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Let's Start!

Coping Strategies and Quality of life in Drug Addicts

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Coping Strategies and Quality of life in Drug Addicts

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Abstract

Substance abuse has disastrous effects on human lives. Quality of life depends upon the coping strategies in the patients of substance use disorder. If the coping strategies are higher than quality of life in drug addicts are higher. So the drug addicts of big cities may be able to use more coping strategies to deal with their addiction as compare to those addicts who live in small cities. The level of coping strategies is high among drug addicts of big cities because they can avail more opportunities to deal with their addiction by approaching addiction centres, NGOs, professionals and experts, hospitals etc. This article explores the significant positive relationship between coping strategies and quality of life. Further to examine the impact of coping strategies on quality of life in drug addicts. The sample of 60 male drug addicts was selected from Sahiwal and Lahore. Participant's age range was 25-44 years. In this research, non non-probability purposive convenient sampling technique was used for the selection of research sample. Correlation research design was used in this study. Finding highlightst a significant positive relationship was present between coping strategies and quality of life in drug addicts. Moreover, drug addicts of Lahore have high level of coping strategies than the drug addicts of Sahiwal. Additionally, drug addicts of Lahore also have high level of quality of life than drug addicts of Sahiwal. It was concluded that there was a significant relationship between coping strategies and quality of life in drug addicts. And a significant difference regarding coping strategies and quality of life was present in drug addicts of Lahore and Sahiwal

Key words:. Addiction, Drug addiction, Quality of life, Coping strategies.

INTRODUCTION

DRUG ADDICTION

Addiction is a lot like other diseases, such as heart disease. Addiction have serious and dangerous effects and disturb the normal, healthy functioning of an organ in body, both are in many cases preventable and treatable. They may lead to death and can last a lifetime if left untreated. Addiction is a psychological and physical inability to stop consuming a chemical, drug, activity, or substance, even though it is causing psychological and physical harm. A person

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who cannot stop taking a particular drug or chemical has substance dependence (Morse & Flavin, 1992).

Drug addiction is a complex and unremitting brain disease. People who have a drug addiction experience compulsive, sometimes unmanageable, desire for their drug of choice. Drug addiction is a complex and chronic brain disease. People who have a drug addiction experience compulsive, sometimes uncontrollable, craving for their drug of choice. Typically, they will extremely negative consequences as a result of using drug. (American Society for Addiction Medicine, 2012). Drug addiction is a complex neurobiological disease that requires integrated treatment of the mind, body, and spirit. It is considered a brain disease because drugs change the brain, they change its structure and how it works. Without treatment, these brain changes can be long-lasting. Addiction is chronic, it is progressive, and if left untreated, it can be fatal.

Individuals struggling with drug addiction often feel as though they cannot function normally without their drug of choice. This can lead to a wide range of issues that impact professional goals, personal relationships, and overall health. Over time, these serious side effects can be progressive, and if left untreated, fatal. (Volkow et al., 2007).

CHARACTERISTICS OF ADDICTION

According to the American Society of Addiction Medicine (ASAM), addiction is characterize by failure of desire for substance or pleasing experience, devastation in behavior control, continually give up from substance, diminished gratitude of significant problem with your behavior and interpersonal relationship. Inability to consistently abstain from the substance or rewarding experience (as in gambling, sex, or overeating) ,Impairment in behavioral control ,Craving for the substance or rewarding experience ,Diminished recognition of significant problems with your behavior and interpersonal relationships ,A dysfunctional emotional response. Although the above five characteristics are usually present in most cases of addiction, ASAM noted that these five features cannot be used to diagnose addiction (Henden, 2017).

COMMONLY USED ILLEGAL DRUGS

Drugs are classified in a number of ways. Many are potentially addictive and harmful. Examples of illegal drugs include: Heroin, Cocaine or crack cocaine, Methamphetamine, Bath Salts, Methadone, Ecstasy, Marijuana, LSD, Mushrooms, and PCP *(*Salamone, 1992*).*

COMMONLY USED PRESCRIPTION DRUGS

Prescription drugs which can be obtained legally are also used by all age groups for non-medical reasons, often in combination with alcohol. The risks of drug interaction or accidental overdose can be deadly. Commonly used and misused prescription drugs include: Opioid painkillers, Benzodiazepines, Stimulants, such as those used to treat ADHD, Antidepressants, Anti-obsessive agents, Mood stabilizers (Rang, 2003).

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WARNING SIGNS OF DRUG ADDICTION

The warning signs of alcohol abuse or misuse are very clear/ visible, sometimes. Other times, they can take longer to exterior. The chance for a successful recovery increases extensively, when drug addiction is discovered in early stages.

Common signs of drug addiction include: Loss of control, Continued problems despite negative consequences, Spending less time on activities that used to be important, such as hanging out with family and friends, exercising, or pursuing hobbies or other interests, Drop in attendance and performance at work or school, Taking serious risks in order to obtain one's drug of choice, Acting out in personal relationships, particularly if someone is attempting to address their substance problems, Going out of one's way to hide the amount of drugs taken, Serious changes or deterioration in hygiene or physical appearance, Needing to use more and more of the drug in order to produce the same effect, Withdrawal symptoms such as shakiness, trembling, sweating, nausea or fatigue (Tiffany & Wray, 2012).

DRUG ADDICTION CAN RESULT IN OVERDOSE

Any drug overdose can be either accidental or intentional. The leading causes of death for Americans under than 50 are drug overdoses. Accidental overdose be inclined to happen when people take more of prescription medication than originally planned to achieve certain results, and trying to get a better high results when they use too much of an illegal drug. Intentional overdoses are usually a result of someone trying to commit suicide. Regardless of the intent, any loss of life due to an overdose is tragic and any overdose can have severe and lasting repercussions (Angres & Bettinardi, 2008).

AFFECTS OF DRUG ADDICTION IN BODY

To one side, there are many undesirable / bad medical effects of drug addiction. These include: Cardiovascular disease, Contraction of HIV, hepatitis and other illnesses, Heart rate irregularities, heart attack, Respiratory problems such as lung cancer, emphysema, and breathing problems, Abdominal pain, vomiting, constipation, diarrhea, Kidney and liver damage, Seizures, stroke, brain damage, changes in appetite, body temperature, and sleeping patterns, Stroke, Pancreatitis, Gastrointestinal problems, Malnutrition, Insomnia and sleep disorders (Volkow, Koob & McLellan, 2016).

CO-MORBIDITIES OF DRUG ADDICTION

Drug addiction is referred as a co occurring disorder as the coexistence of both a mental illness and a substance use condition. Co-occurring disorders may include any combination of two or more substance use disorders and mental disorders identified in the (DSM-5, 2013).

People with a mental health issue are more likely to experience a substance use disorder than those not affected by a mental illness. According to SAMHSA's 2012 National Survey on Drug Use and Health (NSDUH), approximately 8.4 million adults in the United States have a co-occurring disorder. No specific combinations of substance use disorders and mental disorders are defined uniquely as co-occurring disorders. Some of the most common mental disorders seen in MAT patients with co-occurring substance use include: Anxiety and mood

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disorders, Schizophrenia, Bipolar disorder, Major depressive disorder, Conduct disorders, Post-traumatic stress disorder, and Attention deficit hyperactivity disorder (NSDUH, 2012).

COPING BEHAVIOR

In psychology, coping strategies is the method of organizing tough situation, expanding effort to solve personal and interpersonal problems and looking for master, minimize, diminish or bear stress or conflict. In coping with stress, people tend to use one of the three main coping strategies: either appraisal focused, problem focused, or emotion focused coping (Weiten & Lloyd, 2009).

Appraisal-focused strategies occur when the person modifies the way they think, for example: employing denial, or distancing oneself from the problem. People may alter the way they think about a problem by altering their goals and values, such as by seeing the humor in a situation. People using problem focused strategies try to deal with the cause of their problem. They do this by finding out information on the disease, learning new skills to manage their disease and rearranging their lives around the disease (Sincero, 2012).

PROBLEM-FOCUSED COPING

People using problem focused strategies try to deal with the cause of their problem. They do this by finding out information on the disease, learning new skills to manage their disease and rearranging their lives around the disease. Problem focused strategies aim to remove or reduce the cause of the stressor, including; problem solving, time management, obtaining instrumental social report (Lazarus & Folkman, 1984).

EMOTION-FOCUSED COPING

Emotion focused strategies occur when the person modifies the way they think, for example: employing denial, or distancing oneself from the problem. People may alter the way they think about a problem by altering their goals and values, such as by seeing the humor in a situation (Lazarus & Folkman, 1984).

MEANING-BASED COPING

The people with AIDS suffers, spinal cord injuries etc has reported high level of depression and also experience high level of positive emotion which enabled them to cope. And coping mechanism will change over time, and may use a mixture of these different types of coping. All these methods can prove useful, but some claim that those using problem focused coping strategies will adjust better to life. Men often prefer problem focused coping, whereas women can often tend towards an emotion focused response. Problem focused coping mechanisms may allow an individual greater perceived control over their problem, while emotion focused coping may more often lead to a reduction in perceived control. Certain individuals therefore feel that problem focused mechanisms represent a more effective means of coping. An individual can cope with a taxing situation by either approaching the source of the conflict by addressing it directly, or AVOIDING the problem (for example repression, denial, ignoring) (Folkman & Moskovitz, 2000).

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COPING STRATEGIES

Coping strategies refer to the specific efforts, both behavioral and psychological, that people use to master, bearable, decrease or minimize stressful events. Two coping strategies have been well known as problem solving and emotion focused coping strategies. Problem-solving strategies are efforts to do something active to alleviate stressful circumstances, whereas emotion-focused coping strategies involve efforts to regulate the emotional consequences of stressful or potentially stressful events. Research indicates that people use both types of strategies to combat most stressful events (Folkman & Lazarus, 1980)

EMOTION-FOCUSED COPING

The negative emotional responses connected with stress such as embarrassment, fear, anxiety, depression, excitement and frustration, so emotion focused coping involves trying to reduce. This may be only reasonable selection when the source of stress is outside the person's control. Drug therapy can be seen as emotion focused coping as it focuses on the arousal caused by stress not the problem. Other emotion focused coping techniques include: Distraction, e.g. keeping yourself busy to take your mind off the issue, Emotional disclosure. This involves expressing strong emotions by talking or writing about negative events which precipitated those emotions (Pennebaker, 1995) this is an important part of psychotherapy, praying for guidance and strength, Meditation, e.g. mindfulness, Eating more, e.g. comfort food, Drinking alcohol, Using drugs, Journaling, e.g. writing a gratitude diary (Cheng, Tsui, & Lam, 2015), Cognitive reappraisal. This is a form of cognitive change that involves construing a potentially emotion-eliciting situation in a way that changes its emotional impact (Lazarus & Alfert, 1964), suppressing (stopping/inhibition of) negative thoughts or emotions. Suppressing emotions over an extended period of time compromises immune competence and leads to poor physical health (Petrie, Booth & Pennebaker, 1988).

PROBLEM-FOCUSED COPING

Problem-focused coping targets the causes of stress in practical ways which deals the problem or stressful situation that is causing stress, as a result directly reduction in stress. Problem focused strategies aim to eliminate and get rid of the stressor, including, Problem-solving, Time-management, Obtaining instrumental social support (Lazarus & Folkman, 1984).

COPING THEORIES

Lazarus and Folkman (1984), one of the pioneers of the coping theory. The coping theory is a vast area of study that is classified into two independent parameters: (a) Focus-oriented theories (trait and state). (b) Approach-oriented theories (micro-analytic and macro-analytic). The focus-oriented state and trait theories of coping recognize a person's internal resources and mental capacities for evaluating how well he can adapt to a situation. On the other hand, the approach-oriented micro and macro analytic coping theories revolve around how concrete or abstract the coping mechanisms are (Carver, 1997).

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FOCUS-ORIENTED THEORIES TRAIT AND STATE

REPRESSION-SENSITIZATION

This theory explains that coping happens along a bipolar dimension with repression at one end and sensitization at the other. People who cope by repression tend to deny or ignore the presence of a stressor to minimize its effect. On the flip side, sensitizers tend to react with extreme thoughts, worrying, and obsessive impulses to cope with the sudden encounter (Miller & Mangan, 1983).

MONITORING AND BLUNTING THEORY

This theory explains that one can reduce the impact of a stressful stimulus by using his cognitive processes. Blunting mechanisms such as denial, restructuring, and distraction help overlook temporary stressors. Monitoring strategies, including information processing and emotional management, are more helpful for dealing with ongoing negative stress and anxieties. (Miller & Mangan, 1983).

MODEL OF COPING MODES (MCM)

This theory is an extension of the monitoring-blunting model and has some connections to the repression-sensitization theory. It expands on the concept of cognitive avoidance and suggests that we are naturally inclined to avoid a stressful situation and perceive it as ambiguous (Krohne, 1993).

QUALITY OF LIFE

Quality of life is an important term for the quality of various domains in life. The expectation of an individual or society for a good life is call standard level. These expectations are guided by the values, goals, and socio-cultural context in which an individual lives. Quality of life (QOL) is an overarching term for the quality of the various domains in life. The extent, to which one's own life coincides with this desired standard level, put differently, the degree to which these domains give satisfaction and as such contribute to one's subjective well-being, is called life satisfaction (Barcaccia & Barbara , 2013).

Broadly speaking, there are two types of social indicators to be used to measure and monitor the quality of life, objective social indicators and subjective social indicators, which are referring to objective and subjective quality of life components. Though it can be debated where the borderline between the two actually is exactly located, objective indicators are measures informing about a factual situation (e.g., the size of the house someone lives in), whereas subjective indicators are about an evaluation of that situation (Allardt, 1993).

MASLOW'S THEORY OF QUALITY OF LIFE

In 1962, Abraham Maslow published his book Towards a Psychology of Being, and established a theory of quality of life, which still is considered a consistent theory of quality of life. Maslow based his theory for development towards happiness and true being on the concept of human needs. He described his approach as an existentialistic psychology of self-actualization, based on personal growth. When we take more responsibility for our own life, we take more of the good qualities that we have into use, and we become freer, powerful, happy, and healthy (Bandura, 1994).

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In modern medicine the Maslow's concept of self actualization can play an important role. In spite of best biochemical treatment, as most chronic disease often do not disappear. It may be that the real change our patients have for betterment understands and living the noble path of personal development. The hidden potential for improving life really lies in helping the patient to acknowledge that his or her lust for life, his or her needs, and his or her wish to contribute, is really deep down in human existence one and the same. But you will only find this hidden meaning of life if you scrutinize your own life and existence closely enough, to come to know your innermost self (Bennett & Richard, 1991).

AN INTEGRATIVE THEORY OF QUALITY OF LIFE

Quality of life (QOL) means a good life and we consider that a good life as living with a high quality. This paper presents the theoretical and philosophical framework of the Danish Quality of Life Survey, and of the SEQOL, QOL5, and QOL1 questionnaires. The notion of a good life can be observed from subjective to the objective, where this spectrum incorporates a number of existing quality of life theories. We call this spectrum the integrative quality-of-life (IQOL) theory and discuss the following aspects in this paper: well being, satisfaction with life, happiness, meaning in life, the biological information system ("balance"), realizing life potential, fulfillment of needs, and objective factors. The philosophy of life outlined in this paper tries to measure the global quality of life with questions derived from the integrative theory of the quality of life. The IQOL theory is an overall theory or meta-theory encompassing eight more factual theories in a subjective-existential-objective spectrum. Other philosophies of life can stress other aspects of life, but by this notion of introducing such an existential depth into the health and social sciences, we believe to have taken a necessary step towards a new humility and respect for the richness and complexity of life (Ventegodt et al., 2003).

STATEMENT OF PROBLEM

This research was proposed to investigate the relationship between coping strategies and quality of life in drug addicts. Additionally to check out the impact of coping strategies on quality of life in drug addicts. The purpose of this study was to check the how coping strategies effects the quality of life of the patients of drugs. According to the most recent study conducted by the National Center on Addiction and Substance Abuse at Columbia University, 85 percent of inmates have been substance involved and 65 percent have met the medical criteria for alcohol or other drug abuse and addiction in the United States. Despite the overwhelming prevalence of substance abuse among inmates, and compelling evidence that addiction is a treatable brain disease, most do not participate in residential treatment programs. Further Substance abuse is one of the most serious problems in Indonesia and is highly prevalent among adolescents. Therefore, psychotherapy is needed in preventing substance abuse for adolescents. This study aims to analyze the influence of coping skills training and family health education on self-esteem in adolescents, because low economic countries need high coping strategies that improve quality of life.

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SIGNIFICANCE OF THE STUDY

The present study was conducted to examine the effects of coping strategies on quality of life among the drug addicts. It was intended to test the level of coping strategies and quality of life among the patients of drug addiction. The purpose was to check the how coping strategies effects the quality of life of the patients of drugs. Current study will add information about coping strategies and quality of life among drug addicts in Pakistan culture. Specific recommendations and counseling strategies would be developed specifically to developed proper coping strategies as well as enhance quality of life in patients with drug addiction.

RESEARCH OBJECTIVES

- To find out relationship of coping strategies and quality of life in drug addicts.
- To find out the impact of coping strategies on quality of life among drug addicts.
- To find the quality of life among patients of drug addiction of Lahore and Sahiwal.

HYPOTHESES

1. There would be a relationship between coping strategies and quality of life in drug addicts.
2. There would be high level of coping strategies in drug addicts of Lahore than the drug addicts of Sahiwal.
3. There would be better quality of life in drug addicts of Lahore than drug addicts of Sahiwal.

DEFINITION OF KEY TERMS

ADDICTION

Addiction is a psychological and physical inability to stop consuming a chemical, drug, activity, or substance, even though it is causing psychological and physical harm (Enoch & Goldman, 2001).

DRUG ADDICTION

Drug addiction, also called substance use disorder, is a disease that affects a person's brain and behavior and leads to an inability to control the use of a legal or illegal drug or medication. Substances such as alcohol, marijuana and nicotine also are considered drugs. When you're addicted, you may continue using the drug despite the harm it causes (Aceto, et al., 1996).

COPING STRATEGIES

Coping is defined as the thoughts and behaviors mobilized to manage the internal and external stressful situations. It is a term used distinctively for conscious and voluntary mobilization of acts, different from 'defense mechanisms' that are subconscious or unconscious adaptive responses, both of which aim to reduce or tolerate stress (Coppens, et al., 2010).

QUALITY OF LIFE

The standard of health, comfort, and happiness experienced by an individual or group. The things that are needed for a good quality of life (Oliver et al., 2010).

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RESEARCH FRAME WORK

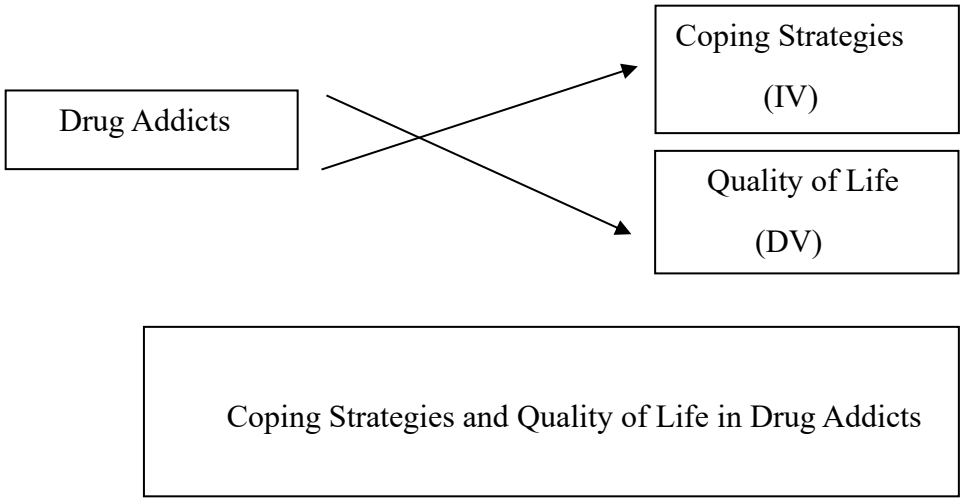

FIGURE 1:

Theoretical frame work of the study of coping strategies and quality of life in drug addicts showed that coping strategies is independent variable which predict the dependent variable that is quality of life.

MATERIALS AND METHOD

PARTICIPANT CHARACTERISTICS

Research participants were with the age range of 25-44 years as well as with the education status as metric, intermediate, bachelor and masters. They have with the family income from 5000 to above 100,000.

INCLUSION CRITERIA

- Only diagnosed patients with any kind of drug addiction were added in this research.
- Drug addicts with the duration of admission of 1 year were the part of this study.
- Drugs addicts with the age range of 25-44 years were included.
- Patients with the education of at least metric were included.
- Only males were included in current research.

EXCLUSION CRITERIA

- Patients with the duration of admission of less than 1 year were excluded.
- Drug addicts with the education of less than metric were not included.
- Female drug addicts were not the part of this study.

SAMPLE SIZE

This researched was conducted on 60 drug addicts (males) including 30 addicts from Sahiwal city and 30 addicts from Lahore city.

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RESEARCH DESIGN

The current study was carried out to find out effect of coping behavior on quality of life among the patients of drug addiction. Co relational research design and purposive sampling were used in this study.

SAMPLING TECHNIQUE

Non probability, purposive sampling technique was used in present research.

MEASUREMENTS/ INSTRUMENTS

DEMOGRAPHIC FORM

Demographic form was self structured form. Demographic form was formulated to obtain some basic information about participants of current study. Items of demographic form included age, gender, education, family income, city and duration of admission in hospital.

WHOQOL-BREF (WHO, 1998)

It has total 26 items which measures the following domains including physical health, psychological health, social relationship, and environment. The WHOQOL- BREF (WHO, 1998) is shorter version of the original instrument. This questionnaire has also 5 points rating scale as not at all =1, a little =2, moderately=3, mostly=4 and completely= 5. The values for Cronbach's alpha reliability were acceptable (>0.7) for domains 1, 2 and 4 i.e. physical health Q3, Q4, Q10, Q15, Q16, Q17, Q18 (a=0.82), psychological Q5, Q6, Q7, Q11, Q19, Q26 (a=0.81), environment Q8, Q9, Q12, 13, Q14, Q23, Q24, Q25(a=0.80) but marginal for the domain of social relationships Q20, Q21, Q22(a=0.68). This scale has high discriminant validity, content validity and test-retest reliability.

BRIEF COPE SCALE (CARVER, 1997)

The Brief Cope is a short version of the Cope scale which was developed by Carver. (1997) to assess the different ways in which people respond to stress as coping strategies. The Brief COPE consists of 28 items with fourteen subscales. Each item is rated on a 4 points Like t- type scale that ranges from 1(I haven't been doing this at all) to 4(I have been doing this a lot) rated with no reversal scoring. The responses are then summed up for assessing coping scores (Carver, 1997).

PROCEDURE

Current study investigated the relationship between coppicing strategies and quality of life among diagnosed patients with drug addiction. First of all for the collection of data, permission was taken from head of hospitals of Lahore and Sahiwal city as Lahore General Hospital and Haji Abdul Qayyum Hospital Sahiwal After getting permission drug addicts were taken by using purposive sampling. Then participants have to fill consent form and informed them the purpose of present study. Demographic information was taken by using demographic form. After that Urdu version of WHO Quality of Life-BREF and Brief Cope Scale were filled by the participants for this study with 15 to 20 minutes. After collecting data, analyses were done on the scores of participants by using SPSS 21st version.

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ANALYSIS PLAN

For the purpose of analyzing the data, (SPSS) statistical package for the social science is suitable to use in statistical examination procedure of the composed information. Statistical Package for the Social Sciences (SPSS) Quinter, (2013) a setup that is statistical package for the social sciences is a common use for analysis. The software is now accepted in the other areas of research as well, counting the sciences and advertising. Software is generally used in program for analysis in social sciences. In the advertisement of the package is in researchers, health, Survey Company, management, learning researches, organizations and other areas (Nuggets, 2013). Nie, (1970) SPSS manual explains "sociology's most important books" for statistical examination. Norman, (1968) developed the first description of this software released as spss.

ETHICS

There were a number of ethical principles that used in current research. First of all informed consent was taken by research participants and assure them confidentiality regarding their information. After that debrief participants about the purpose of current study. Further maximization of benefits was also under consideration as well as minimization of risks regarding participants. There was also a right to every research participant to withdraw from research at any step.

RESULT

INTRODUCTION

The aim of current study was to find out the relationship of coping strategies and quality of life in drug addicts. This chapter of current study highlighted the results of main study. In current research two scales were used for data collection that included Brief COPE Scale (Carver, 1997) to measure coping strategies and World Health Organization Quality of Life-BREF (1998) to measure quality of life in drugs addicts. Further, demographics characteristics of participants and hypotheses testing were included in this chapter. Following statistical analyses were used to test hypotheses as correlation and independent sample t-test. The results have shown in tables below.

DESCRIPTIVE STATISTICS

TABLE 1: FREQUENCIES, PERCENTAGES, MEAN & STANDARD DEVIATION OF DEMOGRAPHIC VARIABLES (N=60)

Demographic Variables	M (SD)	*F*	%
Age	1.95 (.96)		
23-29		24	40.0
30-34		20	33.3
35-39		11	18.3
40-45		5	8.3
Gender	1.00 (.00)		
Male		60	100.0
Education	2.61 (.82)		

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Matriculation		6	10.0
Intermediate		18	30.0
Bachelor		29	48.3
Masters		7	11.7
Marital status	1.40 (.49)		
Married		36	60.0
Unmarried		24	40.0
No. of Children	1.25 (1.34)		
0		25	41.7
1		13	21.7
2		9	15.0
3		8	13.3
4		5	8.3
Family income	2.90 (.68)		
5000-20,000		1	1.7
21,000-50,000		14	23.3
51,000-80,000		35	58.3
81,000-above1,00000		10	16.7

***Note. f* = Frequency, % = Percentage**

The table above showed the mean, standard deviation, frequencies and percentages of demographic variables of participants. It was shown that the mean age of participants was (*M* = 1.95, *SD* = .96) and age ranges of 25-29, 30-34, 35-39 and 40-45 with the frequency of (*f* = 24, *f* = 20, *f* = 11, *f* = 5 respectively). Further, mean of education was (*M* = 2.61, *SD* = .82) with the frequency of metric participants was (*f* = 6), frequency of intermediate participants was (*f* = 18), frequency of bachelor participants was (f =29) and frequency of masters participants was (*f* = 7). Furthermore the frequency of married participants was (*f* = 36) and unmarried participants was (*f* =24) with the mean (*M* = 1.40, *SD* = .49). Moreover, the ranges of family income of participants were 5000-20,000, 21,000-50,000, 51,000- 80,000 and 81,000-above 100,000 have frequencies (*f* = 1, *f* = 14, *f* = 35, *f* = 10 respectively) with the mean (*M* = 2.90, *SD* = .68). Moreover frequencies of no. of children were (*f* =25, *f* =13, *f* =9, *f* =8, *f* =5 respectively).

HYPOTHESES TESTING

TABLE: 2CORRELATION BETWEEN BRIEF COPING STRATEGIES & QUALITY OF LIFE IN DRUG ADDICTS

Scales		BCS	WHOQOL-BREF
BCS	-		.55**
WHOQOL-BREF		-	-
M		51.48	72.56
SD		9.50	25.81

***Note.* BCS= Brief COPE Scale; WHOQOL-BREF= WHO Quality Of Life-BREF**

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**$p < .001$

Correlation was conducted to see the relationship between coping strategies and quality of life in drug addicts. Results indicated that significant positive relationship was present between coping strategies (M = 51.48, SD = 9.50) and quality of life (M = 72.56, SD = 25.81), r =.55**, p = .000 that means when the level of coping strategies increases then the level of quality of life also increases in drug addicts.

TABLE 3: MEANS, STANDARD DEVIATIONS, T-VALUE AND P VALUE OF BRIEF COPING STRATEGIES IN DRUG ADDICTS OF SAHIWAL & LAHORE (N=60)

	Sahiwal (n=30)		Lahore (n=30)				95% CI		Cohen's *d*
	M	SD	M	SD	T	P	LL	UL	
BCS	45.10	6.04	57.86	7.92	-7.01	.00	-16.41	-9.12	1.81

***$p < .001$, df =58

Independent sample t-test was conducted to see the difference of coping strategies in drug addicts of Sahiwal and Lahore city. Results indicated that a significant difference was present; t (58) = -7.01, p =.000, d = 1.81, that means drug addicts of Lahore have high level of coping strategies than the drug addicts of Sahiwal.

TABLE 4: MEANS, STANDARD DEVIATIONS, T-VALUE AND P VALUE OF QUALITY OF LIFE IN DRUG ADDICTS OF SAHIWAL & LAHORE (N=60)

	Sahiwal (n=30)		Lahore (n=30)				95% CI		Cohen's *d*
	M	SD	M	SD	T	P	LL	UL	
QOL	52.80	9.76	92.33	21.25	-9.25	.00	-48.08	-30.98	2.39

***$p < 0.001$, df =58

Independent sample t-test was conducted to see the difference of quality of life among drug addicts of Sahiwal and Lahore. Results indicated that a significant difference was present; t (58) = -9.25, p =.000, d = 2.39, that means drug addicts of Lahore have high level of quality of life than drug addicts of Sahiwal.

DISCUSSION

INTRODUCTION

This research was intended to investigate the relationship between coping strategies and quality of life in drug addicts. Further to check out the impact of coping strategies on quality of life in drug addicts. Demographic form was designed to collect information from participants. Brief COPE Strategies (Charles S.Carver, 1997) and WHO Quality of Life-BREF (1998) were used to collect data. Further informed consent was also used and confidentiality was assuring to the research participants.

It was hypothesized that there was a significant relationship between coping strategies and quality of life in drug addicts. Results of current study indicated that there was a significant

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relationship was present between variables and hypothesis was accepted. As significant positive relation relationship was present between coping strategies and quality of life in drug addicts of Sahiwal and Lahore. These findings were supported by previous research of Bavojdan, Towhidi and Rahmati (2015) as there was a significant positive relation was found between emotion-oriented coping strategy and mental health in drug addicts. However, people who employ emotion-oriented coping strategy instead of problem-oriented strategy, they try to control the emotional consequences of the problem and are more influenced by their emotions. Ultimately coping strategies affect the mental health and quality of life in a positive way among drug addicts.

Further in current study the focus was to find out the difference of coping strategies in drug addicts of Lahore and Sahiwal. It was hypothesized that there would be high level of coping strategies in drug addicts of Lahore than the drug addicts of Sahiwal. This hypothesis was accepted as drug addicts of big cities may be able to use more coping strategies to deal with their addiction as compare to those addicts who lives in small cities. The level of coping strategies is high among drug addicts of big cities because they can avail more opportunities to deal with their addiction by approaching addiction centres, NGOs, professionals and experts, hospitals etc. this finding of current research was supported by literature as Lewayne et al. (2009) conducted a research to find out level of skills enhancement to prevent substance abuse among American Indian adolescents. It was find out that addicts who belonged to developed and large communities have better knowledge of drug effects and better interpersonal skills for managing pressures to use drugs. Subjects were also less likely to label or consider themselves as users of these substances.

Another hypothesis of current study declared that there was a difference in drug addicts of Lahore and Sahiwal regarding quality of life. Results indicated that there was a significant difference was present; that shows drug addicts of Lahore have high level of quality of life than drug addicts of Sahiwal. Because drug addicts of big cities have better coping strategies as compared to small cities that's why quality of life is also high in drug addicts of big cities. Additionally, these findings were also supported by previous study that was concluded that mental disorders were one of the leading contributors to the global burden of disease in both high and low income countries. But common issues such as depression, anxiety and suicidal thoughts in drug addicts belonged to low income countries were high. Drug addicts who came from small areas of Delhi, revealed an impoverished, vulnerable and isolated population whose lives were shaped by a significant level of psychosocial distress. The prevalence of depressive and anxiety symptoms among this population of men who inject drugs in Delhi was very high and suicidal thoughts and acts were disconcertingly common. That's why the level of quality of life was low in individuals of small cities of India as compared to large and developed cities (Armstrong et al., 2002).

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DECLARATION OF INTEREST STATEMENT

It is hereby solemnly declared that the ADCP thesis entitled

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'Coping Strategies and Quality of life in Drug Addicts" has been done by me and not has been presented by anyone of his/her partial fulfillment of any degree etc. it is further declared there is no plagiarism in my research work. (Nargis Parveen)

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