessments of the significance and meaning of their lives. Their attempts to maintain their dignity and self-esteem while faced with losing their physical abilities and encountering the negative attitudes of the community and others have towards them have a detrimental effect on them. Therefore, the strengthening of addicts' spiritual attitudes and religious beliefs, and encouraging and justifying their performance of related actions, can improve their quality of life. The institutionalization of religious and spiritual beliefs and performing related actions superficially, can help such people to increase their self-confidence, self-esteem, and dignity. In short, the moral and religious training offered by professionals and community leaders can guarantee the health and quality of life for all members of society.

This study was conducted using a questionnaire and has the limitations found in all questionnaire-based studies, such as concerns about the degree of confidence in the testable responses. Also, the desired population and sample (those available) of this study were in the city of Birjand, Iran. Therefore, generalizing the results to other cities and provinces should be made with caution. It is suggested that future studies use random sampling and other techniques when choosing addict and non-addicts for additional research. A review of other risks and protective factors is also suggested.

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