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Compare of readiness for Change Life in married and single self-resorted addicts to clinics and treatment camps

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ABSTRACT: The present study was conducted in order to comparatively examine the amount of readiness for change life of self-resorted addicts to clinics and treatment camps. Regarding the subject of the study, which compares two separate groups based on desired variables, the research method used in this study was Ex-Post Facto. In this study, subjects completed a questionnaire at each stage. Due to special circumstances of these two separate groups; two samples of population were examined who completed the Stages of Change and Treatment Eagerness Scale for drug abusers (SOCRATES-8D) questionnaire. The study population included all clients of addiction clinics and camps of Sari city and using a simple random sampling, the sample size for each group were selected as 50 subjects (total n = 100). SPSS software was used for the interpretation and analysis of data and Independent T-test was used to test the hypotheses. The results of this study showed that mean of readiness to change in married subjects are higher than single addicts. Comparisons showed that readiness to change has significance difference between 2 groups at 95% confidence level. According to the research results, it is suggested that more attempts must be exerted in satisfying the mental and spiritual needs of addicts in the treatment process of drug addiction and these needs must be more stressed and taken into account than their physical treatment.

Keywords: Addict, Passion, Change Life, Attitude to life.

INTRODUCTION

Opiate dependence remains a global major health issue and is a classic example of a chronic relapsing disorder. Compared to the general population, opioid-dependent individuals encounter a much higher risk of death, contracting infectious diseases and are plagued with psychosocial problems (Maremmani , 2009). From the statistics of the World Drug Report 2010, the United Nations has estimated that between 155-250 million people or 3.5% to 5.7% of the total population aged 15 and above had used illicit substances in 2008 including more than 15 million of opiate users worldwide after cannabis and amphetamine type stimulant users (World Drug Report, 2010). The global epidemic of opioid use continues to spread and appears to be an increasing burden, mainly in developing countries and particularly in South-East Asia and Western Pacific regions (World Health Organization, 2010). Addiction leads to engaging the community, the individual and the economic, social, psychological and physical problems. Main symptoms of addiction in psychological and personality aspects are weakness of will, lack of attention to individual responsibility, personal weakness, lack of emotion, nervousness, mental imbalance, unbalanced and unstable personality, and lack of confidence. Mental health professionals used passion as a therapeutic to clients, however have been investigated very limit (Volkmann, 2009). Development and spread of drug addiction as a disease of modern societies have caused an international, global and social problem of humanity concerned by academic, political, religious and cultural communities (Ahmadi, 2008). Due to its border with the largest drug manufacturing, Iran is not only considered as a major route of drug transit, but also it has

become a good market for drugs produced in Afghanistan. In addition, drug addiction is growing in the country due to unemployment and other psychological-social problems and the fact that Iran's population is largely young; so that, number of addicts seems to be relatively more than statistical estimation of Drug Control Headquarter (nearly 2 million). Some unofficial resources estimated addicts at even up to 6 million; reason of the failure to estimate the actual number of addicts, perhaps, is due to the criminal nature of addiction or some cultural factors in Iran (Raoofi, 1999). According to estimates, the economic damage caused by drug abuse and drug trafficking in Iran is estimated at over 700 billion Tomans per year (Aqabakhshy, 1999). In DSM, the most important characteristic of opioid dependence is a series of cognitive, behavioral and psychological signs implying that one continues to use drugs while suffering considerable problems related to drug use. A pattern of repeated drug taking usually leads to emergence of tolerance, withdrawal, and compulsive drug taking behaviors. Dependence symptoms are similar in different types of drugs; nevertheless, some symptoms are less prominent for certain classes and signs do not exist in few cases (Nikkhoo, 2010). Drug use can cause a variety of Psychiatric disorders such as anxiety disorders, mood instability, depression, psychosis and various physical illnesses and problems; in addition, social and economic pressure on the addict as a stress causes different psychiatric disorders. Many physical and mental disorders, impaired social relationships and spending considerable time and cost for addiction lead a person fail to meet the job and education duties; therefore, the addict experience impaired performance in these areas too (Farhoodian, 2011). Therefore, prevention of drug abuse can also avoid high costs to society (Taremian, 2001). Although addiction has wide effects, conventional treatments are not enough efficient. Even the best treatments reported success rate of 30-50% per year (Brien & Mcleellan, 1996). The course of drug addiction and the cognitive dimensions of behavioural change i.e. readiness to change (RtC) and the confidence level in ability to change in Iranian addiction treatment programmes are still not well described. RtC is generally accepted as an important factor in determining how individual behave with regard to tackle and changing substance misuse problems (Flynn et al., 2003). In the recent years, most discussions of motivation to change behaviour have been dominated by the stages of change or Transtheoretical Model (TTM). The TTM of behavioural change has provided an increasingly popular model for understanding how people intentionally modify addictive behaviours (Prochaska et al., 1992). Any changes of individual behaviours are expected to undergo progress through discrete stages as suggested by this model (Prochaska , 1992). TTM has been readapted and modified several times with the most popular version identifying the five important stages of Precontemplation, Contemplation, Preparation, Action, and Maintenance (Sutton, 2001). The Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES), the Readiness to Change Questionnaire (RCQ) and the University of Rhode Island 8D (Isenhart, 1994). A shorter version (19-item) of the SOCRATES was later developed and was shown to be related to the longer scale (39-item). The SOCRATES-8D yields three subscales namely Recognition, Ambivalence and Taking Steps (Miller and Tonigan, 1996). The Recognition resembles the Precontemplation and Preparation stages whereas the Ambivalence subscale reflects the Contemplation stage. On the other hand, Taking Steps subscale included items originally intended to assess Action and Maintenance based on the TTM (Napper et al., 2008). In attempts to help drug abusers remain abstinent as well as to modify their attitudes related to constant illicit drug use and to address psychosocial issues, it is deemed beneficial if the current practice is embedded with strong behavioural aspects. The aims of this study were therefore to determine the general level of readiness for change in single and married self-resorted addicts to clinics and treatment camps, Sari, Iran.

MATERIALS AND METHODS

The research sample consisted of 100 Iranian men (Sari, Iran) that selected from clinics and treatment addict camps (36 single and 64 married).

Study instruments

The instrument employed was the SOCRATES-8D which was originally designed by Miller and Tonigan (Miller and Tonigan, 1996). It comprised of 19 items and measured three relatively independent subscales: Ambivalence, Recognition and Taking Steps. The SOCRATED-8D responses are scored on a 5-point Likert scale ranging from (-2) = Strongly disagree to (+2) = Strongly agree. To facilitate interpretation, the SOCRATES-8D scale was renumbered so that 1 = Strongly disagree, 2 = Disagree, 3 = Unsure, 4 = Agree to 5 = Strongly agree, were equivalent to the response scales of other instruments such as RCQ and URICA (Napper et al., 2008). The first subscale was meant to detect Recognition level which contained 7 items with a total score between 7 to 35. The second subscale was to determine Ambivalence level which contained 4 items with total score ranging from 4 to 20. The last subscale measured was Taking Steps which was sampled by 8 items (minimum score = 8, maximum score = 40). Finally the total RtC score was generated via the summation of all three subscale scores to give the

Overall RtC level of all respondents. The Overall RtC score ranged from 19 to 95. The interpretation of SOCRATES-8D scores is based on a sample of 1,726 respondents in an alcohol treatment programme (Project MATCH Research Group, 1997). Each level of RtC was interpreted as: 1 = very low, 2 = low, 3 = medium, 4 = high and 5 = very high.

Statistical approach

This study employed the Statistical Package for Social Sciences version 15 (SPSS 15) for data analysis. The t-test was utilized to test for group comparisons for RtC level which were presented as mean rank and its corresponding p value. The value of $p < 0.05$ was considered significant

RESULTS AND DISCUSSION

Results showed that mean of readiness to change in married subjects are higher than single addicts. Comparisons showed that readiness to change has significance difference between 2 groups at 95% confidence level (Table 1).

Table 1. Compare the readiness to change between single and married edicts

Groups	N	M	SD	t	df	sig
Single	36	53.42	16.349	1.671	98	0.000
Married	64	68.89	12.134			

Discussion

Our finding showed that married addicts has higher readiness to change and are differ from single addicts. There still remains many questions to be answered concerning when, how and why persons who are dependent on drugs make efforts to change their lifestyle. To better understand how ready they change their substance use habit and why a large number of them turn to relapse, it seems reasonable to look more closely at the subjective and dynamic behavioural aspects and patients' RtC apart from pharmacological treatment alone. With this awareness as a starting point, the concept of motivation to change and motivation for treatment have been theoretically illuminated and increasingly employed in addiction research during the last 20 years (Ekendahl, 2007). Furthermore, positive attitudes toward RtC to some extent could determine their readiness to seek treatment, prolong the treatment duration as well as predict the effectiveness of the treatment received. This was encouragingly supported by a number of studies which claimed that motivation to change influenced entry and length of stay in opioid abuse treatment and these factors could in turn, predict follow-up outcomes (Joe et al., 1998; Simpson, 2001). It has been shown for example, that motivation to change at earlier stage of treatment was related to favourable follow-up outcomes in drug use, positive trends in reducing dropout rates and also to treatment retention and engagement (Simpson, 2001, Shen et al., 2000). The majority of our respondents were still not ready to change and possessed low to medium level of RtC. It was probable that they were still unclear with their goals towards being drug-free and at the same time to promote their behavioural change. In support of this, Miller and Rollnick reported that the lack of the confidence level in patients and poor support during the treatment could be the factors underlining this phenomenon (Miller and Rollnick, 2002).

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