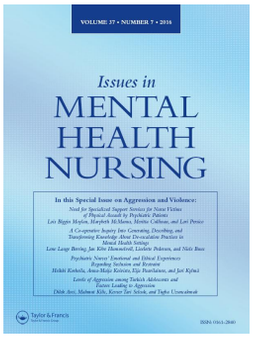

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Experiences and Perceived Social Support among Iranian Men on Methadone Maintenance Therapy: A Qualitative Study

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ABSTRACT

The use of drugs predominantly among Iranian men leads to health and social problems. Iran has established methadone maintenance therapy centres but there is limited research exploring the experiences of men who make use of this therapy. The aim of this qualitative study was to explore the experiences of men on methadone maintenance therapy in Urmia, Iran. Sixteen opioid-dependent males on methadone syrup substitution therapy were interviewed. Transcribed data were subjected to thematic analysis. Three themes emerged from the data: (1) the role of family in drug addiction; (2) the role of environment in drug addiction; and (3) the support needed to overcome drug addiction. While drug rehabilitation programmes in Iran can help the person, their family is seen as the most important support that they need together with sociocultural acceptance to overcome stigmatisation.

Introduction

The use of illicit substances has increased and presents a significant global health care problem (Cleary & Thomas, 2017; Worley, 2017; Zavar, Afshari, Alidoust, Pourandi, & Dadpour, 2012). Afghanistan is the largest producer of narcotics in the world and its border with Persian Gulf countries such as Iran has readily enabled the distribution of drugs there (Alam Mehrjerdi et al., 2013; Zavar et al., 2012). The majority of countries in the Persian Gulf prohibit substance use such as opioids in accordance with Islamic teachings, traditions, law and social customs (Alam-mehrjerdi, Noori, & Dolan, 2016). Despite digressing from Islamic teachings and the resultant stigma, drug use flourishes (Alam-mehrjerdi et al., 2016). Iran has the highest use of opium worldwide with some 450 million tons consumed annually (Zavar et al., 2012), and drug and alcohol use disorders account for approximately 2% of Iran's total burden of diseases (Moazen et al., 2015). As Iran is acknowledged as having one of the highest levels of drug seizures for cannabis, heroin and methamphetamine, it is not surprising that drug and alcohol use disorders are attributed to some 2% of the burden of disease (Moazen et al., 2015). Current estimates suggest that opiate addiction in Iran is reportedly the highest per person in the world (Ahmadpanah, Ghaleiha, Jahangard, Mosavi, & Haghighi, 2014) with some 1.8–3.3 million people using drugs and this is reportedly continuing to rise (Darrodi, Younesi, Bahrami, & Bahari, 2010).

The negative consequences of drug use extend beyond the physical effects of the drug to include other physical disorders as well as psychological and social issues (Darrodi et al., 2010; Moazen et al., 2015). Negative health practices include unsafe sex and injection of substances. These factors have led to an increased incidence of infectious diseases such as HIV /AIDS and viral hepatitis (Moazen et al., 2015; Radfar, Cousins, Shariatirad, Noroozi, & Rawson, 2016). Drug use can also exacerbate other diseases such as cancer and cardiovascular disorders (Moazen et al., 2015).

The impact of drug use is not exclusive to the user but also has detrimental effects on the family and society (Darrodi et al., 2010). Drug use by a family member may have significant impacts on family health and well-being including impaired communication, changes in family roles, finances and acceptability within society (Fereidouni et al., 2015). Traditionally, Iranian families are close knit. Religious and cultural values, practices and beliefs are strong. Importantly they are influential in family responses to life situations: children are expected to respect their elders, be supportive of their parents and ensure their care throughout their lives. Addiction then has negative consequences and stigma for family members particularly as drug use is contrary to the teachings of Islam (Fereidouni et al., 2015). Further, the family may be ostracised by others not wanting to befriend or mix with someone whose family member does not uphold religious and societal expectations.

For the family this may lead to: financial pressure; marital stress; aggressive and problematic behaviours – all impacting self-confidence and coping abilities – these problems may intensify when both partners have addiction issues (Darrodi et al., 2010). In Iran, patterns of behaviour adopted by the family together with how they live their lives may be accepted as inevitable responses to dealing with addiction (Darrodi et al., 2010). Dysfunctional behaviours among couples may be further enabled as a consequence of prior agreements enabling the

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person to continue their substance use. Alternatively if the relationship is more functional, the spouse may be more inclined to be supportive towards their partner seeking and sustaining treatment (Darrodi, 2010). The need to address substance use is obvious.

Over time, commitment to reducing opioid addiction in Iran is evidenced through community harm-reduction and treatment programmes (Alam-mehrjerdi et al., 2016). Wide-ranging inpatient and outpatient services supported by government and other providers have included a hotline, opioid substitution therapy, detoxification programmes, HIV testing, counselling and psychiatric services and rehabilitation programmes (Alam-mehrjerdi et al., 2016). These have been supported by religious leaders working in consultation with government and health providers to also remove the stigma arising associated with opioid treatment. Recommendations from researchers also highlight the need for community health education programmes focussing on prevention of drug use (Alam-mehrjerdi et al., 2016).

Collectively these issues highlight the need for ongoing research and recommendations to diminish substance use. Iran has continued to expand methadone maintenance therapy and now has about 2,700 programmes with more than 160,000 participants (Shariatirad, Maarefvand, & Ekhtiari, 2013). For opioid dependence, opium tincture is generally used in the methadone maintenance therapy in Iran (Daneshmand, Alam Mehrjerdi, & Samiee, 2014; Nikoo et al., 2017). Against this background, the aim of this study was to explore the experiences of men on methadone syrup substitution therapy and their perceptions of the support they required to overcome addiction.

Method

Ethical approval for this qualitative research project was obtained from the Ethics Committee of Urmia University of Medical Sciences (42–2448). Inclusion criteria were males aged 18 years or over who had used chemical drugs or opioid derivatives and had attended at least 9 months of rehabilitation at the Razi De-Addiction Clinic. The Razi De-Addiction Clinic is affiliated with Urmia University of Medical Sciences in Urmia (Center of West Azarbaijan province in northwest of Iran).

Information about the study was distributed to potential participants at the clinic by the attending doctor. Interested persons were then referred to the researcher to arrange a mutually convenient time to conduct the interview. Prior to the interview commencing participants signed a consent form and confidentiality was assured. A purposive sample of 16 opioid-dependent males on opioid substitution therapy, specifically methadone syrup substitution therapy, were recruited through the De-addiction outpatient clinic.

All interviews were conducted in person at a mutually agreeable time and venue by the first author and occurred between May 2015 and March 2016. Interviews were conducted in Persian. The interview schedule was based on key issues identified in the literature and comprised demographic questions followed by open-ended questions focussing on participants' experiences, perceived needs for support and the present supports available. Interview length varied between 40 and 135 minutes, and interviews continued until no new data emerged and saturation was achieved (Cleary, Horsfall, & Hayter, 2014). Interviews were recorded and transcribed verbatim. Confidentially was maintained by the de-identification of transcripts prior to data analysis commencing.

Data analysis

Raw data were translated by a professional translator from Farsi (Persian language) into English and checked by the first author. Transcripts were analysed using thematic analysis to identify themes and subthemes and the relationship/s between these through coding (Braun & Clarke, 2006; Clarke & Braun, 2013). Each transcription was coded line by line by the first author. A total of 348 initial codes were gathered, after which selective coding was applied to revalidate the relationships, and refine and develop the themes. Memos including ideas, reflections and interpretations about the data during this process were noted. Subsequently, the team discussed these findings and differing views were resolved through discussion and careful review of the data to understand experiences and perceptions of participants (Lincoln & Guba, 1985).

Findings

Demographic characteristics

Sixteen males participated in this study, ranging from 18 to 48 years. Four had completed university education while the remaining eight either had a high school diploma or had not attained this level of education. Ten participants were married, two were divorced and four were single. All had used chemical drugs or opioid derivatives and attended outpatient treatment for at least nine months (range 9–28 months) (Table 1).

Thematic findings

Three themes emerged from the data: (1) the role of family in drug addiction; (2) the role of the environment in drug addiction; and (3) the support needed to overcome drug addiction.

Theme 1: The role of family in drug addiction

Family behaviours and values are important influences in preventing drug addiction and relapses. Taking drugs can become a form of escape form the reality of everyday life. Families do not always treat one another as equals. This can arise as a consequence of the behaviour of family members that has characterised their relationship with one another throughout

Table 1. Demographic characteristics ($n = 16$).

Variables		Frequency (percentage) Mean (SD; range)
Marital status	Single	4 (25%)
	Married	10 (63%)
	Divorced	2 (12%)
Education	High school	8 (50%)
	Diploma	4 (25%)
	College	4 (25%)
Drug addiction*	Relapse	3 (SD = 1.71; range = 1–7 times)
	Duration (years)	3.5 (SD = 4.24; range = 0.5–18 years)
Outpatient treatment*	Number of months	14 (SD = 6.70; range = 9–28 months)

*Based on sum of treatment periods.

their life. When people feel unsupported by their family they may also feel abandoned by them and resort to drug use as a means of escape as illustrated in the following quote:

> *My father had a bad temper and often annoyed and kicked me as rubbish, and I think that my mother did not love me. I know that I annoyed them, but I need them to notice me. I thought that nobody liked me; this aggravated me so that I decided to turn to the drug addiction. Why did my father not help me when I needed him? (P13)*

When one member of the family is unhappy this is evident to the rest of the family and can be a source of tension. When a father is seen to be disrespectful towards the mother, then the children may not know how best to respond and choose to avoid the situation rather than deal with it. In this instance, the participant chose to avoid being at home and instead spends his time with other 'addict friends':

> *There were always quarrels between my family members; my parents did not love each other. I had a deep problem with them, especially my father, because he used foul language with my mother in front of us. I preferred to escape from home and waste my time with my addict friends. (P2)*

Family attitudes are important in helping the person to deal with their addiction. When the family blames the person for their addiction, particularly when they are seeking their support this may further contribute to the person's negative feelings of self-worth. Lack of family support may impede their recovery:

> *If they knew how to deal with a drug addict like me, I would not like to use the drug. When they blame me, I lost my self-confidence and I could not continue the recovery. (P15)*

Sometimes participants 'blamed' their family for their circumstances.

> *I would not be an addict if I got help from my friends or family members. They did not show interest in me. As I told you, I was not a good son for my family, but they did not have the right to tell me to leave the home. (P6)*

Some factors were attributed to contributing to family relationships. Ill health and family size may influence how the head of the family copes with the responsibilities of this role.

> *My father had no time to control what we did. All of the time he was depressed and tired. There was no control in our crowded family. I and all of my brothers abandoned school in early adolescence to be alive. In our workplace, nobody could control us for our addiction. (P1)*

Rather than taking pity on themselves because they believe no one cared what happens to them, some participants deemed that they need to come to the realisation that ultimately they are responsible for the choices they have made:

> *As a miserable person that nobody cares about him, an addict thinks that addiction is the best way to forget all sufferings. But this idea is wrong and conditions gets worse and it looks that everything is not exactly right. (P2)*

Theme 2: The role of the environment in drug addiction

Drug addiction occurs in response to multiple factors including the environment. Factors influencing drug use identified by participants were: societal expectations; peer pressure; access to money and unemployment. Addiction can impact the individual's quality of life and participants identified employment as being a major factor. Loss of employment contributed to a downward spiral in all aspects of the person's life culminating in poverty and malnutrition, and a sense of loss of control of their future. In addition, peer pressure for boys to engage in risk-taking behaviour starts early in life.

> *… In the place that I live, a boy must prove his braveness by theft and cigarette smoking. If you do not smoke cigarettes, your friends will reject you from their gang. (P3)*

Ready access to money to buy drugs supported addiction. Peer pressure from others acted as an incentive to take drugs so that they are accepted by their peers as reflected by this participant's experience:

> *Because of I had enough money to go on to be a drug abuser, my friends encouraged me to pay and provide drug for me and them. If I did not pay, I would lose my friends, because they did not accept me in their gang and I should be alone and isolated. (P5)*

Unemployment sometimes results in people having too much time on their hands. The boredom that ensues can lead to drug use and consequently a loss in focus on working towards the achievement of life goals. Ready access to drugs, and at no cost, can perpetuate addiction and poor self-esteem:

> *Because of my unemployment, I am so disappointed … I wished to become a doctor, but at present I am a drug abuser … When you became an addict, if you cannot pay for drug, … At that time, one does not know what to do. Everybody forgets you, even your family. (P15)*

Ongoing drug use effects the person's capacity to meet their job responsibilities with one participant describing the spiral of loss - unemployment, income and poverty:

> *I was so confused. I lost my position at my work place. I could not do the things that I did before and I often needed somebody to help me. After unemployment, I had to beg money to sustain my life. Sometime I am hungry and cannot find anything to eat. I am an ill person who suffers from malnutrition. Most of the time, I thought about what will happen in my future? Am I a cursed person? (P6)*

An important outcome of the rehabilitation journey was to achieve life goals including stable employment. Difficulties experienced in gaining employment added additional stress and participants perceived that the government did not provide job opportunities nor protect them. Societal views further exacerbated their ability to find employment. Participants believed that these beliefs were unhelpful and that they required others to advocate for them in gaining employment:

> *Nobody employed me. They believe that I, as an addict, am a dishonest person who commits theft for drugs. If I have money, I do not commit theft or other crimes. Who is ultimately responsible for the protection of us? (P5)*

Despite good behaviour, a history of addiction once known, can lead to dismissal:

> *My friend has a healthy life after abandoning drug addiction, but when his employer knew that he was an addict, he dismissed him suddenly. (P4)*

Theme 3 – the supports needed to overcome drug addiction

Participants identified the need for psychological, social and financial support to overcome their drug addiction. Others did

not know that there was any treatment for addiction or understood that drug and medical treatment was expensive and would not have any effect on them. Some stated that they were unable to afford treatment costs and were seeking help and support from government and non-government organisations. Beyond medication and medical therapy, they from time to time also required psychosocial treatments and consultation which can be expensive. Participants also reported the need for psychological support from their families but family members were not always willing to provide this support because they believed the person was beyond help:

> *We need help from our family to solve our problems. We need psychological support from them such as consultation for our wrong and dangerous habits, but everybody prefers our death and believes that any kindness for us is wasting time and money. (P14)*

This lack of family support, from the participant's perspective was further reflected when the families asked the person to leave the family home even though they had inadequate money to be able to rent or purchase a place for themselves:

> *I need a place to live. I want to die and I can't kill myself … and I do not have any shelter. (P5)*

Supportive interactions can be protective. Some participants are ill informed of the consequences of addiction and may be unaware of the ultimate outcomes. In retrospect, some participants believed that they would not have become substance dependent if they had been supported by family or friends.

> *When I began to become an addict, I could not understand that my life was at risk. Nobody was there to guide me, not even a friend or a family member cared to help me. (P10)*

> *I want to be considered as a human being by the people. I hate to be pitied by them. Really, is there anybody responsible to help me to solve my difficulties? I don't know … (P7)*

Another participant expressed the need for social support not merely from family but also from government and other agencies to address stigma:

> *I am afraid that my addiction causes problems that prevent support from others. We will have fewer difficulties if there is somebody responsible. I think that an addict does not get sufficient social support. At first, his family may do that, but ultimately they will be tired. If I do wrong, does it mean that everybody reproaches me? As a citizen I expect more aid for myself and my family. My children are innocent and should not to be punished for my wrongs. (P9)*

Participant also described being 'labelled' by the stigma of addiction.

> *I am so worried; no one has ever listened to my needs as a human being. Social stigma is a heavy pressure on me. I am a forgotten creature. Nobody helps me with my psychological difficulties. I need a person who behaves with me as a human being and not as an addict. (P12)*

Some participants said that they needed more information regarding support services available to help them cope with their addiction and seek treatment:

> *Nobody told me about organizations that can help or inform us. I did not know how to attend a de-addiction clinic and find it by accident. We need somebody to guide me about what to do. If there is a specific organization that can protect me and my family, nobody tells about it. I did not know how to get rid of my addiction, when nobody tells me how to cope with it? (P16)*

In this instance the participant felt he was not adequately informed about his treatment and believed the health professional was unwilling to answer his questions. This made the person feel unsupported and uniformed regarding their treatment:

> *I was confused; the doctor only prescribed methadone and did not ask any questions. Yesterday, I had a headache, I told my doctor, but he did not pay attention to me … They do not like to answer my questions. One is not important to anybody here … (P18)*

The notion of feeling unimportant or unvalued by health professionals because of their addiction is further highlighted:

> *If they gave me guidelines or consultation, it would feel better. Here, it is ridiculous that I got advice from other people, not from the clinic staff. (P11)*

Without the support they need to rehabilitate, the participants were aware of the losses and fear of what their future may hold:

> *After becoming an addict, I felt that I had lost my healthy life. I could not do anything what I did in the past such as my daily activities. This new condition frightened me and I am feeling discontent with the present and uncertain about the future! (P10)*

Given that drug dealing and purchase is illegal, it is not surprising that participants described incidents with the police. For this participant, this 'event' reaffirmed for them the possible loss of control over their life:

> *For the first time, when I was arrested by police, I saw my hopes ending and thought I lost everything for the rest of your life. (P4)*

Discussion

Increased production and distribution of opium and heroin from Afghanistan throughout the Persian Gulf region has resulted in increased levels of use and addiction among men and consequently is one of the leading priorities for health services in Iran (Alam-mehrjerdi et al., 2016). Drug use and dependence in Iran is a seemingly intractable heath issue given its proximity to drug trafficking corridors from Afghanistan, its predominantly young population and high levels of unemployment, poverty and discrimination (Dehghani & Amiri, 2016). Ready access to these drugs pose unparalleled challenges for the person, their family and society particularly in relation to attitudes, values and accepted norms regarding the role of men within Iranian society as a moral guide and role model (Alam-mehrjerdi et al., 2016). Further the financial consequences for families, health care services and governments are significant. Factors leading to addiction among the Iranian population are: unemployment, poverty and poor role models (Ahmadpanah et al., 2014). These factors also feature in our study findings. Family behaviours influencing substance use in our findings included poor role models and abuse causing the person to feel unsupported and abandoned. Drug use was perceived as a means of escaping the harsh realities of their family life. These responses are likely to be associated with stigma. This finding also contrasts with that of other studies where a family member living with addiction, becomes the focus of other family members leading to increased stress and

anxiety among family members and a stressful family environment (Bortolon et al., 2016).

Unemployment was highlighted in our findings as an important precursor influencing substance use and leading to poverty as noted elsewhere (Ahmadpanah et al., 2014). Unemployment and poverty also influence whether or not a person can access services and treatment. Participants in our study also highlighted the importance of receiving psychological support from their families. Following the introduction of methadone in Iran, many clinicians recognised the effects on opiate dependence and dismissed the need for further psychological interventions (Shariatirad et al., 2013). Whilst psychological interventions were not always evident in participants' experiences, it is nonetheless an important issue. This lack of support may also be associated with family attitudes and religious beliefs as well as stigma (Alam-mehrjerdi et al., 2016).

Given the continuing high rates of substance use in Iran, timely action is necessary to curb this health issue. Further in-depth research targeting contributing factors to substance use is important to inform government policy, preventative education programmes and interventions. This is particularly important because in Eastern Iran, methamphetamine is easily accessible and the use of crack and crystal containing heroin is spreading widely among youngsters (Karrari, Mehrpour, & Bconsequencealali-Mood, 2012). The emergence of parallel methamphetamine and methadone use further supports the need for psychosocial interventions and an update of treatment protocols (Shariatirad et al., 2013). Whilst heroin with methamphetamineis identified as an epidemic health concern, research has identified the importance of providing comprehensive treatment programmes which address the personal, family, social and the cultural needs of the individual (Alam Mehrjerdi et al., 2013).

In this study, researching the views of service users was important to inform current and future health care programmes and is consistent with Neale and colleagues' (2015) research. To facilitate recovery-oriented services, supports, accommodation, employment opportunities and community participation all need to be taken into account (Neale et al., 2015; Raeburn, Schmied, Hungerford, & Cleary, 2016). Participants' responses highlight that whilst in recovery, personal histories cannot simply be put aside. Rather, recovery is embedded within the broader circumstances of the individual and requires recovery capital such as regular paid employment, stable accomodation, supportive friends, family and social networks, and education (Neale et al., 2015; Raeburn et al., 2015).

The study is not without limitations, it was exploratory in nature, confined to one centre, and included only male participants, although the literature found that men experience more consequences of drug and alcohol use disorders than women particularly as they are perceived as the moral elders and role models within the Iranian society (Moazen et al., 2015). Notwithstanding this, drug addiction rates for women in Iran are lower than that of men and influenced by the fact that girls have less freedom than boys: how they spend their time and with whom are decided by their parents rather than themselves (Fereidouni et al., 2015). However they are expected to respect and care for their spouse irrespective of the choices the spouse may make and the implications this may have on their family such as poverty, discrimination and being ostracised within their social group (Ahmadpanah et al., 2014; Alam Mehrjerdi et al., 2013).

Finally, the study provided insights into methadone substitution therapy and the identification of support needs to overcome addiction. The study also showed how addiction is interwoven within the sociocultural, economic and political context of Iran. Whilst treatment programmes are fundamental to treating drug addiction, preventative education is fundamental to influencing public perceptions regarding abuse. Education provided by religious leaders, schools and communities may be influential in reducing drug demand (Alam-mehrjerdi, 2016). Importantly, women also need this education not only to prevent them from initiating substance misuse but also to inform them of the impact of drug misuse on individuals and families providing insight into how they may influence decision-making within families (Fereidouni, 2015). To enable this cultural attitude reconsidering access to education and societal roles may require consultation and collaboration between stakeholders: religious leaders, government, education and health care sectors (Alam-mehrjerdi, 2016). These measures provide a multi-pronged approach to addressing drug use and support the development of community and family-centred services (Fereidouni et al., 2015).

Conclusion

Drug use is a complex problem requiring multi-pronged interventions within a primary health care framework. This may include focussing on greater public awareness to broaden the population's understanding of the consequences of drug addiction especially among the younger population. Referral-specific efforts for drug user treatment services need to be made the priority of health care professionals and most importantly to focus more on not only reducing or eliminating drug addiction but on improving treatment engagement for sustained and long-term outcomes.

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