



## Comparing Anger Management, Anger Dimensions, and Quality of Life in Methadone Maintenance Treatment Addicts and Non Addicts

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**ABSTRACT:** The purpose of present research is "The Comparison of Anger Control, Anger Dimension and Quality of Life in Methadone Maintenance Treatment (MMT) Addicts and Non Addicts. Method of research was fundamental research and casual comparative (expose facto). The research population consisted of all males who suffered from substance abuse in Shahrood who have visited clinic for treatment substance abuse in 2013 year. Statistical sample of present study include 150 addict males and 150 non addict males that have chosen from four clinic from Shahrood city. The sampling method was accidental (available). Subjects replied to the Silberberg Anger Questionnaire STAXI-2, and quality of life questionnaire for Varosherobon. Multivariate variance test were used to analyze the finding of hypothesis. The findings indicated there were not significant differences between addict males and non-addict males regarding anger dimensions and there were significant differences between addict males and also non addict males regarding anger control and quality of life addict males and non-addict males.

**Key words:** Anger Control, Anger Dimension, Quality of Life, Methadone Maintenance Treatment

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### INTRODUCTION

As the vulnerable individuals of society, addicts are facing mental, emotional, social, and economic problems in addition to the physical consequences of this disease. These consequences have adverse effects on the quality of their lives and prevent them from their usual daily activities (Habeli, 2005). The quality of life is the understanding of individuals of their situation in life as concerns cultural aspects and value systems which are associated with their goals, wishes and standards (Barbot et al., 2001). Therefore, an appropriate definition of Quality of Life can be a set of physical, mental, and social welfare such as happiness, satisfaction, honor, health, economic situation, educational opportunities, and so on, which are perceived by an individual or group of individuals (Dali and Marlat, 2005). Addiction with narcotic substances as a biological, mental, and social issue deteriorates many components of Quality of Life (Dali and Marlat, 2005).

One of the common treatments of addicts is detoxication. When the addict experiences hangover symptoms during methadone detoxication, he is given methadone, which is gradually reduced until the usage is adjusted and the patient's status becomes stable depending on the physical reactions of the individual (Akbari, 2006). In addition to methadone detoxication, the individuals could be trained and informed about the reason of attitude toward narcotic substances, and the associated impacts of drugs and the physical, mental, and social hazards. Bolton (2004) believes that a great percentage of our attention is focused on medical healing of addicts and we ignore the mental

health and the emotions of the addict. The role of emotions is evident particularly as regards anger and identifying its impacts on drug seeking behavior (Turner and Larimer, 2004) and hence helping the individual to prevent from recurrence. Anger is the most experienced emotion (Schiman, 2003 quoted from Etemadina, 2010). Anger is always concentrated on a topic (self, others, fate). Psychologists differentiate the anger aspects as anger trait and anger state (Spielberger and Sarson, 2005).

Spielberger and Sarson (2005) called the anger experience as anger state from phenomenological point of view. State anger is referred to a transient biological and mental feeling that varies between mild anger to severe anger. In severe anger state, the automatic nervous system is activated. When the individual tends to experience the anger in order to respond to the greater domain of stimuli, the anger is called trait anger. Anger experiences from under the impact of cognitive appraisals, particularly those associated with intentionality, blame worthiness, unfairness (dishonesty) (Kaslinove and Sokhodolsky, 2005).

Anger is a reflection of a multidimensional phenomenon and a combination of anger-in, anger-out, and anger control. Anger-in reflects the tendency to suppress anger thoughts and feelings. On the contrary, anger-out reflects the tendency to participate in aggressive behaviors toward objects or persons in the environment. Finally, anger management is referred to the individual's ability to manage and prevent from experiencing or expressing

anger (Sukhodolsky et al., 2001 quoted from Abdolmanafi, 2010).

Attwood and associates (2009) believe that there is a difference between anger-in and anger-out initiators. The events that stimulate anger-out include identifiable conditions such as getting stuck in traffic or facing unfavorable behaviors of others. Anger-in initiating factors include thinking about an unpleasant confrontation. Inability of the individual to effectively express his feelings is related with anger. This can be a major stimulus of addiction recurrence. Researchers state that patients who express their anger repeatedly and severely during abstinence are at a higher risk of recurrence. Some findings show that the anger-out is significantly related with alcohol abuse and some narcotic substances and tobacco (Wills et al. 2001, Eftekhari et al. 2004, Parrot and Giancola, 2004). Some studies have focused on anger as a predictive factor of narcotic substances such as cocaine (Eckhardt, Christopher, 2007). In line with stress and vulnerability pattern, other findings prove that criminal and unacceptable social behaviors increase with the environmental pressurizing factors and decrease proportionate to the control skills and resources (Treno et al. 2008). Some researchers state that environmental pressures directly influence criminality and aggressiveness problems. They consider that the anger from stressful conditions mediate to problematic behaviors and nonconforming responses (Parrott and Giancola, 2004). Sujata *et al.* (2008) pointed out to the relationship between stressful living conditions and involvement of juvenile in drug abuse and criminal behaviors. They further introduced stressful ambient as a stimulus of anger and aggression which lead to reduction in socially conservative behaviors. Parrot and Giancola (2004) in a study showed that people who experienced failure might show angry feelings in criminal activities and drug abuse. Therefore, it seems that problematic behaviors are the result of an inefficient confrontation with anxiety and anger particularly severe and unmanaged expression of anger. Anger could act as a mediate to trigger nonconforming confronting responses to criminal acts (such as drug abuse, and so on). (Spielberger and Sarason, 2005). Hence, anger can directly or indirectly relate to addiction. According to the above, this research seeks to find if there is any significant relationship between the addicts being treated with methadone and non-addicts concerning the aspects of anger, managing anger, and quality of life.

## MATERIAL AND METHODS

This study is a casual-comparative (post-facto) study which compares the addicts under treatment

with methadone with healthy individuals for the components of anger and Quality of Life. The statistical population of research consists of 150 addicts under treatment with methadone (who referred to the addiction control clinics of the city in 2012) and 150 healthy people (non-addicts) who were selected by random sampling method.

### Tools

Spielberger Anger Questionnaire STAXI-2: The STAXI-2 57-item Questionnaire was developed by Spielberger in 1988. It consisted of six scales of anger state (which consisted of three angry feeling subscales "five items"), tendency to verbally show the anger (5 items), tendency to physically show the anger (5 items), trait anger (including angry mood and angry reaction subscales), the anger-out expression scale, the anger-in scale, the anger-out control scale, and the anger-in control scale. Cronbach's alpha coefficient for anger state scale, anger trait, feeling angry, tendency to verbally show anger, tendency to physically show anger, anger-out expression, anger-in expression, anger-in management, and anger-out management were respectively 87.93, %, .85, .87, .88, .83, .70, .67, .80, .69. (Spielberger and Sarason, 2005). High internal consistency between scales and subscales of anger and their positive relationship with other scales of anger and aggression indicate their appropriate validity (Spielger, 1996).

**Quality of Life Questionnaire:** SF-36 Questionnaire was devised by Varosherbon in 1992 in the USA. It assesses eight domains of general health, physical health, limitation in role playing due to physical problems, limitation of role playing due to emotional reasons, physical pain, social function, fatigue or vivacity and mental health. "Internal consistency" analysis showed that except vivacity scale ( $\alpha=.65$ ), other Persian type scales SF-36 have the minimum reliability standard coefficients within.77 to.90. This research found reliability by Cronbach's alpha method equivalent to.80. "Convergence validity" test yielded favorable results in order to study the measurement hypotheses using correlation of each question through the hypothesized scale. All correlation coefficients were obtained more than the recommended value .4 (the scope of coefficient changes.58 to.95). The factorial analysis test yielded two main components which justified 65.9% of the dispersion among the scales of SF-36 Questionnaire (Montazeri et al., 2005).

## RESULTS

Multivariate variance analysis (MANOVA) test was used according to several subscales in order to test the research hypotheses. The Hotelling statistics in table 2 shows that it is possible to reject the

assumption of similarity of the population's means based on the dependent variables for the two groups and use MANOVA test to study the difference between the means of the two groups of healthy persons and addicts.

The results of MANOVA test are mentioned in table 3. According to table 3, as concerns anger aspects (anger state and anger trait), there is no significant difference in the scores mean of the addicts under treatment with methadone and healthy individuals in anger state and anger trait. But there is a significant difference between the scores mean of addicts being treated with methadone and healthy individuals in anger management aspect. Based on table 1, as concerns anger-in management, the mean

of addicts under treatment with methadone (20.47) is significantly less than the mean of healthy individuals (22.80).

According to tables 1 and 3, the scores mean of addicts under treatment with methadone (20.40) are significantly less than the scores mean of healthy individuals (22.60) in anger-out management aspect.

T-test was used for the two independent groups in order to compare the mean of the quality of life in the addicts under treatment with methadone and healthy people. T was calculated 8.818 which was significant in significant level 0.000. According to table 1, the mean of the quality of life scores in healthy people was significantly higher than the mean of the quality of life scores in the addicts.

**Table 1.** Mean and Standard Deviation of Research Variables Depending on Group

Variables	Addicts		Healthy	
	Mean	SD	Mean	SD
Anger state	33.86	11.75	33.17	16.77
Anger-in management	20.48	5.58	22.80	5.99
Anger-out management	20.40	5.77	22.60	5.70
Quality of life	89.07	10.03	97.77	6.72

**Table 2.** Hatling test result

Impact	Value	F	df hypothesis	df error	Sig.
Hatling	.580	10.93	15	283	.001

**Table 3.** The Test Results of the Intergroup Impacts of MANOVA concerning Anger, Anger Management, and Quality of Life

Variable	SS	DF	MS	F	Sig.
Anger state	35.840	1	35.840	.185	.668
Anger trait	115.923	1	115.923	2.358	.126
Anger-in control	396.562	1	396.562	11.777	.001
Anger-out control	358.702	1	358.702	10.858	.001

**DISCUSSION**

The statistical analysis showed that there was no significant difference between addicts under treatment with methadone and non-addicts concerning anger aspects (anger state and anger trait). The findings of the present research were contradictory to the findings of Nargesi and Davoodi (2012), Spielberger and Sarason (2005), and Sharmasoman Marti and Marimoto (2011). Methadone is an artificial narcotic substance which enters the human body system at lower speed than crack and heroine. It remains in the body for a longer period. The spree and hangover due to taking methadone may cause the individual fail to have a realistic perception, logical thinking, and proper judgment about his behaviors. Perhaps this is one of the reasons of insignificance of this research. Another reason could be inappropriate selected tools to assess the trait and mood of anger in the addicts. In this research, addicts gained higher scores than healthy people in anger state and anger trait. The difference was not significant albeit.

There was a significant difference between addicts under treatment with methadone and non-addicts as concerns anger management (anger-in control and anger-out control). This part of results were consistent with the results of research works by Eckhardt, Christopher, 2007, Wills et al. 2001, Eftakhari et al. 2004; Jazayeri, Jafarizadeh, and Poorshahbaz 2002. Lack of impulse control in the people with high levels of anger provided the grounds to direct them to take drugs. In the addicts who developed inefficient control responses (Spileberger and Sarason, 2005), severe and unmanaged anger played the role of a mediate. This would finally led them choose the simplest way, i.e. nonconforming control responses such as drug abuse. Emotions such as anger can act as mediate for the individual's interest in drug seeking behavior (Turner and Larimer 2004). The individual's inability to effectively express feelings was associated with anger. This could act as one of the main stimuli of addiction recurrence. Research shows that relief seekers are at a high risk of recurrence. In the

meantime it should be stated that getting angry is an important mediatory factor that can make the individual resort to an emotional and illogical strategy like drug abuse to face extreme conditions and stressful events. In a research, Parrot and Giancola (2004) proved that people who experienced failure could show their angry feelings in their criminal activities and drug abuse. Therefore, it seems that problematic behaviors are the result of inefficient coping responses to anxiety and anger particularly severe and uncontrolled expression. In the meantime, people who experience ecstasy due to high consumption of substances report lower levels of anger management (Parrot and Giancola, 2004).

Also the present research shows that there is a significant difference in the quality of life between the addicts being healed with methadone and non-addicts. These are in conformity with the results of the works of Katibayi et al. (2010); Hosseinian et al. (2008) and Dalahan and Malart (2005). Addiction as a biological, mental, and social issue influences various aspects of the addict and ruins the components of the quality of life and lowers the level of the quality of life (Dali and Malart, 2005). In the meantime, addicts have biological, psychological, social, and emotional needs that are different compared to the needs of healthy people. Drug abuse influences the individual's mood and increases depression, anxiety, pessimism and paranoia (one of the indicators of the quality of life). These effects influence the addict's spouses and family too and deeply influence the behavior and other aspects of his and his surrounding's life. For example, drug seeking behavior, anger, and inability lead to the feeling of sin and depression in spouse and family members. Drug abuse leads to intensified aggressive behavior, children abuse, impulse control disorder and misjudgment. Also, drug abuse has direct social impacts (one of the indicators of the quality of life) on the family due to legal problems of the consumer, divorce, marital disputes, financial problems, unemployment, and high cost of drugs (Newleon 2005).

Among the limitations of this research are lack of interest of addicts in responding to the research questions, lack of cooperation and precision of some addicts to answer the questionnaires, and low literacy level and information of respondents (addicts). Among other limitations of research are the different lengths of time that addicts were under treatment with methadone.

Regarding the variety of some components of anger and the quality of life in the addicts under treatment compared to ordinary people, it is recommended to plan for programs to reduce the anger components and increase the quality of life beside methadone treatment and study the effect of

this program in quitting addiction and non-recurrence. In the meantime it is suggested to consider gender differences for the next research.

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