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THE EFFECTIVENESS OF GROUP WELL-BEING THERAPY ON DEPRESSION, ANXIETY AND STRESS (DASS) INDICES IN MEN AND WOMEN DEPENDENT TO METHAMPHETAMINE

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The present study aimed to examine the effectiveness of group well-being therapy on depression, anxiety and stress indices in men and women dependent to methamphetamine. The present study was quasi-experimental with pre-test, post-test, follow-up, experimental group and control group. 40 men and women eligible for the study were selected randomly among the patients dependent to drug who referred to Addiction Clinics specialized for stimulant drugs and were assigned into experimental(10 men and 10 women) and control (10 men and 10 women) groups. First, all participants completed DASS-21 Scale and were interviewed using the Structured Clinical Interview. Participants of experimental group received Rayf's group well-being therapy for twelve 50-minute sessions weekly. They were also evaluated using the mentioned questionnaire in pre-test, post-test and follow-up. Data were analyzed using multivariate covariance analysis (MONCOVA). Findings showed well-being therapy has a significant effect on improving anxiety and stress. The findings indicate that group well-being therapy was effective in improving anxiety and stress indices in patients dependent to stimulant drugs but it had no significant effect on depression index in methamphetamine users. Although, the effect on anxiety and stress was not stable in follow-up. The results of the present study can be beneficial in the

assessment, planning therapeutic interventions and the prospects for future researches on methamphetamine users.

Key words: Well-being therapy, Addiction group-therapy, Depression, Anxiety, Stress, DASS scale, Methamphetamine

INTRODUCTION

Addiction is a disease with progressive nature which seriously reduces the health, safety and economy of the nations around the world (Caetano and Cunradi, 2002). It endangers the individuals' health, family and society in all aspects (Moal and kooh, 2007), its dimensions are added day to day (Hyman and Malenka, 2001) and its unpleasant consequences are of the most important problems of the public health in the world (Daley and Marlatt, 1992). 8 individuals die because of addiction every day in Iran (Legal Medicine Organization, 2013). Continuity of drug abuse causes disruption in the family, workplace and broadly in the society (Leshner, 1999). According to a study, 26.5 % of the divorce is related to the consuming alcohol or drug(Tavasoli and Ghiasi, 2011) and more than half of the incoming prisoners are drug users (Farnia, Ebrahimi, Shams and Zamani, 2010). The amount of methamphetamine use in the years 2005-2008 had an increase of 150 times (Radfar and Rawson, 2014). The growing amount of addiction in the world including Iran, has made the field of addiction one of the priorities of the research communities and brought about great interest to the treatment of addiction as a solution to health and social problems related to them (McLellan, McKay, Forman, Cacciola and Kemp, 2005). Thus, in the present time treating these patients is of great importance (Curran, Byrappa and McBride, 2004). Many researchers have approved the necessity of considering the psychological interventions in order to improve the quality of life in drug abusers (Lash, Wang, Greene, Gadegbeku, Hall and Jones, 2006). The results of the studies conducted on the process of using simulant drugs in Tehran showed the increasing growth of consuming methamphetamine (Taheri Nokhost, Jafari and Gilanipour, 2012). This drug is highly addictive so that the continuous use and its devastating effects over time, leads to a wide range of behavioral, psychological, social and physiological malfeasances (Pates and Riley, 2010). Although various treatments have emerged in this field in recent years, still some patients fail in these medical treatment programs, drug abuse is continuous and the rate of recurrence is high (Adrian, 2001).

Despite the effectiveness of outpatient treatment (including matrix) in the treatment of these patients, still these patients are considered as a high risk group with high probability of treatment failure and this issue is still the main challenge of clinical therapists (Makri, 2011). Investigations show that, in general, about 50 to 60 percent of the patients, during 6 months after finishing the treatment and 80 percent of the patients, one year after finishing the treatment, start abusing the drug again (McLellan, McKay, Forman, Cacciola and Kemp, 2005). Anxiety and depression are of the important psychological components in this area. Results of some studies have shown that psychological disorders are seen more in drug abusers compared to healthy individuals and these disorders are mainly including anxiety and depression (Friedman, Schwartz, Schnall, Landsbergis, Pieper and Gerin, 2001). McCuller, Sussman, Dent and Teran (2008) conducted a study and found that family conflicts, anxiety, depression, attitudes and positive beliefs about drug are the strongest predictor of drug use (McCuller *et al*., 2001). Graziano, Reavis, Kean and Calkins (2010) found in their study that individuals who get low grades in mental health, depression, anxiety and physical complains indices, compared to their peers, intend to drug abuse more (Graziano et al., 2010). Sinha (2011) found in a study that drug users are more affected to psychological problems including stress, anxiety, hopelessness, suicidal thoughts and depression(Sinha, 2011). Parker, Taylor, Eastabrook, Schell and Wood(2008) found that the failure to establish an emotional relationship with others can lead to drug abuse in individuals (Parker et al., 2008). Drug use is associated with depression (Bousman, Crsonherner, Ake,Letendre, Atkinson and Patte, 2009), antisocial behavior and depression(Embry, Hankins, Biglan and Boles, 2009). Also, some studies have shown the effectiveness of cognition therapy on depression disorder (Siegle, Steinhauer, Friedman, Thompson and Thase, 2011). Driessen and Hollon (2010) showed that cognitive- behavioral techniques alone or with pharmacotherapy have important role in managing anxiety, depression and relationship with others and increase individuals' life satisfaction. The results of the study by Ranjbar, Ashk Torab and Dadgari (2010) entitled Examining the Effectiveness of Group Cognitive-behavioral Therapy on the Amount of Depression showed that group cognitive- behavioral therapy is effective on decreasing depression in patients with mild depression. The results of a study by Kamar Zarin, Zare and Beroki (2012) entitled The

Effectiveness of Cognitive- behavioral Therapy on Increasing Self-efficacy and Improving Addiction Symptoms in Patients Dependent to Drug showed that cognitive-behavioral therapy is effective on increasing self-efficacy and improving the symptoms of addiction. Treatments focused on the positive psychology including well-being therapy is of the psychotherapies that has significant role in the field of addiction. Well-being therapy is one of the new therapies in the field of positive psychology that is derived from cognitive- behavioral treatment. It is used in various studies alone or with cognitive-behavioral therapy (Fava, Rafanelli, Cazzaro, Conti and Grandi, 1998) and its effectiveness is approved in treating emotional and mood disorders and increasing psychological well-being (Rafanelli, Park and Fava, 1999). Well-being therapy is a short-term (8- session), structured, guideline and problem- oriented that is based on Ryff's psychological well-being pattern (Ryff, 1989) that in which self-review, writing diaries regularly and the interactions between client and the therapist are used to increase client's psychological well-being (Peterson and Seligman, 2004). Ryff's psychological well -being pattern (1989) has six dimensions including environmental mastery, personal growth, purpose in life, autonomy, self-acceptance and positive relations with others. The purpose of therapists of applying well-being therapy is helping the clients with low function level in order to reach the high levels of all six targeted areas of psychological well-being (Fava *et al*., 1998). Therapists help the clients to reach the optimum and pleasant levels of the functions from the functional impairments and find the well-being experiences in their past and present life. These experiences are noteworthy, no matter how short they are. First, clients become totally aware of well-being cases in their life, in the next step, they receive help to identify the beliefs and thoughts that disturb their well-being experience and also the feelings accompanying the well-being (Fava *et al*., 1998). This step of the treatment is similar to the identification of automatic thoughts or irrational beliefs in traditional cognitive therapy (Rafanelli, Park and Fava, 1999) but the difference is that in well-being therapy the self-review of the clients of their thoughts are mostly based on well-being not on discomfort and tension. In general, the main methods for helping clients to overcome the existing shortcomings in well- being therapy include: cognitive reconstruction of automatic thoughts, timing of activities that produce a sense of mastery and control or pleasure, assertiveness training, audacity and problem

solving (Ruini and Fava, 2004). Therefore, considering the significant prevalence of simulant drugs use and its personal, family and social damaging effect, and considering the promising effects of positive therapies such as well-being therapy on the treatment of mood disorders, the present study was conducted with the aim of examining the effectiveness of group well-being therapy on depression, anxiety and stress indices in men and women dependent to methamphetamine.

METHODOLOGY

Study design and participants

The present study was quasi-experimental with pre-test, post-test, follow-up and control group. All men and women dependent to methamphetamine(glass) who referred to Addiction Center of region 2 in Tehran during September to December of 2014, were diagnosed of drug abuse using Structured Clinical Interview by trusted psychiatrist and received outpatient treatment in the center, consisted the statistical population of the present study. Among them 24 men and 24 women were selected and were randomly assigned into experimental (12 men and 12 women) and control (12 men and 12 women) groups. During the treatment stages, 4 participants of experimental group left the therapy sessions before the end of the study. Also, 4 participants of control group did not participate in post- test. So, the final participants of experimental group was 20 persons (10 men and 10 women) and the final participants of control group was also 20 persons (10 men and 10 women). Inclusion criteria included: 1)age range of 25-45 years,2) having the education level of at least diploma, 3) having the background of using drug for 5 to 10 years and 4)the amount of use(between 0.5 to 1.5 gram per day). Exclusion criteria included: 1) simultaneous dependence on other drugs, 2) personality disorder, retardation or sever psychiatric disorders and 3)severe physical diseases. The two groups were homogenized in terms of social class, educational background, age, experiences, and similar use amount and the possible effect of these variables on dependent variable was eliminated.

Instruments

In this study, Demographic Questionnaire, the Structured Clinical Interview for Disorders DSM- IV (SCID) and DASS- 21 Questionnaire were used.

1) Demographic Questionnaire was developed and applied by the researcher in order to gather personal information such as age, education, socioeconomic condition, disease background, treatment background and the duration of drug use.

2) The Structured Clinical Interview for Disorders DSM- IV (SCID) is a clinical interview that is applied for diagnosis of the disorders on axis 1 based on DSM-IV. The inter- rater reliability coefficient was reported 0.60 (First, Spitzer, Gibbon and Williams, 2002). Diagnostic agreement of this tool in Persian for most specific and general diagnoses with the reliability higher than 0.60, was satisfactory. Kappa coefficient for all current and lifetime diagnoses was obtained 0.52 and 0.55, respectively (Sharifi, Assadi, Mohammadi, Amini, Kaviani *et al*., 2009).

3) Depression, Anxiety and Stress Scale (DASS-21) is designed by Lovibond (1995). It is a set of three self-report subscales for measuring negative emotional states of depression, anxiety and stress. Each of its three subscales has 7 items. Depression subscale measures dysphoria, hopelessness, devaluation of life, self-depreciation, lack of interest/involvement, anhedonia, and inertia. Anxiety subscale measures autonomic arousal, skeletal-muscle effects, situational anxiety and subjective experience of anxious affect. Stress scale is sensitive to the level of chronic and nonspecific arousal and measures difficulty in relaxing, nervous arousal, being easily upset/agitated, irritable/over- reactive and impatience. Lovibond and Lovibond (1995) evaluated the reliability of DASS for all three scales of depression, anxiety and stress using Chronbach's alpha (0.91, 0.84 and 0.90, respectively), acceptable. These results were similar to the results that were obtained from the clinical population (Antony, Bieling, Cox, Enns and Swinson, 1998; Brown, Chorpita, Korotitsch and Barlow, 1997). The correlation of this questionnaire with Beck's Depression Questionnaire (r=0.74) and Beck's Anxiety Questionnaire (r=0.81) was reported high (Lovibond and Lovibond, 1995). Sahebi, Asghari and Salari reported the correlation of 0.70 between DASS Depression Subscale and Beck's Depression Questionnaire, correlation of 0.67 between DASS Anxiety Subscale and Zung's Anxiety Questionnaire and correlation of 0.49 between DASS Stress Subscale and Perceived Stress Test in Iran.

Research process: The present study was conducted in a Methamphetamine Addiction Center in Saadat Abad by a clinical psychologist. The moral criteria of the study such as written informed consent of participating in the treatment sessions, the possibility to leave the study at any stage of the study, keeping the participants' secrets, and supporting their welfare and comfort were observed. Group well-being therapy was implemented for ten one-hour sessions. After finishing the treatment sessions, participants

of both groups were evaluated by Depression, Anxiety and Stress Scale (DASS). The content directory of well-being therapy is presented briefly based on the treatment sessions.

Table1: Summary of Well-being Therapy sessions

Session	Topic
First	Interview
Second	Defining the instructional-therapeutic program and the targets for the participants attended in the treatment process/ presenting forms and diaries/ stipulating mutual obligations in the program/ pre-test.
Third	Discussing the frame of well-being therapy/ discussing the role of therapist and clients' responsibilities/ presenting the role of lacking positive emotions in continuity of dependence to drug/ the worksheet of introducing self-record.
Fourth	Checking the homework of the previous session/ identifying recovery periods using identifying the po The mean of depression, anxiety and stress scores in experimental and control groups in post-tes and follow-up are significantly different in at least one of the components. sitive emotions/ encouraging the client to write the events in diary/ the worksheet of getting rid of hatred.
Fifth	Checking the homework of the previous session/ optimism and hope/ directing the clients to think again about the time that fail in an important activity/ asking the clients to pay attention when a door becomes closed/ asking the clients to pay attention what other doors become open/ worksheet of opening the new doors in life.
Sixth	Checking the homework of the previous session/ accepting the self and its role in mental calmness/ accepting frustrating experiences instead of denying them or attempt to forget them/ the worksheet of hope.
Seventh	Checking the homework of the previous session/ using public places for identifying illogical arguments/ objectivity of the reaction of long-term goals in directing the life / the worksheet of blessings.
Eighth	The worksheet of blessings/ explaining forgiveness as a strong tool that can change the anger into positive emotions/mastery on the environment as a component of mental health/ the worksheet of forgiveness.
Ninth	Checking the homework of the previous session/ personal growth and examining the amount of cognitive and social change or possible periods of recession/the role of inefficient cognitions in developing recession/ the worksheet of recording the emotions.
Tenth	Checking the homework of the previous session/ discussing the appreciation as a durable thank and highlighting the good and bad memories again with the emphasis on the appreciation/ practical examples of the effect of optimism and pessimism on using drug and avoiding the drug use/ worksheet of appreciation.
Eleventh	Checking the homework of the previous session/ presenting autonomy components and positive relationships with others/ reviewed progress/ concluding what is said/ post-test.
Twelfth	Separating from the group/ determination of periodic meetings with participants of experimental group and presenting the results after data analysis.

RESULTS

The findings of data analyzing in descriptive statistic (the mean and standard deviation) and inferential statistic (multivariate covariance analysis) were analyzed using SPSS software and are shown in the tables below.

Table 1 shows the frequency distribution according to the sex and group.

Table 2 shows the mean and standard deviation of the results of the participants in mental health variable.

Considering the data, depression index in participants of the experimental group significantly decreased in post-test compared to the participants of control group but this process was not that much stable in follow-up. There is a difference in post-test in both groups, nevertheless the anxiety index is significant in participants of experimental group compared to the participants of control group. The stress index significantly decreased in post-test in participants of experimental group compared to the participants of control group.

The results presented in the tables including the significance level in M Box Test and equality of error variance in Leven Test show that assumptions of covariance analysis test are observed.

The F value and significance level for depression variable show that there was not a significant difference between experimental and control groups in post-test while the mean of anxiety and stress scores significantly decreased in participants of experimental group compared to the participants of control group. It indicates the effectiveness of group well-being therapy. Thus, group well-being therapy led to improving anxiety and stress indices in patients.

The F value and significance level in depression variable show that experimental and control groups are not significantly different in follow-up, the same as in post-test. Thus, group well-being therapy did not lead to improving depression in patients. Considering the data of the table, also in anxiety and stress variables participants of experimental group did not maintain the improvement after finishing the treatment sessions.

Table 2: The frequency of distribution according to the sex and group

Group	Sex	Frequency	Percent
	Woman	**10**	**50**
Experimental	**Man**	**10**	**50**

	Sum	**20**	**100**
	Woman	**10**	**50**
Control	**Man**	**10**	**50**
	Sum	**20**	**100**

Table 3: The mean and standard deviation of two groups in depression, anxiety and stress indices

Index	Group	Test	mean	Standard deviation	Maximum	Minimum
Depression	Experimental	pre-test	14.10	4.35	24	7
		post-test	10.95	2.30	17	7
		Follow-up	13.15	3.25	21	7
	Control	pre-test	13.70	3.50	21	8
		post-test	11.55	2.60	17	8
		Follow-up	12.10	2.35	16	8
Anxiety	Experimental	pre-test	22.95	4.75	32	12
		post-test	15.65	3.05	20	8
		Follow-up	20.85	4.45	28	12
	Control	pre-test	22.90	5.65	32	8
		post-test	17.45	3.22	22	10
		Follow-up	19.55	3.30	25	12
Stress	Experimental	pre-test	18.70	2.82	22	13
		post-test	13.45	1.38	16	11
		Follow-up	15.50	2.09	18	10
	Control	pre-test	17.05	3.62	23	10
		post-test	14.65	1.80	19	12
		Follow-up	15.05	2.40	21	8

Table 4: M Box Test

M Box	F	Significance level
28.53	**1.12**	**0.31**

Table 5: Leven Test for examining the equality of error variance

Index	Test	F	Significance level
	post-test	**0.605**	**0.45**
Depression	**Follow-up**	**0.453**	**0.50**
	post-test	**0.121**	**0.73**
Anxiety	**Follow-up**	**1.65**	**0.20**
	post-test	**0.003**	**0.95**
Stress	**Follow-up**	**0.156**	**0.68**

Table 6: Multivariate covariance analysis in order to compare the mean of depression, anxiety and stress in post-test and follow-up

TEST	Value	F	Degrees of freedom	Error degree of freedom	Significance level
Pillay effect	**0.74**	**13.77**	**6**	**30**	**0.001**
Wilks Lambda	**0.26**	**13.77**	**6**	**30**	**0.001**
Hatling effect	**2.75**	**13.77**	**6**	**30**	**0.001**
The highest root	**2.75**	**13.77**	**6**	**30**	**0.001**

Table 7: Covariance analysis of the difference in mean of depression, Anxiety and stress in post-test with elimination of the effect of pre-test

The reference of changes	Group	Sum of squares	Degrees of freedom	Mean of squares	F value	Significance level
pre-test(Depression)	Experimental	0.007	1	0.007	0.001	0.97
	Control	9.38	1	9.38	1.58	0.21
pre-test(Anxiety)	Experimental	277.20	1	277.20	374.59	0.001
	Control	34.18	1	34.18	46.82	0.001
pre-test(Stress)	Experimental	41.03	1	41.03	27.45	0.001
	Control	28.40	1	28.40	19	0.001

Table 8: Covariance analysis of the difference in mean of depression, Anxiety and stress in follow-up with elimination of the effect of pre-test

The reference of changes	Group	Sum of squares	Degrees of freedom	Mean of squares	F value	Significance level
pre-test(Depression)	Experimental	194.64	1	194.64	200.77	0.001
	Control	3.42	1	3.42	3.52	0.06
pre-test(Anxiety)	Experimental	111.40	1	111.40	9.55	0.004
	Control	5.05	1	5.05	0.42	0.51
pre-test(Stress)	Experimental	99.94	1	99.94	58.08	0.001
	Control	1.89	1	1.89	1.08	0.30

DISCUSSION

It seems that psychology now more than ever before, needs an efficient plan about humans' optimal function. The responsibility of psychology in future is understanding the factors that make the capabilities. Finally, positive psychology needs expanding effective interventions to increase and enhance these processes. The present study was conducted with the aim of changing the view from problem- oriented approach to the developing capabilities approach. The aim of the present study was examining the effectiveness of group well-being therapy on improving depression, anxiety and stress in patients dependent to drug. The results showed well- being therapy was effective in improving anxiety and stress indices in patients dependent to drug. The findings of the present study were consistent with the results of the studies that approved the effectiveness of well- being therapy in treating emotional and mood disorders and increasing psychological well-being. A study was conducted by Fava and Tomba (2009) entitled Increasing Psychological Well-being and Tolerance Using Well-being Psychotherapy Methods with the aim of examining the effectiveness of well-being therapy. The findings indicated that prosperity and flexibility can be developed through special interventions that lead to positive self- evaluation, stable growth feeling, believe in positive and meaningful life, the process of positive relationships with others, the ability to effective

life management and sense of self-determination. Also, reducing vulnerability to depression and anxiety due to well-being therapy was seen (Fava and Tomba, 2009). A study was conducted by Moeenizadeh and Kumar(2010) entitled Well- being Therapy of Depression. It was conducted on 40 samples in 2010 and the results showed that there was a significant difference between the scores before and after treatment and well-being therapy was more effective than cognitive- behavioral therapy. The results indicated the feasibility and clinical benefits of inclusion of well- being therapy into other sets of treatment techniques. Fava, Rafanly, Kazarv, Conti and Grandi (1998) applied well- being therapy as a new treatment approach for the remained signs of mood disorders, major depression, phobia disorder with agoraphobia, social phobia, generalized anxiety disorder and obsessive-compulsive disorder that were treated successfully using behavioral or pharmaceutic techniques. Researchers assigned this individuals randomly into well- being therapy and cognitive therapy groups. The results showed that both well- being therapy and cognitive-behavioral therapy significantly decreased remained signs. In addition, Golbar Yazdi, Sherbaaf and Moeenizadeh (2011) showed that well- being therapy is effective on reducing stress and increasing psychological well–being in infertile women. The effectiveness of well- being therapy can be largely due to the group form of this treatment. Interaction with the same group in treatment center can be associated with treatment efficacy (Barnett and Swindle, 1997). Swindle and Peterson (1995) conducted a study on 466 patients. Participants were randomly assigned into two treatment programs related to alcohol dependency. The first treatment program presented the comprehensive individual treatment and the second one was dependent on the interaction of the same group. The patients who were entered the second program showed better therapeutic outcome (Swindle and Peterson, 1995). It indicates the potential importance of the same group in alcoholism treatment programs (Norouzi, 2010). Sometimes the programs are individually but there is an interaction between patients, they listen to each other and in such a way interact. Group therapy has the advantage that others in the group also can say that they feel better. The experience and support of people with same condition, is of importance in treatment process. On the other hand, because of damage in short-term memory (working memory) in individuals dependent to methamphetamine, cognitive- behavioral therapies and well-being therapy that are based on the words and do not use visualization and mental imagery, are less

effective (Rawson, Huber, Shoptaw, Farabee, Reiber et al, 2002). Implementation process of cognitive -behavioral therapy is often based on pen and paper. Considering the known damages of methamphetamine on the structure of brain and obvious damage of memory and decrease in concentration, the traditional model of pen and paper can less be adapted to the needs of methamphetamine users. Thus, the lack of visual aspects is strongly felt. Considering the previous experiences of the researcher, in the present study it was attempted the treatment process become more objective using soft wares. The present study was conducted with the aim of examining the effectiveness of group well-being therapy on depression, anxiety and stress indices in men and women dependent to methamphetamine and the results showed this therapeutic method was significantly effective in treating the individuals dependent to the drug.

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