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Structural Modeling of the Relationship between Distress Tolerance and Quality of Life Based on the Mediating Role of Religious Beliefs in Patients with Opioid Abuse

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Abstract

Introduction: The world is currently facing the drug crisis as a serious threat. This study was conducted with the aim of investigating the structural modeling of the relationship between distress tolerance and quality of life based on the mediating role of religious beliefs in opioid abuse patients.

Methods: The method of this research is descriptive correlation based on the model of structural equations. The statistical population of this research included all patients suffering from opioid abuse who referred to the community center for addiction treatment in SAYEBANE ARAMESH located in RASHT city. From this community, 300 qualified volunteers entered the study by the convenience sampling method. The WHO Quality of Life-BREF (1998), Simmons and Gaher Distress Tolerance Questionnaire (2005), Allports Religious beliefs Questionnaire (1967) were used for data collection, and AMOS24 software was utilized to analyze the findings.

Results: The results showed that all the fit indexes are at an optimal level. The relationship between distress tolerance and intrinsic religious beliefs (0.32) is positive and significant (P<0.01). The relationship of this variable with extrinsic religious beliefs (-0.36) is negative and significant (P<0.01). The relationship between distress tolerance (0.19) and intrinsic religious beliefs (0.33) with quality of life is positive and significant (P<0.01). Also, the relationship between extrinsic religious beliefs and quality of life (-0.22) is negative and significant (P<0.01).

Conclusions: According to the results, intrinsic religious beliefs in opioid abuse patients, has direct impact on distress tolerance and quality of life. In fact, the higher the intrinsic religious beliefs in opioid abuse patients, ends in the higher the distress tolerance and quality of life. Also, extrinsic religious beliefs in opioid abuse patients, has inverse impact on distress tolerance and quality of life. In fact, the higher the extrinsic religious beliefs in opioid abuse patients, ends in the lowerthe distress tolerance and quality of life. Therefore, intrinsic religious beliefs as an Islamic moral variable can affect the distress tolerance and quality of life of opioid abuse patients.

INTRODUCTION

The world is currently facing the drug crisis as a serious threat. In Iran, the estimation of drug users is close to 1.8 to 3.3 million people, of which opioids are the most consumed substances [1]. Addiction to opioids leads to serious consequences such as loss of physical and mental health, joblessness, lack of education, and unstable social relationships with friends and family, and degrades the quality of life of the addicted person [2, 3]. Theorists believe that quality of life, like life itself, is a complex and multidimensional concept [4]. The World Health Organization defines quality of life as a standard of life that people consider to be aligned with their culture, values, goals and expectations of life and it is a basic predictor for the sustainability of health and overall well-being [3]; Researches conducted in Iran and other countries show that addicts' quality of Life is low [3, 4]. Due to the importance of mental health and prevention of mental dysfunction in patients suffering from opioid abuse, it is important to know the factors affecting the quality of life.

Studies have shown that one of the influential variables which has negative effect on the quality of life in opioid users is low distress tolerance [5]. Distress tolerance is often defined as a person's perceived ability to experience and tolerate negative emotional, or the behavioral ability to persist in goal-oriented behavior when experiencing emotional distress and annoying physiological states [5]. Amiri and Ghorbani [6], as well as Jangi et al [7]., in a study showed that there is a significant difference between the distress tolerance of addicts and normal people. In general, the intolerance of distress is considered one of the main obstacles for treatment in drug users. Impulsive behaviors and out of distress can appear as a trigger and lead to the formation of a tendency to use in sufferers and their inability to resist it, and ultimately, provide the background to return to substance use again [8].

Every culture has different attitudes, beliefs, norms and expectations towards drug use and this is reflected in the behavior of drug users. According to research results, one of the most important and influential factors in psychological and social traumas is religion and religious attitudes of people; since religion impacts the attitude, knowledge and behavior of individuals and affects the thought process and evaluation of the daily events of a person's life [2]. Allport believes that there are two various ways of being religious: Extrinsic and Intrinsic. Intrinsic religious beliefs express a mature and interalized form of religiosity. People who have this tendency, consider religion to be the main reason for their life and observe religious principles strictly. It seems those with intrinsic religious beliefs are tolerant and compassionate due to religious teachings [9]. Extrinsic religiosity is an immature form of religion that is characterized by utilitarian values. Individuals who have extrinsic religious beliefs, misuse religion to achieve non-religious goals (such as gaining support and building good social relationships). This form of religion uses only to serves other ultimate interests and it is formed to satisfy other needs [9].

Jafarimanesh et al. research showed that there is a significant positive relationship between intrinsic religious orientation and all areas of quality of life; and a significant negative relationship between extrinsic religious orientation and quality of life [10]. Moreover, in a similar result, Ghaderi and Moustafaee state that there was a positive and significant relationship between intrinsic religious beliefs and dimensions of quality of life, and not only there was no significant and positive relationship between extrinsic religious beliefs and dimensions of quality of life, but also it was negative in two dimensions (physical pain and playing an emotional role) [11]. Drabel et al [12]; and Grimm and Grimm [13] consider religious beliefs and faith as one of the positive and important factors in the prevention and treatment of addiction as well as improving the quality of life among addicted people. They also believe that religiosity can be used as a protective factor to prevent addiction in women. Moreover, Chen et al. showed that religious beliefs are effective in substance abuse, relapse and quality of life in substance abusers [14].

On the other hand, the relationship between distress tolerance and religious beliefs has been confirmed in several studies. Mahmoudpour et al., believed that the religious beliefs in divorced women are a strong predictor for enduring their distress, and having faith increases people's tolerance against hardship and assist them overcome life's challenges and problems [15]. This study is aligned with the research of McIntosh et al., who confirmed the role of religion and religious beliefs in the suffering of the colored population [16]. Similar results in Amral et al.'s study [17]; and Ali Mohammadi et al. [18], is seen Besides, research backgrounds show that despite the antiquity of religious beliefs, there are conflicting views about the effects of religious beliefs on mental health and quality of life, and some researchers stated in their research that no evidence can be found that shows the positive effect of religion on mental health and quality of life [19-22].

The widespread harm of drug use and the number of addictive is increasing. Also, the phenomenon of addiction, in addition to the high financial cost, has many negative effects on all aspects of the lives of individuals and society; as a result, paying attention to psychological aspects in the treatment of addiction plays an important role in reducing relapse and increasing the

level of tolerance for quitting and ultimately improving the quality of life of patients [2]. For this purpose, the present study was conducted in the form of a structural model to investigate the relationship between distress tolerance and quality of life based on the mediating role of religious beliefs in opioid abuse patients.

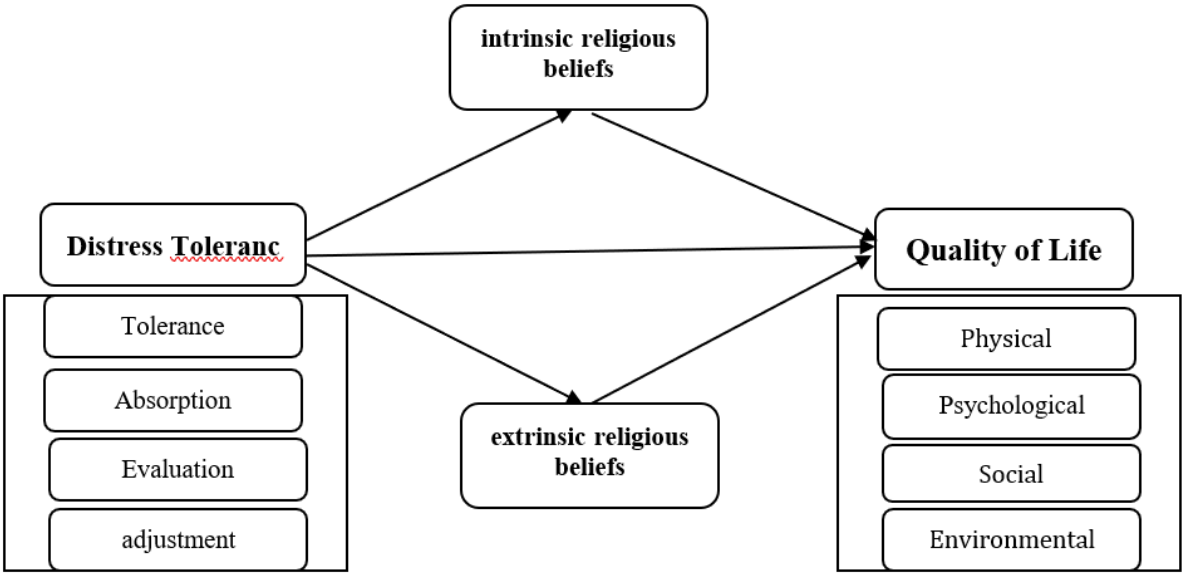


Figure 1. Conceptual model of the relationship between distress tolerance and quality of life based on the mediating role of religious beliefs in opioid abuse patients.

METHODS

The current research is based on the objective, applied and the type of correlational descriptive method. The statistical population of this research included all the patients referred to the community center for addiction treatment in SAYEBANE ARAMESH (One of the largest addiction treatment complexes) located in RASHT city, and a sample of 300 people was selected using Convenience sampling method. The sample size was estimated based on the method of Kline [23] including all the indicators of the present study (16 indicators in total) and 20 samples for each indicator (320 samples in total) and 330 questionnaires were distributed considering the sample volume drop. After collection and investigation, questionnaires related to 30 participants were eliminated from the research due to incompletion; and finally, 300 questionnaires were analyzed. The inclusion criteria are as following: to be male sex; the age range was between 20 and 40 years; there is no acute physical and mental disorder; and the exclusion criteria include of failure to complete the questionnaire. In order to collect data, a demographic questionnaire and three standard questionnaires were used. The demographic questionnaire included age, marital status, education and occupation.

The second questionnaire was the Distress Tolerance Questionnaire, which is a self-measurement index of emotional distress tolerance made by Simmons and Gaher (2005). This scale has 15 items and four subscales named tolerance (tolerance of emotional distress), absorption (being absorbed by negative emotions), evaluation (mental assessment of distress) and adjustment (regulating efforts to relieve distress). The method of scoring the questions is a five-point Likert scale, the options of which range from completely agree [1] to completely disagree [5]. Question 6 is scored in reverse on this scale. To obtain the overall distress tolerance, the scores of all the questions are added together, and to obtain the score of each dimension, the scores of the questions of each dimension are added together. The score of 45 is the cut-off point of the questionnaire. Scores greater than 45 indicate high distress tolerance and scores less than 45 indicate low distress tolerance. Simmons and Gaher reported the alpha coefficient for the subscales as 0.72, 0.82, 0.78 and 0.70, respectively, and total scale score as 0.82. Also, this questionnaire has good criterion validity and initial convergence [24]. In Iran, Alavi (2008) used this tool in his thesis and reported that the validity of the whole scale is 0.68 and has high internal consistency reliability ($\alpha = 0.71$) and the subscales have moderate reliability (tolerance 0.54, absorption 0.42, evaluation 0.56 and adjustment 0.58) are [25]. In the present study, the content validity of the questionnaire was confirmed after the evaluation by professors and experts, the reliability using Cronbach's alpha for the total score equals 0.88 and for the components of tolerance, absorption, evaluation and adjustment respectively equal to 0.81, 0.79, 0.86 and 0.71 were obtained.

The third questionnaire was WHO Quality of Life-BREF (WHOQOL-BREF), which was designed by the World Health Organization in 1998. This scale has 26

questions that evaluate 4 areas of people's quality of life. These areas include physical health, psychological health, living environment and relationships with others [26]. The scoring method of this scale is that the score of each item is placed in a range of (1 to 5) in the order of not at all, low, medium, high and completely, or very dissatisfied, not satisfied, relatively dissatisfied, satisfied, completely satisfied. The scoring key of this scale is as follows: physical health area (questions 3-4-10-15-16-17-18), psychological area (questions 5-11-7-6-26, 19-11), social relations area (questions 22-21-20) and living environment (questions 8-9-12-13-14-23-24-25). It should be noted that questions 3, 4 and 25 are graded in reverse. The quality-of-life group in the World Health Organization (1996) has reported the correlation coefficient between the whole scale and subscales from 0.53 to 0.78 and between the subscales from 0.51 to 0.64 [26]. In Iran, Nejat et al., examined validity and reliability assessment through retest and showed that the Persian translated questionnaire has acceptable validity and reliability. Reliability coefficient was obtained above 0.70 by test-retest method with an interval of two weeks in all four components of Physical, Psychological, Social relationships, and Environment. Reliability using Cronbach's alpha with 1167 people was as follows: physical, 0.70; psychological, 0.73; Social relationships, 0.55; and environment, 0.84 [27]. In the present study, the content validity of the questionnaire was confirmed after the evaluation by professors and experts. Reliability was obtained using Cronbach's alpha for the total score equal to 0.89 and for the physical, psychological, social and living environment components equal to 0.81, 0.83, 0.79 and 0.76 respectively.To measure religious beliefs in the present study, Allport and Ross religious orientation questionnaire was used. Allport and Ross prepared this questionnaire in 1967 to measure the intrinsic and extrinsic orientation of religion. This questionnaire contains 21 items and is graded based on a four-point Likert scale from completely disagree to completely agree (1 to 4). Items 1 to 12 measure extrinsic religious orientation and items 13 to 21 measure intrinsic religious orientation. This questionnaire does not have a cut-off point and the more scores the subjects get in the examined scales, the more they have that trait [9]. This questionnaire has been translated and normalized in Iran by JanBozorgi. Its internal consistency using Cronbach's alpha is 0.71 and its retest reliability is 0.74 [28]. In the present study, the content validity of the questionnaire was confirmed after the trial implementation and the review and evaluation of the professors and experts. Reliability was obtained using Cronbach's alpha for the total score equal to 0.91 and for intrinsic and extrinsic components equal to 0.87 and 0.89 respectively.

Data analysis was performed by AMOS24. Descriptive statistics including setting frequency tables and determining central indicators were done. The normality of quantitative data was measured based on kurtosis and skewness, all of which were normal. The maximum likelihood method was used for testing the theoretical model of the research and its fit with the collected data. Also, Mardia's normalized multivariate kurtosis value was applied to investigate the normality of multivariable. And in order to estimate the main parameters of the structural equation model, the bootstrap method was conducted. The bootstrap in the AMOS program evaluates the sampling distribution of the parameter estimates and the corresponding standard error. Such an evaluation is useful for determining the robustness of the parameters under the assumptions of multivariate normality or ill-formulation of the model, comparing alternative models and comparing estimation methods. All the statistical tests were two-sided, using a significance level of $P < 0.05$.

3 basic reasons justify the use of this method in the present study. Firstly, in the Sobel test, there is a problem related to the non-normal distribution of the indirect effect of the sample, and because the bootstrap method provides an empirical representation of the distribution of the indirect effect of the sample, the researcher no longer faces such a problem, and secondly, the bootstrap method has more statistical power. Thirdly, it was not possible to obtain sample data again or to cross-validate by dividing the samples into two halves. Based on this, in order to estimate the main parameters of the structural equation model, the bootstrap method was used [29].

RESULTS

In this study, 300 Patients with Opioid Abuse were participated. The demographic variables of the participants are shown in Table 1.

According to the demographic characteristics (Table 1), the participants were homogeneous in terms of age, occupation, education, and marital status ($P> 0.05$). In the job variable, the lowest frequency belonged to government jobs. Also, in the field of education, the lowest frequency was related to bachelor's degree and the highest frequency was related to diploma. The descriptive indexes of research variables are shown in Table 2.

In Table 2, descriptive indexes of the variables including mean, standard deviation, skewness and kurtosis are presented. To investigate the univariate normality of data distribution, the absolute value of skewness and kurtosis of the variables should not be further than 3 and 10, respectively. Considering it, in this study, the absolute value of skewness for all variables was less than 3 and the absolute value of kurtosis for all variables was less than 10; therefore, the assumption of causal modeling, i.e., univariate normality, is maintained [23].

Table 3 shows the correlation matrix of research variables.

According to Table 3, the correlation matrix of research variables showed that the relationship between distress tolerance and intrinsic religious beliefs (0.32) is positive and significant (P <0.01). The relationship of this variable with extrinsic religious beliefs (-0.36) is negative and significant (P <0.01). The relationship between distress tolerance (0.19) and intrinsic religious beliefs (0.33) with positive quality of life is significant (P <0.01). Also, the relationship between extrinsic religious beliefs and quality of life (-0.22) is significant (P<0.01).

The maximum likelihood method was used to test the theoretical model of the research and its fit with the collected data. The use of this method requires multivariate normality of the variables. In the research, Mardia's normalized multivariate kurtosis value was used to investigate the normality of multivariates. This number was obtained in the present study as 21.76, which is less than the number 120 which was calculated through the p (p+2) formula. In this formula, p is equal to the number of observed variables, which is 10 in this research [30].

Table 1. Demographic Results

Variable	Frequency Percentage	Frequency
Age		
20-30 years	47.7	143
31-40 years	52.3	157
In total	100	300
Job		
unemployed	28.3	85
Non-governmental jobs	67	201
Governmental jobs	4.7	14
In total	100	300
Degree		
Under diploma	26	78
Diploma	50.7	152
Post diploma	13.3	40
Bachelor's	10	30
In total	100	300
Marriage status		
Single	46	138
Married	54	162
In total	100	300

Table 2. Descriptive Indexes of Research Variables

Variable	Mean	Standard Deviation	Skewness	Kurtosis	Minimum Score	Maximum Score
Tolerate distress	37.18	9.47	0.36	- 0.25	15	75
Intrinsic religious beliefs	25.01	8.81	0.74	- 0.37	12	48
Extrinsic religious beliefs	31.87	7.31	- 0.37	0.62	9	36
Quality of Life	62.32	15.04	-0.33	0.07	26	130

Table 3. Correlation matrix of research variables

Variable	1	2	3	4
Distress tolerance	1			
Intrinsic religious beliefs	0.32**	1		
Extrinsic religious beliefs	-0.36**	0.04	1	
Quality of life	0.19**	0.33**	-0.22**	1

*P<0.05, **P<0.01

Table 4. Goodness of Fit Indexes of the Tested Research Model

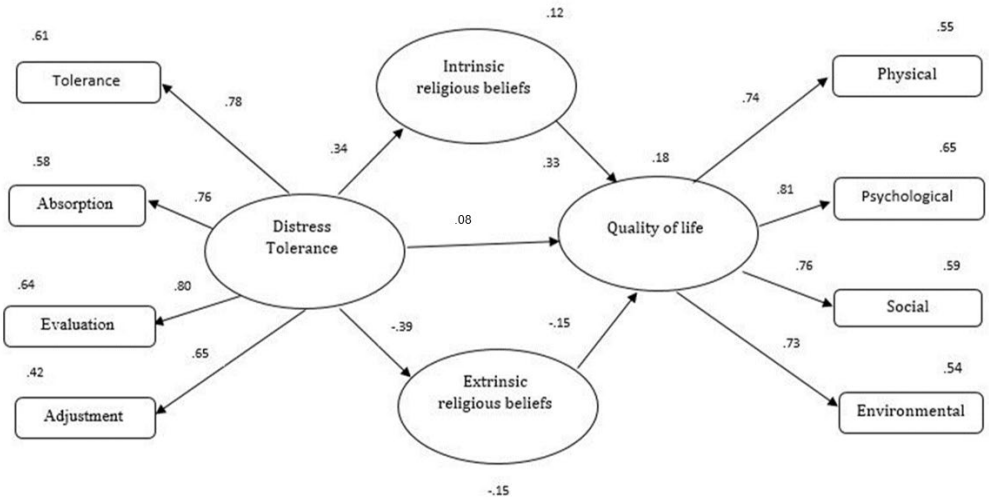
Absolute Fit Indexes			
Variable	GFI	AGFI	SRMR
Obtained amount	0.95	0.92	0.01
acceptable quality limit	More than 0.90	More than 0.80	Less than 0.05
Comparative fit indexes			
Variable	CFI	NFI	NNFI
Obtained amount	0.96	0.93	0.96
acceptable quality limit	More than 0.90	More than 0.90	More than 0.90
Adjusted fit indexes			
Variable	X2/df	PNFI	RMSEA
Obtained amount	2.43	0.66	0.07
Acceptable quality limit	Less than 3	More than 0.60	Less than 0.08

In Table 4, the absolute, comparative and parsimonious fit indexes are reported separately. Goodness of Fit Index (GFI), Adjusted Goodness of Fit Index (AGFI) and Standardized Root Mean Square Residual (SRMR) as fit indexes of Comparative Fit Index (CFI), Normalized Fit Index (NFI) and Non-Normalized Fit Index (NNFI) as comparative fit indices and chi-square on degree of freedom (X2/df), Parsimony Normed Fit Index (PNFI) and root mean square error of approximation (RMSEA) were considered as parsimonious fit indexes. According to Table 4, all the fit indices are at the optimal level and it can be concluded that the tested model has a good fit with the collected data.

According to Figure 2, distress tolerance, intrinsic and extrinsic religious beliefs explain a total of 18% of the variance of quality of life. Distress tolerance also explains 12% of the variance of intrinsic religious beliefs and 15% of the changes of extrinsic religious beliefs. In Table 5, the results related to the direct effects of the variables are reported.

According to Table 5, the direct effect of intrinsic religious beliefs (0.33) on the quality of life is positive and significant (P<0.01). The direct effect of extrinsic religious beliefs on the quality of life is negative (-0.15) and significant (P <0.01). But distress tolerance does not have a significant direct effect on quality of life (0.08). The direct effect of distress tolerance on intrinsic religious beliefs (0.34) is positive and significant (P <0.01). Also, the direct effect of distress tolerance on extrinsic religious beliefs (-0.39) is negative and significant (P <0.01). In Table 6, the results related to the indirect effects of the variables are reported.

According to Table 6, the indirect effect of distress tolerance on quality of life through intrinsic religious beliefs (P<0.01), and extrinsic religious beliefs (P<0.05) is significant. Therefore, it can be said that intrinsic and extrinsic religious beliefs play a mediating role in the relationship between distress tolerance and quality of life.



GFI= .951, AGFI=.917, CFI=958, RMSEA=.069

Figure 2. The Tested Model of the Research

Table 5. Direct Effects of Research Variables Result

Path	Parameter Estimation	Path Coefficient	Standard Error of Estimate	T Statistic	The Significance Level
The effect of distress tolerance on quality of life	0.23	0.08	0.21	1.12	0.26
The effect of intrinsic religious beliefs on quality of life	0.17	0.33	0.03	5.03	0.001
The effect of extrinsic religious beliefs on quality of life	-0.09	-0.15	0.03	-2.36	0.01
The effect of distress tolerance on intrinsic religious beliefs	1.76	0.34	0.33	5.28	0.001
The effect of distress tolerance on extrinsic religious beliefs	-1.88	-0.39	0.31	-5.99	0.001

Table 6. Indirect Effects of Research Variables Result

Mediator	Path Coefficient	Standard Error of Estimate	Significance Level	Lower Limit	Upper Limit
Intrinsic religious beliefs	0.11	0.03	0.01	0.06	0.16
Extrinsic religious beliefs	0.06	0.01	0.05	0.01	0.11
Both variables	0.17	0.04	0.02	0.09	0.23

DISCUSSION

The present study was conducted with the aim of investigating the relationship between distress tolerance and quality of life based on the mediating role of religious beliefs in opioid abuse patients. The first result of the research showed that distress tolerance does not have a significant direct effect on the quality of life, so this hypothesis is not confirmed. This finding is aligned with the results of Brandon et al.,'s research findings that stress tolerance is not related to quality of life of drug users [31], and it is inconsistent with the findings of Amral et al [17], and Alimohammadi et al. [18], who showed that higher levels of distress tolerance are related to higher overall quality of life. In explaining this finding, it can be noted that drug addiction is a recurring and chronic disease that is accompanied by severe motivational disorders and loss of behavioral control and it leads to personality changes; in particular in patients with chronic use. The occurrence of fundamental changes in brain circuits may remain after detoxification. The behavioral effects of these brain changes may manifest as frequent relapses and strong cravings for drugs when a person is exposed to drug-related stimuli [5]. In general, it can be said that addiction is a biological, psychological and social disease. Several factors are involved in the etiology and treatment of drug abuse and addiction, which interact with each other and lead to the drug use and then addiction [1]; on the other hand quality of life is defined as individuals' perceptions of their position in life in the context of the culture and value systems where they live and in relation to their goals, standards, expectations and concerns [32]; therefore, distress tolerance alone may not have a decisive role in the quality of life of sufferers.

Although distress tolerance did not have a significant direct effect on quality of life, the results of structural equations showed that the direct effect of distress tolerance and religious beliefs is significant. Also, the indirect effect of distress tolerance via intrinsic religious beliefs as a mediator on the quality of life in patients suffering from opioid abuse is positive and significant; and it is negative and meaningful via the mediation of extrinsic religious beliefs. Therefore, it can be said that intrinsic and extrinsic religious beliefs play a mediating role in the relationship between distress tolerance and quality of life. These results are aligned with findings of Jafarimanesh et al. [10], and Ghaderi and Moustafaee [11], Drabel et al. [12], Grimm and Grimm [13], and Chen et al. [14]. Religious people have faith in religious principles and rules, and feel committed towards the implementation of God's orders and reaching perfection; Through the establishment of an intrinsic moral order, religion provides opportunities for them to acquire learned competencies and comply with social laws, which plays an effective role in the occurrence or prevention of social and moral problems, mental-physical health, and drug abuse [10]. In other words, religious belief and its acceptance act as a protective shield against addiction, and adherence to religious beliefs makes these people less likely to use alcohol and drugs than people without religious beliefs [10]. In general, religiosity in difficult situations helps individuals to maintain the meaning and coherence of life and to rely on a force beyond themselves, to maintain peace and subsequently enjoy a higher quality of life [31]. Among the studies that are inconsistent with the present study, we can refer to Badle Shamoshki et al.,'s [20] and Yilmaz and Gengiz's [21] research, which did not find a significant correlation between religious beliefs and quality of life. The reason can be due to the difference in demographic characteristics, cultural differences, lack of uniformity in questionnaires or instruments and the number of subjects. Also, this difference in the results express the important matter that when religious beliefs are intrinsic there is a positive relationship between religion and quality of life, and pessimistic claims about the negative role of religion on quality of life are usually true when it's extrinsic religious beliefs and the person intends to exploit the religion [11, 22].

One of the limitations of this study is that results are gathered through self-reporting scale questioner and attendee's respond is influenced by personality, individually, and situational factors. On the other hand, the samples of the present study were Muslims, and whether our results can be generalized to other countries and other religions is not yet clear. Considering that the only data collection tool was the questionnaire, it is suggested to use other tools such as interviews along with the questionnaire. Also, according to the different teachings of religions, it is better to conduct studies in others as well.

The information obtained from this study should increase awareness among addiction specialists about a wide range of psychosocial factors affecting patients with opioids. It is suggested De-addiction centers and those involved in dealing with addicts and their families Conduct courses and workshops using the results of the current research in order to prevent the relapse of recovered patients so that the treatment is not limited to drugs and biological components and we would witness a more effective and stable treatment.

CONCLUSION

According to the results, the higher the intrinsic religious beliefs in opioid abuse patients is, the higher the distress tolerance and quality of life will be. Also, extrinsic religious beliefs in opioid abuse patients have a negative effect on distress tolerance and quality of life. Therefore, intrinsic religious beliefs as an Islamic moral

variable can affect the distress tolerance and the quality of life of patients suffering from opioid abuse; and in treatment of patients who suffer from opioid abuse, special attention should be paid to belief, value and intrinsic factors and religious beliefs in order to they can bear their distress and as a result enhance their quality of life.

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ETHICAL CONSIDERATION

According to the authors of the article, the current research is taken from the doctoral dissertation of the first author of the article, which was approved by the ethics committee of Rasht Azad University with the ethics code IR.IAU.RASHT.REC.1400.012.

CONFLICT 0F INTEREST

According to the authors of this article, there is no conflict of interest.

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AUTHORS' CONTRIBUTION

Research idea, data collection, writing to review and approval of the final version of the manuscript is by the first author. Designing the study, writing until revising and approving the final version of the manuscript and responsibility for the research is by the corresponding and second author. Writing until revising and approving the final version of the manuscript is by the third author; and research idea, writing to review and approval of the final version of the manuscript is by the fourth author.

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