Perceived Social Support and Clinical Anger among Drug Addicts of Southern Punjab, Pakistan

Muhammad Saleem (Corresponding Author)
Lecturer, Department of Applied Psychology
The Islamia University of Bahawalpur, Pakistan
E-mail: Chsaleem_1@hotmail.com

Muhammad Azam Tahir
Associate Professor, Department of Psychology
University of Baluchistan, Quetta, Pakistan
E-mail: drazamtahir@hotmail.com

Najam Ul Huda
Department of Applied Psychology
The Islamia University of Bahawalpur, Pakistan
E-mail: psy.najam.iub@gmail.com

Abstract

This study was set out to investigate perceived social support and clinical anger among drug addicts of Southern Punjab, Pakistan. The research contained a sample of seventy (70) registered drug addicts of age18-65 years, selected randomly from three major cities/divisions of Southern-Punjab (Bahawalpur, Multan, and Dera Ghazi Khan). Sample was divided into two age groups; young adults (18-35 years) and middle adults (36-65years). Multidimensional Scale for Perceived Social Support (MSPSS) by © Zimet, Dhalem, Zimet and Farley (1988) and Clinical Anger Scale (CAS) by © Snell (2002) were used. Tukey's test, R-square, P-values, t-test and regression analysis were used towards the analysis of results of research. Results indicated an inverse relation between perceived social support and clinical anger. All the sub-groups in clinical anger showed a significant difference. Finally, it was established that majority of drug addicts had severe level of clinical anger with positive perception about family.

Keywords: Perceived social support; clinical anger; drug addiction, Pakistan.

1. Introduction and Literature Review

Addiction may be defined as an initial, chronic, neurological problem with inherited psychological, social, and environmental factors that influence development and appearance of an individual. Different behaviors result due to addiction such as disturbed control for drug use, continuous use of drugs without harm (American Academy of Pain Medicine: American Pain Society and American Society of Addiction Medicine, 2001).

Western literature review indicated that drug dependence is due to different number of psychological risk factors like clinical anger, violence and isolation that are important regarding to addiction (Ahmed and Shafi, 1990). According to Baron and Byrne (2005) the family relationship plays an important role in misuse patterns of substance, either family, friends and significant others may helpful in elimination of addictive behaviors by positive social support. As narrated by Kaplan and Sadock (2006) nearly, 90 % addicted population suffer from different type of psychological disorders. It was also noted that about 15 % of drug addicts tried for suicide at least one time in life.

Murdoch, Pihl, and Ross (1990) established a link with drug addiction and violent crimes by saying 62% of criminals committed the crime after taking alcohol. Alcohol plays an important role in committing the violent crime than that of non-violent crimes. In Finland a study showed that homicidal criminals have a great relation between violence and rapid use of alcohol. In this research 39.2% were male and 32.1% were female who met the criteria of DSM-III-R for alcoholism and the second highest ratio was 6% that was of schizophrenics (Eronen, Hakola, and Tiihonen, 1996). Hoaken and Stewart (2003) conducted the research on another major class of drugs (benzodiazepines), that has produced a great confusion among some psychologists as well as in normal people that whether benzodiazepines produce violence or not. Similarly, Dietch and Jennings (1988) indicated that anger and aggression is being increased with the use of benzodiazepine in the start of 1960's. These drugs are usually used to decrease the level of anxiety. Another study suggested that benzodiazepines produce less amount of violence than that of alcohol (Shader and Greenblatt, 1993). Veteran clinical psychologists totally deny for its clinical observations (Shader and Greenblatt, 1993) as a fact these drugs are considered as anti-aggression (Corrigan, Yudofsky, and Silver, 1993). According to European Monitoring Centre for Drug and Drug Addiction (2006) marijuana, easily available drug, is used by teenagers as well as adolescents.

Snell (2000) stated that Clinical anger is a syndrome that consists of a number of symptoms with different levels of the intensity and strengths. In this type of anger a number of the health risks are present. Anger is an emotional condition of an individual that disturbs the psychological and biological changes. Anger changes from minor condition to higher (APA, 2007). A comparative study of social support, social comparison, anger and its expressions provided an idea of negative relation among anger in or anger out and social comparison (Dskender and Tanrikulu, 2010).

Golden (2003) investigated that anger is a response to stress that relates to the environmental condition. The anger that cannot be controlled may cause significant problems that result in depression, suicidal ideation, drug addiction, hostility, and serious violent crimes. There are two types of anger, first, state anger that causes emotional responses to any event in an individual, second, trait anger which is more effective to produce an emotional response (Spielberger, 1999). Anger affects our social behavior and psychological responses (Puskar and Bernardo, 2007).

Review of a study by Akmaz (2009) stated a linear significant relation among anger in and insecure attachment style. Strong relation between family and substance users appeared in the research. Different family structures have been observed among different drug addicts even tobacco users (Hundleby and Mercer, 1987; Adlaf and Ivis, 1996; Amey and Albrecht, 1998), as well as alcohol (Burnside et al., 1986; Adlaf and Ivis, 1996), marijuana and other drugs (Adlaf and Ivis, 1996; Amey and Albrecht, 1998).

Different styles of drug use have been observed, like forever usage (Flewelling and Bauman, 1990; Turner et al., 1991). These different styles provide a massage to the researcher about different families that parent-child relationship may be seen through different angles (Amey and Albrecht, 1998). It also differentiates the boundaries provided by parents (Dornbusch et al., 1985). Grogan (2008) conducted a research on the impact of social experience and social support, it was seen that body image is constructed by the society, influenced by social support and social experience.

For healthy development in different areas (Social and Psychological) of life it is necessary for an individual to attain social support from family and friends (Oswald and Suss, 1994). Whenever, the support is not provided in a proper way by the family, friends, etc. it may create different types of disturbances like depression, anxiety, etc. To decrease the depression level people may rush toward drug addiction. Poor attachment and communication with the family are the causes of drug addiction. Moreover, in lower income families the influence of drug addiction is low than that of high income families (Watts and Wright, 1990).

According to Piko (2000) who investigated psychological, social strength and perceived parental support may cause drug addiction in adolescence. It is also noted through this study that low perceived social support by father may cause greater risk of all types of addiction as compared to mother and friends perceived support. There is a major role of family in the life of a drug addicts. There are different ways of addiction through which the family is involved. The addict's dependency, response to addiction is closely dependent of the family influence. The treatment of the individual also depends on the family support (Nirmala, 2005). There is a positive effect of social support on self esteem (Esenay, 2002; Kahriman, 2002; Unuvar, 2003). Social support is a most powerful force through which a person can cope the stress in an easy and successful manner (Afsar Dir, 2011).

In the eyes of Hawkins, Catalano and Miller (1992) socio-economic status plays an important role in substance use. Low socio-economic family individuals are more likely to use drugs than that of high status families. According to Blum (1970) a number of high drug addicts gave the response that their parents provide less interest in their health. For a proper and good treatment of drug addicts family plays an important role in recovery. Being an authority in family support allows a good and reasonable parenting father (Isacco, Garfield, Rogers, 2010).

Objective of present study was to estimate the severity level of clinical anger among drug addicts and to find the relationship between perceived social support and clinical anger amongst drug addicts.

1.1 Problem statement

The present research was aimed to study Perceived Social Support and Clinical Anger among those adults who use different kinds of drugs in Southern-Punjab.

1.2 Hypotheses

It was hypothesized that vulnerability due to severe clinical anger would prevail in majority of drug addicts

Secondly, it was predicted that positive perceived social support would cause less clinical anger in drug addicts.

2. Method

2.1 Participants

The sample comprised of 70 (N=70) randomly selected male registered drug addicts (participants) from three representative cities of southern-Punjab (Bahawalpur, Multan and Dera Ghazi Khan) with age range 18 to 65 years. i.e. 13 participants from Nai Umeed Hospital Dera Ghazi Khan are taken, 23 participants from Nai Zindage Hospital Multan are taken and similarly, 34 participants from Bahawal-Victoria Hospital Bahawalpur are taken.

2.2 Inclusions and Exclusions

Only those drug addicts were included in current study that fulfilled the criteria of drug abuse and drug dependence according to DSM IV-TR, 2000. The only male adults are included in the research because the area under investigation had very low rate of registered female addicts. The class of drugs is not specified in the research because of unavailability of the same drug sample.

2.3 Sample size, precision, and power statistics

Number of registered drug addicts was 260, found to inhabit three cities combining. By setting confidence interval at 10, confidence level at 95%, with population being 260 and statistical power level at 80%, priori testing calculated a sample size of 70 registered drug addicts that is the true representative sample for this research.

2.4 Instruments
2.4.1 Multidimensional Scale for Perceived Social Support (MSPSS)

Multidimensional Scale for Perceived Social Support developed by © Zimet, et al., (1988), containing 12 items and scored on seven point likert-scale, range from 1 (very strongly agree) to 7 (very strongly disagree), is used in the study. This scale measured the perception of the participants through judging their surroundings in three areas of society such as family, friends and significant others. To get mean score of the scale, there have been some steps involved like: the sum across Items of subscales: family, friends, and significant others are divided by 4 then their total sum is divided by 12. The internal reliability of the scale was 0.90 (Zimet, et al., 1988). This questionnaire was translated into Urdu by © Jabeen, T. and Khalid, R. (2010) with a reported reliability 0.90.

2.4.2 Clinical Anger Scale (CAS)

Clinical Anger Questionnaire by Snell © (2002) contained 21 questions in which the feelings of the participants are noted about their surroundings. Actually, it is feeling inventory that is developed by the author to measure the clinical anger. It is an objective self-report instrument that is designed to measure the psychological symptoms presumed to have relevance in the understanding and treatment of clinical anger. Subjects were asked to read each of 21 group of statements (4 statement per group) and select the single statement that best described how they felt (items 1, A: stood for, I do not feel angry: stood for, I feel angry, C: stood for, I feel angry most of the time now, and D: stood for, I feel so angry all the time that I can`t stand it). The four statements in each cluster varied in symptom intensity, with more intense clinical anger being associated with statement "D". Each cluster of statement was scored on a 4 point likert scale, with A=0, B=1, C=2, and D=3. Subject`s responses on the CAS were summed so that higher score corresponded to higher to higher clinical anger (21 items ranged 0-63). The internal

consistency of 21 items on the clinical anger scale analyzed and yielded reliability coefficient .95 (male only) and validity statistics was .61 while the test re-test reliability was .78 by the author.

2.5 Procedure

First of all, the researcher got departmental permission letter and submitted the letter to the respective department and got permission from the head of department. When the data collection is started a consent form is signed by the participants and researcher. Participants are given the assurance that information taken from them should be kept confidential. Researcher also explained the method of attempting all items to the participants. Demographic form is filled by the participants in 10 minutes. Break of 10 minutes are given after filling the form. Multidimensional scale for perceived social support filled by the participants that got 15 minutes approximately to complete the MSPSS questionnaire. A break of 10 minutes is taken after completing the MSPSS questionnaire. After wards the clinical anger scale questionnaire is administered within 20 minutes.

2.6 Statistical Analysis of Data

Variables were checked according to normal assumption of distribution of data. Descriptive statistics was used to calculate significant difference of clinical anger among sub-groups, relationship among perceived social support and clinical anger, and different levels of clinical anger by applying Tukey's test, standard deviation, t-test, and regression analysis. Regression analysis was employed by assuming all data to be homoscedastic (variance of error term is constant), the variables were non-autocorrelated, with imperfection in linear correlation.

2.7 Operational Definition of Variables

2.7.1 Perceived Social Support

It is the perception of an individual regarding to the family, friends and whole of the society. Social support may be defined as to attain value, respect, care and love from the society (Gurung, 2006).

2.7.2 Clinical Anger

It is an intense, naturally existing capability of an individual due to disliking action or behavior of surroundings. Anger is the problem that disturbs our emotions in a clinical set up (Lachmund and Digiuseppe, 1997). APA (2007) defines Anger as an emotional situation of an individual that causes negative psychological and biological changes. According to Snell (2002) Clinical anger is a syndrome having number of symptoms with intensity and strengths of various levels.

3. Results

Table 1: Reliability Statistics for the Clinical Anger Scale Questionnaire

Cronbach's Alpha	No. of Items
.912	21

Table-1 provides information that the questionnaire of Clinical Anger Scale contains 21 items and the reliability statistic Cronbach's Alpha value is 0.912 which indicates the

sufficient reliability and validity of the questionnaire which is used for the respective population.

Table 2: Reliability Statistics for the Perceived Social Support Questionnaire

Cronbach's Alpha	No. of Items
.739	12

The concerned questionnaire contains 12 items and the reliability statistic Cronbach's Alpha value is 0.739 which indicates the sufficient reliability and validity of the questionnaire.

Table 3: Descriptive Statistics

Variables	Minimum	Maximum	Mean	Std. Deviation
Anger	0	46	23.47	10.395
Age	18	54	32.21	8.293
Overall Support	37	81	60.21	11.247
Other Support	11	28	22.39	4.391
Family Support	4	28	23.00	4.600
Friends Support	4	28	14.83	8.731

Table-3 shows all the descriptive statistics of all the variables. From the table we can conclude that the average score of anger is 23.47 which are lying in the moderate level of anger. Same as the average age is 32.21 years.

Table 4: Relationship between Perceived Social Support and Clinical Anger

Models	R-Square	Regression Constant	Regression Coefficient	Std. Error	T-Test	P-value
Overall Support	.070	38.236	-0.265	10.096	-2.269	0.026
Family Support	0.081	38.232	-0.284	10.040	-2.443	0017
Friends Support	0.011	25.325	-0.105	10.413	-0.870	0.387
Significant Other Support	0.030	32.653	-0.173	10.312	-1.451	0.151

$P<0.05$

Table-4 shows the relationship between the social support and clinical anger. Regression analysis is used to check the dependence of clinical anger on all types of social supports one by one and their value of R-Square and P-values are observed separately. All the regression coefficients are negative which shows that the relationship between social support and clinical anger is negative i.e. if social support increase then the clinical anger decreased. From the table it could be concluded that dependence of anger on overall support is significant at 5% level of significance and dependence of family support is also

significant but the dependence of friends support and other supports are non-significant at 5% level of significance.

Table 5: Clinical Anger in the Overall Respondents

Anger	Frequency	Percent	Cumulative Percent
Minimal	13	18.6	18.6
Mild	12	17.1	35.7
Moderate	21	30.0	65.7
Severe	24	34.3	100.0
Total	70	100.0	

Table-5 shows the level of anger in the respondents. According to the calculated score, anger is categorized into four levels. The respondents getting score from 0 to 13 are minimal level, from 14 to 19 are mild, from 20 to 28 are moderate and the respondents having score from 29 to 63 are at the severe level of anger. Conclusively, 34.3% people are at severe level, 30% are at moderate, 17.1% respondents are at mild and the remaining 18.9% people are at minimal level of anger.

Table 6: Significant Difference of Clinical Anger among Sub-Groups

Level of Anger	N	Subset for alpha = 0.05			
		1	2	3	4
Minimal (0 to 13)	13	8.62			
Mild (14 to 19)	12		16.08		
Moderate (20 to 28)	21			23.62	
Severe (29 and above)	24				35.08

Table-6 provides results of Tukey's test to check the significance difference among the levels of clinical anger in drug addicts. Since all the subsets/sub-groups contain only one value indicates clear and significant difference among all the levels of clinical anger therefore all drug addicts do not prevail the same level of clinical anger that supports the validity of clinical anger scale because it can describe all the levels of clinical anger in an individual.

4. Conclusions and Discussion

Result analysis shows that major number of drug addicts remain in severe and moderate level of clinical anger. Twenty four participants' responses are at severe level and their cumulative percent in the result is (100%). That provides a strong ground for the severity of clinical anger in drug addict. Whereas minimum number of participant responses are at mild level. It provides an idea for the drug addicts that usually their personality remains at both ends such as very high or very low. As a reaction to clinical anger a number of

drug addicts commit suicide due to drug addiction as reported in the research of Kaplon and Sadock (2006). According to Piko (2000) psychological, social strength and perceived parental support may cause drug addiction in adolescence. Negative relationship among perceived social support and clinical anger is stronger in family related responses than that of responses to the items of friends and significant others. For healthy development in different areas (social and psychological) of life it is necessary for an individual to attain social support from family and friends (Oswald and Suss, 1994).This study has also investigated the positive perceived social support with family and friends exhibit less clinical anger that is supported by a research. According to Blum (1970) a number of high drug addicts gave the response that their parents provide less interest in their health.

Role of family brings significant influence in the life of drug addict; there is inverse relation between perceived social support and clinical anger (Nirmala, 2005). Similarly, Snell (2002) point out family environment is compared with the level of clinical anger. The results of the research show a strong inverse correlation between clinical anger and family environment such that, clinical anger decreases with increase of positive relations with family. A significant dependency is found in clinical anger and perceived social support that provides a strong a support to the research hypothesis. Tukey's test was applied to represent the significant difference among various levels of clinical anger that shows level of severity in majority of drug addict as compared to other levels (minimal, mild, moderate). A study also supports the same concept such as, Murdoch, Phil and Ross (1990) say in a research that 62% of criminals commit the violent crime after alcohol use. A number of drug addicts commit violent crimes as reported in the study of Eronen, Hakola, and Tiihonen (1996) that are usually caused by clinical anger.

Different types of anger as stated in the research of Spielberger (1999), have various types of psychologically interpersonal and intrapersonal characteristics that is why minimal, mild, moderate and severe levels of clinical anger are introduced in the scale that has properly differentiated the responses of addicts to the society as discussed in table 1. Uncontrollable clinical anger that is of severe level causes various internal disturbances such as depression, suicidal ideation, drug addiction, hostility, and serious violent crimes as supported by Golden (2003). Usually addicts have various types of behaviors regarding to society, due to clinical anger, depends upon the level of anger that effect social and psychological responses as mentioned by Puskar and Bernardo (2007).

Conclusively, addicts receive more negative perceived social support from others than friends and family. Similarly, drug addicts have more positive perceived social support from family than friends. The reason behind is, they are being rejected by the society due to drug addiction. Addicts have positive attitude towards their friends and family because both support them in a good way, while, those friends who never respond positively to addicts; they may be the cause for their drug usage. Negative perception and rejection leads towards severe clinical anger that may be the root cause of disordered mental health of drug addicts.

4.1 Future Study Directions

Antisocial and borderline personality features must be checked in future researches because usually drug addiction exists in these two types of personalities. The sample of

the study must be divided according to the types of drugs in order to get the extensive results.

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