A SYSTEMATIC STUDY OF DIFFERENCE IN AGGRESSION AND QUALITY OF LIFE AMONG SUBSTANCE USERS AND NON-USERS

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Abstract: 'A systematic study of difference in aggression and quality of life among substance users and nonusers." The study was conducted to assess the difference in Aggression and Quality of life among substance users and non-users. The sample size was 100 adults in which 46 were non users and 54 were users. The age range was 25 to 50 years. Alcohol Smoking and Substance Involvement Screening Test (ASSIST), Aggression Scale and Quality of Life (WHOQOL) were the tools used in this research. The results revealed that tobacco use was the highest among all the other substances. There was no significant difference in the amount of aggression in users and to that of non-users and there was no significant difference in all the four domains of Quality of life of Substance users and non- users.

*Keywords***:** Substance**,** Aggression**,** Quality of life**,** Difference**,** Users**,** non-users

Chapter 1: Introduction

Chapter 1 provides an introductory overview. Its primary purpose is to provide an overview of the research study, set the context for the research, and establish the significance and relevance of the topic. It creates a strong foundation for the subsequent chapters and establishes the context for the findings and conclusions presented in the later sections of the dissertation.

Aggression

While some individuals can redirect their aggressive tendencies towards creative and productive outlets, aggression itself is a form of social interaction that can cause harm or injury to others, either overtly or covertly.

It can occur in response to various triggers or even randomly.

In the social and behavioral sciences, aggressiveness is defined as any action or reaction by one person that causes discomfort or distress to another. According to certain definitions, the aggressor must have the intent to harm another person.

Aggression is seen as a multidisciplinary concept that encompasses a range of mechanisms developed throughout evolution, enabling individuals to assert themselves, protect their kin or allies, acquire resources, or defend them. These mechanisms can involve detrimental and destructive behaviors and are often driven by emotions such as fear, frustration, anger, stress, dominance, or even pleasure. Sometimes, aggression serves as a means to relieve tension or gain a false sense of power. It's important to note that aggression between members of different species, involving predatory or protective behavior, may not be considered aggression in the same sense.

According to Dollard et al. (1939), aggressiveness stems from frustration, which is the negative emotion experienced when facing obstacles that hinder the achievement of a desired goal. This frustration-aggression hypothesis was further developed by Berkowitz, who proposed that any unpleasant event leads to negative affect, which in turn triggers aggressive tendencies and fear responses, rather than the frustration itself. Archer expanded on this by categorizing aggression- and fear-inducing stimuli into three types: pain, novelty, and frustration. He also introduced the concept of "looming," which refers to an object rapidly approaching a subject's visual sensors and can be classified as an intense stimulus.

Aggression can have both beneficial and detrimental effects on adaptation. It encompasses individual or group interactions that are antagonistic and aimed at causing harm or damage. There are generally two main types of aggression that can be distinguished. The first type is hostile, retaliatory, or affective aggression, which is a reactive response to provocation. The second type is instrumental, goal-oriented, or predatory aggression, which employs aggression as a means to achieve a specific objective. For example, physically assaulting someone who insulted you is an instance of angry violence, while committing armed robbery represents hostility used for

practical purposes. The differentiation between emotional and predatory aggression is supported by various studies across different fields. However, due to the complex nature of real-life situations, which often involve conflicting motivations and interconnected causes, some scholars question the practicality of strictly categorizing aggression into hostile and constructive behaviors despite the prevalence of this division in research.

Aggression has been classified and categorized in various ways, taking into account different dimensions. Classification may include not only aggressive actions but also associated emotions and mental states such as anger, impulsivity, and hostility. Aggression can be triggered by social and non-social factors, as well as by stress and coping mechanisms. It can also be used as a means to intimidate.

The definition of aggression can be influenced by moral and political perspectives. For example, political norms dictate how one country should behave towards another, and the non-aggression principle is an axiomatic moral ideal. Different contexts may determine whether certain forms of aggressive behavior are deemed acceptable, such as in the workplace or in competitive sports, while others may not, as seen in cases of workplace bullying. Aggressive behaviors are associated with adjustment issues and various psychopathological symptoms, including antisocial personality disorder (Aspd), Borderline Personality Disorder, and Transient Explosive Disorder.

Biological theories propose that aggression arises from internal energy in response to external stimuli. It is also considered a hereditary trait influenced by hormone fluctuations and shaped by natural selection. Psychological theories view aggression as a destructive impulse, a reaction to frustration, an emotion triggered by negative inputs, a learned behaviour through observation and reinforcement, and a result of various factors that influence individual and situational settings.

Psychologists use the term "aggression" to encompass a wide range of behaviors intended to cause harm, whether to living beings or inanimate objects. Aggression involves causing actual or threatened harm to another individual. While aggression is a normal human emotion, its extreme or pervasive manifestation may indicate a psychological disorder, addiction, or other health issues.

Aggression can be used for a variety of goals, such as:

Express hate or rage, Protest one's power, fear, accomplish a Task, claiming ownership, dealing with fear, In response to pain, rivalry with others.

Aggressive behavior is not simply a state of mind; it involves intentionally causing harm to someone who does not desire that harm. Merely having violent thoughts or moods is not sufficient, and accidental harm does not qualify as aggression. Acts of aggression can take various forms, including:

Physical aggression: This involves using bodily force, such as striking, kicking, beating, or stabbing. Some manifestations of physical aggression may also involve vandalism.

Verbal aggression: This includes actions such as screaming, name-calling, or mocking the target. It can also involve damaging someone's interpersonal relationships by spreading false information or fabricating stories about others.

Passive-aggressive behavior: This refers to actions that allow harm to be done to another person indirectly rather than directly attempting to cause harm. Examples include giving someone a sincere compliment but subsequently ignoring them or deliberately excluding them during a social event.

While the physical manifestations of aggression often receive more attention, the mental anguish that accompanies it can be equally destructive. Verbal abuse, such as berating or intimidating someone, constitutes a form of verbal, mental, and emotional abuse. Cyberbullying is another type of online harassment that has the potential to cause significant harm to the target.

Types Of Aggression

Psychologists have identified two main types of aggression. There are negative consequences for both the attacker and the attacked. **Impulsive Aggression**

Impulsive aggressiveness, also referred to as emotional or reactive violence, is subjected to intense emotions. Hot headed aggression, especially when brought on by anger, activates the brain's acute danger response system, which involves the periaqueductal grey, amygdala, and hypothalamus.

This type of violence is unintentional and frequently occurs in the moment of emotion. You are acting impulsively aggressively if a car shuts you off in congestion and you start cursing and verbally abusing the other driver.

Instrumental Aggression

Instrumental aggression, also referred to as predatory aggression, is characterised by actions meant to further a wider objective. A technique to an aim, instrumental hostility is frequently meticulously planned. This kind of aggressiveness includes hurting a victim during a robbery.

The aggressor's objective is to acquire money, and hurting another person is the way to achieve it.

Cause

What specifically triggers inappropriate or excessive aggression is unknown. It's likely that a number of variables are at play, such as a person's genetics, surroundings, and psychiatric background.

Biological Factors

Hormonal and genetic factors may have a role in the development of aggression. Hormonal and neurotransmitter abnormalities, such as those in cortisol and testosterone, may contribute to aggressive behaviour. However, genetics isn't the only factor at play here; environmental factors also play a role.

A person's skull structure may have a role in their level of aggression. Individuals with structural abnormalities in the amygdala are more likely to exhibit aggressive behaviour. Changes in other regions of the brain may also contribute to aggressive behaviour.

Environmental Factors

Your upbringing may have an effect on how much aggression you show. Experiencing animosity as a child may lead to a lifetime of thinking that aggressiveness and hostility are typical adult social behaviours. Childhood trauma may have a lasting effect on an adult's tendency toward violence.

Learned behaviour may have a role in the development of violent behaviour, as shown by Albert Bandura's famous Bobo doll experiment. In this research, children were significantly more likely to act aggressively against with a Bobo doll following viewing a short video of an adult model acting aggressively toward the doll. **Psychological Factors**

Aggressive conduct can be linked to a number of mental health disorders, including:

Hyperactive/attention-deficit disorder (ADHD) Bipolar illness

Disorder of the borderline personality (BPD)

Narcissism

Trauma-related stress disorder (PTSD)

Aggression may also be influenced by epilepsy, dementia, schizophrenia, a substance use- disorder and anomalies or lesions to the brain.

Impact Of Aggression

Your relationships and health may be impacted by aggression. According to research, there is a connection between inflammatory processes, which can lead to secondary health conditions like cardiovascular disease, and rage. Aggression and rage are linked to several mental health issues. However, it is unclear if those factors inherently make it harder to control strong emotions such as rage and aggressiveness, or if they are caused by uncontrolled anger.

Consequences may also result from aggression shown by a partner, friend, or family member. People who have encountered physical or mental aggression tend to see it negatively, even if their aggressor doesn't. These hostile actions may eventually lead to the end of the relationship.

Unchecked aggressiveness can also complicate work situations and deteriorate friendships. That could make the aggressor feel more stressed out and alienated, which might make the situation worse.

Quality Of Life

The World Health Organization defines quality of life (QOL) as an individual's perception of their position in life considering their goals, expectations, standards, and concerns, in relation to the values and cultural systems of their environment. It encompasses various aspects such as income, work, the environment, mental and physical health, education, social connections, religious beliefs, and feelings of safety, security, and freedom. Evaluating quality of life often involves assessing these factors on a scale, and it is relevant in multiple contexts, including international development, healthcare, politics, and the workplace. Health-related quality of life (HRQOL) specifically focuses on an individual's satisfaction with their health.

When making decisions about how much money to spend, quality of life becomes a significant consideration. Different elements can impact an individual's quality of life, and these factors vary depending on personal priorities. Making trade-offs between different aspects of life can help save or earn more money, but it may come at the expense of overall quality of life. On the other hand, increasing financial expenditure may enhance one's standard of living.

Quality of life has implications for both professional success and personal satisfaction. Having the ability to allocate time and resources to enjoyable activities is often seen as an indicator of a high quality of life within a career context. A job that offers a high salary but demands excessive time and effort, leaving little room for enjoyment, is not considered favourable.

Another factor influencing quality of life is when work schedules allow for leisure and enjoyment but physical or mental exhaustion, injuries, stress, or other factors prevent individuals from truly valuing the money they earn. Nowadays, job satisfaction is influenced not only by compensation but also by other factors.

Considering quality of life is important when planning personal financial strategies. Making sacrifices in the present to improve long-term quality of life may be necessary. Instead of indulging in impulsive purchases, seeking cost-effective alternatives to expensive luxury items can contribute to long-term quality of life enhancement.

The daily commute is an example of a factor influencing quality of life. By choosing to live farther away from central business districts to reduce housing costs, individuals may experience longer commutes. However, this can result in less time spent with loved ones and engaging in leisure activities due to traffic congestion and public transportation delays.

Furthermore, affordable housing options are often situated farther away from entertainment, cultural amenities, and artistic venues. Some individuals consider this trade-off acceptable, while others choose to spend more money to live closer to their workplaces and cultural attractions in order to maximize their quality of life. Certain occupations may expose workers to hazards such as dangerous chemicals, large machinery, or a higher risk of injuries or accidents. In order to provide the desired lifestyle for themselves, their families, and friends, individuals weigh the potential harm that could affect their life satisfaction against the higher wages offered by challenging jobs.

Another indicator of quality of life is the balance between work hours and leisure time. Professionals may opt for high-paying positions that often require late or extended working hours in order to achieve their financial goals. This can include frequent long-distance

business trips for in-person meetings. While such decisions may increase the financial resources available to support personal lives, they also reduce the amount of time available for vacations and other personal activities—essentially, the very things people are striving to accumulate money for. Workplace conditions also significantly impact quality of life. Physically demanding jobs, such as lifting heavy objects or repetitive tasks that can cause long-term physical disabilities, can place a considerable strain on employees. Additionally, some jobs may severely restrict workers' mobility due to confined workspaces, such as operating a toll booth or being stationed at a remote security guard post.

According to the 2021 assessment by U.S. News and World Report in collaboration with the BAV Organization and the National Academy of the University of Pennsylvania, Norway, Denmark, Sweden, Finland, Switzerland, and Australia were ranked as the top six countries in terms of quality of life. Various factors contributed to their high rankings, including political stability, accessible and comprehensive public healthcare systems, strong public education systems, income equality, and family-friendly policies and legislation. In contrast, the United States ranked much lower, at number 20, in terms of quality of life.

If you feel there are areas where your quality of life could be improved, examining your own definition of a decent standard of living is a good starting point. While everyone's definition of a high-quality life may differ, there are some commonalities.

A person's quality of life can be enhanced by having access to decent healthcare, loving relationships, fulfilling employment or volunteer work, scheduling leisure activities, getting enough sleep, eating healthily, and being able to engage in pleasant exercise. Additionally, research show that meditation and the practise of thankfulness might enhance life satisfaction. Experts advise getting enough sleep (at least seven hours each night) to enhance life quality and better manage energy levels and mood. By eating nutrition foods, getting adequate sleep, and finding opportunities to exercise, you may concentrate on increasing your job satisfaction, relationships, home life, and health. Governments may raise the standard of living in their nations by giving access to affordable and quality healthcare, funding primary and secondary education, affordable housing, family-friendly policies, and legislation requiring workers to make a living wage. Quality of life is frequently discussed in relation to how a particular illness affects a patient on a personal level in the context of healthcare. This could be a chronic, endstage disease process, a disabling disability that is not life-threatening, an experience illness that is not terminal, a terminal illness, an elderly person's expected, normal fall in health, an unanticipated mental or physical decline of a loved one.

The Quality of Life Research Department at the Toronto University defines quality of life as "the extent to which a person appreciates the explore and discover of his or her life." Their Life Quality Model is built on the concepts of "being," "belonging," and "becoming," which refer to one's identity and relationship to one's surroundings, respectively. Politicians and economics both use the concept quality of life to describe how livable a particular city or country is. The Where-to-Be-Born Index from the Economic Intelligence Unit and the Quality of Living Surveys from Mercer are two well-known livability indicators. These two metrics use a variety of person's self surveys and objective quality-of-life indicators like rates of divorce, safety, and infrastructure to determine the livability of nations and cities all over the world, respectively. Such statistics do not reflect the general quality of life of an individual, but rather the demographic of a city, region, or nation. In an effort to influence livability, communities design standards like LEED-ND are frequently utilised. Quality of living has a long history and heritage in urban planning. "Quality-of-life crimes" include some property crimes (such as vandalism and graffiti) and some "victimless crimes." The broken windows theory, which asserts that relatively minor issues left unattended (such as litter, graffiti, or public urination by homeless people) send a subliminal message that disorder, in general, is being tolerated, will lead to more serious crimes being committed, was coined by American sociologist James Q. Wilson.

Abuse of substances refers to a pattern of risky utilization of any substance with the intent of altering one's state of mind. The term "substances" can refer to alcoholic beverages, other drugs (whether they are legal or not), and even certain substances that are in no way related to drugs. The term "abuse" refers to the use of a drug in a manner that is either not intended or not advised by the manufacturer, or in a quantity that exceeds what is indicated by the manufacturer. To clarify, a person can experiment with different substances without developing an addiction or even a drug use disorder, as those terms are described in the "International classification of diseases and Statistical Handbook of Mental Disorders, 5th Ed" (DSM-5). 1

The use of dangerous substances, the use of illegal substances, and the misuse of prescription drugs are all topics that are covered in this article. In addition to this, it discusses the risks associated with substance usage as well as some of the substances that are abused most frequently. When recurrent use of a substance causes considerable impairment, such as the following, health experts consider this to be a case of substance abuse rather than just usage of the substance.

Disabilities, Failure to satisfy responsibilities, Concerns over one's health, Control that is impaired, Risky use

Social concerns

To put it another way, if someone drinks to the point where they frequently get hangovers, uses drugs to the point where they forget work or school, smokes marijuana to the point where they have lost friends, or frequently beverages or uses more of it than they destined to use, then their drug use is apparently considered harmful or inappropriate use. Nevertheless, there is a wide variety of different types of substance misuse in today's culture.

Drugs

When people discuss their problems with substance misuse, they are almost always referring to their consumption of illegal narcotics. Abused drugs have more than just an effect on mood. They have the potential to impair judgement, distort perceptions, and slow reaction rates, all of which can raise the chance of being involved in an accident or receiving an injury.

The fact that these medications have the potential to be addictive or that they can have serious adverse effects on one's health is the primary reason why they are prohibited. Some people hold the view that any usage of an illicit substance is irresponsible because of the inherent risk involved.

In order, the following are the types of illegal narcotics that are used most frequently in the United States.

Marijuana Cocaine
weed

Recreational Drugs

Some people believe that using drugs on an occasional, casual basis is harmless and that this type of behaviour does not constitute abuse but rather simple use. Marijuana smokers tend to be the most outspoken advocates for the usage of other drugs for recreational purposes. They contend that, in contrast to "harder" substances, marijuana is not addicted and possesses a wide variety of advantageous properties.

However, new studies have indicated that even cannabis may have greater negative consequences on a person's body, mind, and psychomotor functioning than was previously believed. Numerous new health risks associated with chronic marijuana use are uncovered by researchers in the medical community on an annual basis. In fact, the National Institute of Mental Health (NIDA) has found that persons who use marijuana regularly are more likely to develop a psychological dependence on the drug, which can lead to addiction. The National Institute on Drug Abuse (NIDA) estimates that nine percent of those who use marijuana would develop a dependence on the drug; this number jumps to seventeen percent for those who started using marijuana while they were teenagers.

Prescription Misuse Drugs

In the most recent few decades, there has been a significant growth in the abuse of prescription drugs. According to estimates provided by the National Institute on Drug Abuse, between 8% and 12% of patients in the United States who are given a prescription for opioid pain medications go on to develop a substance use disorder.

The Center for Disease Control and Prevention (CDC) reports that between the years 2018 and 2019, there was a 5% rise in the number of deaths that were due to opioids, with an average of 38 individuals passing away each day in 2019 as a result of an overdose on prescription opioids.

In the United States, there are three primary categories of prescription medications that are frequently abused: opioids, pharmaceuticals that depress the central nervous system, and stimulants. These are the following:

Amphetamines, Barbiturates, Drugs that put people to sleep

It is possible to consume unhealthy quantities of a variety of substances, including alcohol, prescription and over-the-counter drugs, stimulants and chemicals, or even coffee and cigarettes. Many young people get their first experience with substance misuse through the use of inhalants. This is due to the fact that inhalants are included in a wide variety of products that are typically found in the home, and as a result, they are easy to obtain.

Alcohol

In the U.s, drinking alcohol is permissible for people over the age of 21, and there is absolutely no shame in enjoying a few cocktails with good company or as a way to relax and unwind on occasion. On the other hand, one does not need to consume very much alcohol in order to reach a level of drinking that is hazardous; this is the point at which alcohol usage can degenerate into alcohol abuse. Binge drinking is defined as having five or more drinks in one sitting for males and four drinks or more for women. This type of drinking can have a negative impact on both your mental and physical well-being in a variety of different ways.

Nicotine

Nicotine is the substance that is abused more than any other substance in the entire planet. In spite of the widespread awareness of the hazards associated with nicotine use, it is believed that forty million people in the United States continue to be dependent on the substance despite the fact that smoking rates have decreased in recent years. One more time, the fact that it is legal does not mean that it cannot be abused in any way. The fact that it takes a long time for nicotine's adverse effects on health to become apparent likely contributes to the widespread use of tobacco products as a recreational drug. **Caffeine**

Caffeine is the drug that is used the most frequently to alter moods all over the world, whereas tobacco is the medication that is abused the most. And certainly, consuming an excessive amount of caffeine can be bad for your health. Caffeine consumption has also been linked in research to a number of mental illnesses, such as stimulant sleep problems and stimulant anxiety disorder. It is typically recommended that those who have been diagnosed with anxiety disorders, anxiety attack, primary insomnia, or gastroesophageal reflux disease cut back or discontinue their frequent consumption of coffee.

Synthetics

Although so-called "synthetic drugs" and psychoactive substances such as epsom salt and crystal meth are not (yet) considered illegal, their usage is fraught with the potential for abuse, and they may even pose a greater health risk than other substances.

Other synthetic medications that are frequently abused include the following: Ecstasy

LSD

Steroids with anabolic effects

Even while anabolic steroids do not have any qualities that can affect mood or make one feel intoxicated, they can nevertheless be abused. Because of the potentially harmful effects of steroid use, it is unethical to take anabolic steroids in order to improve one's athletic performance or to build muscle and strength. These can vary from being merely bothersome to being really dangerous in certain situations. Abuse of a substance occurs when continued use of that substance results in negative consequences for the user. Abuse is possible with virtually any chemical, at least in theory.

Chapter 2: Review of literature

In Chapter 2 of the dissertation, the focus is on the review of literature. This section provides a comprehensive overview and analysis of existing research and scholarly works relevant to the research topic.

Ferrans, C. E. (2022, November). the standard of living, It is possible that the assessment of the level of life of patients with advanced cancer will make it possible for us to assess the impact that medical and nursing treatments have on clients' lives and, inevitably, to part in the process that may improve the health care provided and the quality of clients' lives. However, the quality of life is a multifaceted term that does not have a single, overarching definition nor a criterion that can be used to quantify it. In order for it to be of any use in therapeutic settings, a clear definition of it is required.

Cella, D. F., & Tulsky, D. S. (2021). Assessing the present-day quality of life: methodological considerations, Even though it is widely acknowledged that having a high quality of life is eventually just as important as having a large quantity of life, most attempts to quantify quality of life end in failure. Definitional differences, in which previous researchers ascribes various meanings to the term and, as a result, are going to measure defined as the differential effect; and inadequate data about available measures, which could also lead to inappropriate test selection and unnecessary rejuvenation of new items are two of the primary reasons for that failure. This article includes a table that provides an overview of the numerous quality of life measurements that are currently available and that have been developed for people with cancer or that are widely used with this population. A good evaluation of one's quality of life requires a number of critical first steps, the most significant of which is the appropriate choice of measures and supplemental questions.

Predictors of Quality of Life in Montreal's Economically Disadvantaged Populations, Caron, J. Caron, J. The Socio-Industrial Revolution The vast majority of epidemiological research are in agreement that communities who are economically poor are the groups that are most susceptible to mental health problems. These studies also reveal a lower quality of life among populations that are economically disadvantaged. It would appear, however, that having access to social assistance is a factor that plays a responsibility to protect against the extreme stress that might emerge from situations such as being poor. The purpose of this research is to determine how much of a difference social support makes to the overall quality of life of financially deprived populations living in two reduced neighbourhoods in the city of Montreal. The interviews were place in the homes of the respondents and involved a random sample of 417 people receiving social assistance. The Pleasure with Life Dimensions Scale was the instrument that was utilised to assess one's quality of life. The Cultural Provisions Scale was utilised in order to evaluate the accessibility of various social support components. Measures of social support were incorporated in a holistic framework that also consisted of a number of other factors that were known to have some sort of connection to mental health. Moral support and support that provided confirmation of worth accounted for the majority of the variability in the quality of life that was predicted by the model, and were two of the 17 variables that were utilized in a multi-regression analysis. People who were younger and those who were suffering food poverty showed a lower quality of life, and psychological distress was another factor that accounted for a fair percentage of the variance in QOL.

Wet milling, K. T. (2008). The purpose of this study is to determine whether or not it is feasible to improve the survivors' quality of life as well as their physical well-being among underserved Latina Americans who have survived cervical cancer. There is a dearth of evidence regarding the usefulness of behavioural therapies for those who have survived cervical cancer (CCS). In the case of CCS, there are disparities in survivability outcomes, particularly for Latino Americans. The purpose of this study was to investigate whether or not it would be possible to conduct a culturally competent intervention that would be carried out by telephone.

Sophia Lee, H., & Petersen, S. R. (2009). In the context of drug misuse treatment, de- stigmatizing those who are already on the margins: the experiences of homeless, substance users at a drop-in centre focused on harm reduction Research and Theory on Addictive Behaviors. The participants of a treatment programme that targets homeless active drug users and is based on an addiction treatment paradigm share their experiences of decriminalisation in treatment in this article. The programme is non-abstinence based. Drug users who had been marginalised as a result of their drug and/or alcohol use are the subjects of the tales that are shared. These drug users had an experience in treatment that was de-stigmatizing, normalising, humanising, and non-judgmental. This article's goals are to (1) describe the sense of decriminalisation that people experience and (2) argue that decriminalisation is an important factor in engaging "hard-to-reach" inhabitants in substance abuse treatment. The purpose of this article is to explain the sense of decriminalisation that participants experienced. It works under the assumption that paying attention to what patients have to say about what is or is not significant to them in therapy can disclose a lot about how well a programme is working for them.

Ompad, D., & Minior, T. (2003). Differences in the experiences of prejudice and the reactions of people who use substances because of their race. A negative association has been shown between discrimination and both personal health, and it is possible that discrimination is a particularly important factor in determining health among underrepresented groups. The purpose of this study was to investigate whether or not Black and Latino active drug users in New York City respond differently to discrimination and whether or not their experiences with discrimination are different. Methods: Recruitment workers, social agencies, and word-of- mouth were utilised to recruit a total of 419 Latinos and 500 Blacks who were currently using active substances. We collected data about the many forms of discrimination experienced (for example, prejudice due to race, gender, or drug use), the contexts in which it occurred (for example, at work, with police), and the responses that individuals had to unfair treatment. The findings showed that the most common kind of discrimination experienced by both Blacks

and Latinos was that of being treated differently because of their history of drug use. Respondents of African descent were more likely than those of Latino descent to report experiencing discrimination as a result of their drug use (79% versus 70%), race (39% versus 23%), poverty (38% versus 26%), gender (18% versus

9%), sexual orientation (38% versus 6%), and gender (18% versus 9%). Latinos, on the other hand, were more likely to encounter rejections from family (81% compared to 70%), friends (73% compared to 60%), law enforcement (86% compared to 79%), employers (72% compared to 56%), and medical care providers (29% compared to 18%).

Respondents of African descent were more inclined to take direct action in response to discrimination, whereas respondents of Latino origin were more prone to internalise their experiences. Conclusions: There are significant disparities between the ways in which African-American and Latino people who use substances react to and cope with discrimination in their daily lives. These distinctions may help explain the racial and ethnic disparities in health among marginalised populations, and they may also help identify possibilities for effective, specialized treatment.

Hornquist, J. O. (2018). The idea of quality of life, as well as its evaluation. A publication of the Scandinavian Society for Social Medicine, It is necessary to perform an analysis on the idea of "quality of life" in order to comprehend and evaluate it. It is hypothesised in this study that the concept of quality of life encompasses not only life in its whole but also its many subfields. Life quality can be defined as a person's level of perceived global satisfaction as well as their level of satisfaction in a variety of important domains, with a particular emphasis placed on their well-being. In this article, a detailed chart of important life domains is offered, as well as an adaptable package of tried-and- true rating methodologies. Pincer operations with a variety of rating types are indicated as the best way to acquire correct and sensitive assessments

Muller, A. E., Skurtveit, S., & Clausen, T. (2016). Many of the factors that correlate with an individual's poor quality of life prior to entering treatment for addiction are not addiction-specific , The factors that have been linked to a lower quality of life in other groups, both healthy and clinical, such as decreased social and bodily well-being as well as mental trauma, were also observed to be associated with a lower quality of life in this sample. In addition to concentrating on substance-related factors, treatment should be directed toward patients who have these particular vulnerabilities, and interventions that have been shown to improve the quality of life of other populations that also have these risks should be explored in the context of substance use disorder (SUD).

Préau, M., & MANIF-2000 Study Group (2018). health-related life quality among present and formerly injecting addicts who are infected with HIV; these individuals have HIV , Since it was discovered that HRQL has a prognosis on the living of HIV patients who became susceptible to infection through drug injection, it follows that providing more quality healthcare (for instance, by focusing more attention to patients' experiences of traumatic situations, meeting their requirements in psychosocial support, and better managing their perceptions of toxicity) could worldwide improve therapeutic efficacy in this vulnerable minority.

De Maeyer, J., Vanderplasschen, W., & Broekaert, E. (2010). the quality of life of those who are dependent on opiates, In the evaluation of health care, quality of life, abbreviated as QoL, has emerged as an important outcome indicator. It is important to make a clear distinction between quality of life (QoL), which focuses on individuals' subjective happiness with their lives as a whole and unique life domains, and health- related quality of life (HRQoL), which relates to the utter lack of pathogenesis. Both concepts are important, but the distinction between the two must be made. This review of the literature aims to summarise and distinguish the available information on quality of life in opiate-dependent individuals. Opiate relying is the primary drug of most people who enter treatment, and the attention paid to quality of life in drug abuse research is growing. Both of these factors contribute to the purpose of this review. A complete evaluation of the available literature was carried out, which included searching for relevant information in databases such as Web of Science, Pubmed, and the Cochrane Systematic Reviews Database. If an article evaluated the quality of life or health-related quality of life of opioid painkiller individuals, used a quality of life or health-related quality of life instrument, and noted at least one particular outcome on quality of life or health-related quality of life, then it was eligible for review. There are a total of 38 articles that have been chosen. The review found that there were 15 different instruments used to measure quality of life, the majority of which were HRQoL measures. Opiate- dependent people have been found to have a lower reported health-related quality of life (HRQoL) compared to both the general public and people who suffer from a variety of medical conditions. In most cases, individuals' (HR)quality of life improved as a result of their participation in substitution treatment; however, the implications of this treatment on individuals over the long term are still unknown. Problems of a mental nature, advanced age, and heavy consumption of alcoholic beverages all appear to be linked to lower (HR)QoL scores. The evaluation of quality of life in opiate dependent study is in its infant stage at this point. Despite this, the persistent nature of drug abuse problems makes it necessary to consider outcomes that go beyond the immediate repercussions of substance misuse and that are based on the requirements of clients. As a result of its one- sided concentration on the functional state of clients, HRQoL is inadequate for the purpose of measuring quality of life because it does not provide information about clients' own perceptions of the quality of their lives or the satisfaction they derive from living. It is necessary to conduct additional study on the subject of quality of life using an approach that is both subjective and multidimensional.

Archer, J. (2009). The make-up of aggressive people. Review of Law and Psychology, an International Forum, We examine human violence from four different ethologically informed theoretical vantage points. The first is its cost-benefit analysis-supported adaptive utility, which is evident across the animal kingdom in contexts including resource competition and offspring protection. The second is how aggression emerged in human evolution, specifically with regards to the brain systems related to rage and repression, the emotion display of anger, and the physical manifestation of aggressive actions. The third considers how early experiences shape aggressive tendencies later on. The important social learning perspective is challenged by the findings of an evolution approach to development, which show, for example, that physical aggressiveness begins early in life and is later characterised by learnt restraint.

The fourth theory looks at the motivational mechanisms at work in regulating aggressive behaviour, which can range from rigid reflexes to more complex systems that incorporate conscious decision-making.

Lina Rowell Huesmann and Lina D. Eron (2021). Aggression as a personality attribute and individual variance, As a psychological construct, aggression has many of the characteristics of an innate character trait. It is strongly correlated with gender, persistent over time and across contexts, and tied to physiological and genetic characteristics; it originates early in infancy but is impacted and modified by a child's life experiences; and it is stable or predictable. Nonetheless, aggressiveness need not be considered a motive in every case. In contrast, we believe that violence is best conceptualised internally as a set of idiosyncratic "scripts" for social behaviour, with an emphasis on aggressive response, and the association structure linking these scripts to one another, to external stimuli, and to outcome expectations. These scripts adhere to established standards for how humans take in and use data. These scripting networks, once set up, may be very difficult to alter. This leads to a collection of mental frameworks that, over time and in different contexts, encourage the same kinds of hostile and instrumental violence.

Bond, A. J., & H. V. Curran (2019). Cognitive bias, aggressive personality traits, and impulsive behaviour in people who abuse substances, This group of substance abusers exhibited a tendency toward anger in their thinking that was not exclusive to MDMA use. Those who scored higher on the trait aggression questionnaire were far more likely to view ambiguous situations as cause for anger and to express this anger in writing when it was not provoked.

Chapter 3: Methodology

The research methodology includes the general approach, research design, data collection methods, and analysis techniques that will be used.

Aim

To study the difference in Aggression and Quality of life among substance users and non-users.

Objective – the objective of the study is to find

To study the difference of aggression in substance users and non users. To study the difference of quality of life in substance user and non users.

Hypothesis •   There will be a significant difference in the level of aggression among substance users and non users.

•   There will be a significant difference in the level of quality of life among substance users and non users.

Design

This study has followed a quantitative design , using 3 standardized questionnaires to investigate the difference in aggression and quality of life amng substance users and non users

Variables

Aggression
Quality of life
Substance use

Sample And Its Selection

For this study , marginalized population males were the sample (25- 30) who participated. The study was conducted in DELHI and GHAZIABAD. The participants of this were 100 out of which 40 are non-substance users and 60 are users. Participants completed the questionnaire.

Tools used

Aggression scale

Aggression scale is used to study the level of aggression. Aggression scale is finally prepared. Now it consists of 55 statements. Each statement describes different forms of individual's aggression in different situation. It is a Likert type 5 point scale. In this scale statements are in two forms that is positive and negative.

WHO – QOL

With its 26 items, the World Health Organization Quality of Life-BREF (WHOQOL-BREF) questionnaire covers areas such as physical health, mental health, social relationships, and the environment.

The WHOQOL-BREF is a condensed version of the original WHOQOL-100, which was developed at 15 different locations throughout the globe. a measurement of quality of life that is applicable across cultures. The questions are appropriate in light of the aforementioned concept of quality of life, which is "defined as conceptions that people have of themselves and their place in the world, both in regard to the

society and the set of values that they are raised in and in comparison to others in relation to their objectives, anticipations, requirements, and worries." The following categories are used to evaluate one's quality of life: The first domain, physical health, including day-to-day activities, reliance on pharmaceuticals and other medical assistance, levels of exhaustion and energy, mobility, and levels of pain and discomfort distress; the ability to sleep and rest; the capability to work); Domain 2 (psychological health, including body image and appearance, negative moods, and addictive behaviours): pleasant sentiments; self-esteem; spirituality or religion; personal views; thinking, learning, and memory; and concentration); Domain 3 (social ties, including personal relationships and social support, as well as sexual activity); Domain 4 (environment—financial resources; freedom,

physical safety and security; availability of and quality of health and social care; the quality of the home environment; possibilities for obtaining new skills and knowledge.

new knowledge and abilities; involvement in and access to recreation and leisure activities; the physical environment (including pollution, noise, and other factors); and traffic/climate]; travel). In most cases, the questions are placed within the context of a time frame of two or four weeks; however, this can vary based on issues related to culture or disease. If the emphasis is on The longer time frame of four weeks may be desirable when considering the impact on quality of life of persons who suffer from chronic health disorders such as arthritis. Also, The passage of time is experienced differently in various cultural contexts, which may have an impact on the time frame that is selected. When combined with other assessment tools, WHOQOL instruments can assist physicians in tracking changes in quality of life and can contribute to the decision-making process on treatment options.

There are four different domain scores that can be derived. There are also 2 things that are evaluated independently: the first question inquires about an individual's general impression of their quality of life, and the second question inquires about an individual's overall view of their own health. The on while of quality of life in each of the four aforementioned domains is reflected in the individual's total score for each domain. The domain scores are scaled in a direction that is positive (ie, higher scores denote higher quality of life). When calculating the

total score for each domain, the mean score of the items in that domain is taken into account. The next step is to multiply the mean scores by four in order to make the domain scores comparable with the scores that are used in the WHOQOL-100. . . On page 1 of the WHOQOL-BREF assessment form, a method for the manual calculation of individual scores is given. This method can be found here. When utilising this method, the method for converting raw scores to scores after transformation is given in [the table that follows]. The first method of transformation changes the score to a range that is comparable to the WHOQOL-100, which is between 4 and 20. The second method of transformation involves converting domain scores to a scale ranging from 0 to 100.

In the event that an evaluation is missing more than twenty percent of its data, the evaluation in question ought to be thrown out. In cases where an item is absent, the average value of the remaining items in the domain is used as a substitute. With the exception of domain 3, which should only be calculated if fewer than two items are missing, the domain score should not be determined if there are more than two items that are absent from the domain.

ASSIST

The ASSIST was developed specifically for use by health care professionals in a variety of different health care settings across international borders. It is also possible that this information will be valuable for professionals who deal with persons who are at a high risk of experiencing problems due to the use of substances. It is possible for this to be linked to a quick intervention that assists high-risk substance users in cutting down or quitting their drug usage altogether, so avoiding the negative effects of their substance use. The ASSIST is an expansion of the WHO's activities that led to the establishment of the AUDIT; however, rather than focusing on alcohol, the ASSIST does so on several substances.

The ASSIST gives data about the substances that people have ever consumed in their lifetime, the substances that they have consumed in the previous three months, the problems that are related to the use of substances, the risk of future or current harm, the level of dependence, and the use of injecting drugs. Tobacco, wine, cannabis, cocaine, amphetamine- type stimulant, sleeping pills, magic mushrooms, inhalants, opioids, and various other drugs are some of the substances that are discussed in this article.

The ASSIST is a brief screening tool that may be completed in five to fifteen minutes. It consists of eight questions that evaluate the incidence of substance use, the effects of use, and the inability to quit or reduce usage. The interview-based version of the ASSIST, which was administered in the beginning, showed very good psychometric qualities. All of the terminology, questions, and structure from the person being interviewed ASSIST were carried over into the computerised version of the ASSIST. Individuals can be classified into an opiate risk group based on their results from the ASSIST, which can be scored to obtain an overview of lifetime and related to substance use, a Global Universe Risk (GRS) score, a Drug Participation (SSI) score, and a Total Narcotic Involvement (TSI) score; these scores can be used to obtain a score (Low, Medium, or High risk).

Procedure

The tools were selected to move forward with the research. After the selection of the tools , they were being filled by the rickshaw pullers , daily wage workers , pan shops through hard copy questionnaires. The participants were given instructions about the research and the purpose of the study. They were also informed about the confidentiality. The results were calculated after the collection of the data. The raw scores were noted and then t-test and correlation were calculated.

Statistical Analysis

After the collection of data , it was entered in Microsoft excel sheet and was then entered in the SPSS software.

Chapter 4: Results

While the introduction may touch on anticipated or preliminary results, the main purpose of this section is to provide justification of the research.

Table 1.

Nonuser (1) Users (2)		N	Mean	Std. Deviation	t value – nonusers	t value – users
physical health	1 2	40 60	65.35 63.99	20.859 19.303	.322	.312
psychological health	1 2	40 60	70.61 72.38	18.023 20.510	.412	.433
social relations	1 2	40 60	64.29 62.33	32.063 27.600	.312	.294
Environment	1 2	40 60	74.65 71.87	22.423 22.052	.579	.575

Table 2. Quality life in users non user

psychological health	Equal variances assumed	.681	1.764	4.277
	Equal variances not assumed	.666	1.764	4.071
social relations	Equal variances assumed	.756	1.957	6.279
	Equal variances not assumed	.770	1.957	6.648
Environment	Equal variances assumed	.564	2.776	4.793
	Equal variances not assumed	.567	2.776	4.823

Table 2 represents the t statistics over the Quality of Life domains of users and non users. The results indicate that there is no significant difference over the Physical health domain of QOL among users and non users (t value .757, t is greater than 0.05) The results indicate that there is no significant difference over the psychological domain of QOL among users and non users (t value .783, t is greater than 0.05) The results indicate that there is no significant difference over the social relationships domain of QOL among users and non users (t value
.752, t is greater than 0.05) The results indicate that there is no significant difference over the environment domain of QOL among users and non users (t test .735, t is greater than 0.05)

Aggression scale

Table 3 Group Statistics

Aggression	Drug Usage	N	Mean	Std. Deviation	t
	Non-Users	40	203.1333	30.74672	.562
	Users	60	206.72	28.38	.545

Table 4

		Levene's Test for Equality of Variances		t-test for Equality of Means						95% Confidence Interval of the Difference	
		F	Sig.	T	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference		Lower	Upper
Aggression	Equal variances assumed	.817	.368	.562	96	.575	-3.58725	6.38160		-16.25463	9.08012
	Equal Variance not assumed			.545	51.736	.588	-3.58725	6.58464		-16.80190	9.62739

This tables shows that there is no significance difference in aggression of users and non-users as the t value is greater than 0.5.

Chapter 5: Discussion

The discussion section in a research paper is where the findings of the study are interpreted, analysed, and contextualized in relation to the research objectives, existing literature, and research questions or hypotheses. It is an essential part of the research paper that allows researchers to delve deeper into the implications, significance, and limitations of their findings.

Table 1 presents the results of a t-test comparing the mean scores of various quality of life domains between substance users and non-users. The four domains examined are physical health, psychological health, social relations, and environment. The Interpretation of the results for each domain in detail is following:

1. Physical Health:
   The results indicated that there was no statistically significant difference in physical health scores between the two group. Previous studies such as a systematic review by Brown and Tapert (2021) investigated the effects of alcohol use on physical health outcomes in adolescents and young adults. The review found mixed findings, with some studies reporting a significant negative association between alcohol use and physical health, while others found no significant effects. The authors emphasized the need for further research to examine the role of individual differences, patterns of alcohol use, and lifestyle factors in understanding the relationship between alcohol use and physical health outcomes.

2. Psychological Health:
   The results revealed a t-value of 0.412 for psychological health. However, the associated p-value was found to be greater than the predetermined significance level, indicating that there was no statistically significant difference in psychological health scores between substance users and non-users. These findings suggest that substance use alone may not be a strong predictor of psychological health.
   For instance, a study by Thompson et al. (2019) examined the relationship between marijuana use and mental health outcomes in a sample of college students. The findings indicated that while heavy marijuana users had higher levels of depression and anxiety compared to non-users, this association did not reach statistical significance after controlling for confounding variables such as socio-demographic factors and co-occurring mental health conditions. This suggests that factors other than substance use, such as pre-existing mental health vulnerabilities, may play a role in the observed outcomes.

3. Social Relations:
   This area aimed to investigate the potential differences in social relations scores between substance users and non-users. The results indicated that there was no statistically significant difference in social relations scores between the two groups. The p-value associated with the t-value was greater than the significance level, suggesting that the observed differences were not statistically significant.

   The mean social relations score for substance users was 64.29, slightly higher than the mean score of 62.33 for non-users. However, without statistical significance, it is important to interpret these mean differences cautiously. The small discrepancy in means may not have practical significance in terms of actual differences in social relations between substance users and non-users.

4. Environment:

The results indicated that there was no statistically significant difference in environment scores between the two groups. The p-value associated with the t-value was greater than the significance level, suggesting that the observed differences were not statistically meaningful.

Previous studies have failed to establish a significant association between substance use and environmental perception. These studies suggest that other factors, such as socio-economic status, education level, and personal values, may influence individuals' perceptions of the environment more strongly than substance use alone. Additionally, the specific context and cultural factors may play a significant role in shaping individuals' environmental perceptions.

Overall, the results of the t-tests indicate that there is no significant difference in quality of life scores between substance users and non-users across the four domains examined. The means and standard deviations for each domain do not vary substantially between the two groups.

These results are specific to the given dataset and may not be generalizable to other populations or settings.

In summary, based on the provided data, there is no statistically significant difference in quality-of-life scores between substance users and non-users in the domains of physical health, psychological health, social relations, and environment.

Table 2 presents the results of t-tests for three different quality of life domains: psychological health, social relations, and environment. For each domain, the t-tests were conducted under the assumption of equal variances and unequal variances.

1. Psychological Health:

The study examined the potential differences in psychological health scores between substance users and nonusers. Two different scenarios were considered: one assuming equal variances between the groups and the other not assuming equal variances. In both cases, the results indicated no statistically significant difference in psychological health scores between the two groups. The p-values associated with the t-values were greater than the significance level, supporting the conclusion of no significant difference. The mean difference in psychological health scores between the groups was consistent across both scenarios, with a value of -1.764 (non-users minus users). The standard error of the difference was calculated for each scenario, providing an estimate of the precision of the mean difference. These findings suggest that there is no substantial difference in psychological health scores between substance users and non-users, regardless of the assumption of equal variances.

2. Social Relations:

The study further examined whether there were any differences in social relations scores between substance users and non-users. Two different scenarios were considered: one assuming equal variances between the groups and the other not assuming equal variances. In both cases, the results indicated no statistically significant difference in social relations scores between substance users and non-users. The p-values associated with the tvalues were greater than the significance level, supporting the conclusion of no significant difference. The mean difference in social relations scores between the groups was consistent across both scenarios, with a value of 1.957 (non-users minus users). The standard error of the difference was calculated for each scenario, providing an estimate of the precision of the mean difference. These findings suggest that there is no substantial difference in social relations scores between substance users and non-users, regardless of the assumption of equal variances.

3. Environment:

The study also aimed to determine if there were any differences in environment scores between substance users and non-users. Two scenarios were considered, one assuming equal variances between the groups and the other not assuming equal variances. In both cases, the results indicated no statistically significant difference in environment scores between substance users and non-users. The p-values associated with the t-values were greater than the significance level, indicating that the observed differences were not statistically significant. The mean difference in environment scores between the groups was consistent across both scenarios, with a value of 2.776 (non-users minus users). The standard error of the difference was calculated for each scenario, providing an estimate of the precision of the mean difference. These findings suggest that there is no substantial difference in environment scores between substance users and non-users, regardless of the assumption of equal variances.

Overall, the t-tests indicate that there is no statistically significant difference in psychological health, social relations, and environment scores between substance users and non-users. In all three domains, the p-values were greater than the significance level, suggesting that any observed differences in means are likely due to random chance rather than a true difference between the groups.

In conclusion, based on the provided results, there is no evidence of a significant difference in psychological health, social relations, and environment scores between substance users and non-users.

The results finally compare the aggression levels between two groups: non-users and users of drugs. The variables analysed include the number of participants (N), the mean aggression score, the standard deviation, and the t-value.

The data reveals that the non-user group consisted of 40 participants, with a mean aggression score of 203.1333 and a standard deviation of 30.74672. Conversely, the user group consisted of 60 participants, with a slightly higher mean aggression score of 206.72 and a slightly lower standard deviation of 28.38.

The t-value of 0.562 was obtained from the t-test conducted to compare the mean aggression scores between the two groups. This indicates a relatively small difference in mean aggression scores between the non-user and user groups.

In summary, based on the available data, it can be inferred that the mean aggression score is slightly higher in the user group compared to the non-user group.

Table 4 presents the results of Levene's test for equality of variances and a t-test for equality of means. These tests were performed with both equal variances assumed and unequal variances assumed, using a significance level of 0.5.

Levene's test, which examines the equality of variances between the groups, yielded a test statistic (F) of 0.817 and an associated p-value of 0.368. As the p-value is greater than the significance level, it suggests that there is no significant difference in variances between the groups, leading to the assumption of equal variances.

The t-test for equality of means was conducted under both the assumption of equal variances and unequal variances. The t-value obtained was 0.562, and the associated p-value was 0.575. With 96 degrees of freedom, the mean difference between the groups was found to be -3.58725, with a standard error of the difference equal to 6.38160.

The 95% confidence interval for the difference in means was provided. Assuming equal variances, the confidence interval had a lower bound of -9.08012 and an upper bound of 16.25463. Without assuming equal variances, the confidence interval had a lower bound of -9.62739 and an upper bound of 16.80190.

In conclusion, based on the available data and the statistical tests performed, the difference in mean aggression scores between the non-user and user groups is not statistically significant.
Interpretation:
Based on the results, the p-value for both the Levene's test and the t-test is greater than the significance level of 0.5. This suggests that there is no statistically significant difference in variances or means between the two groups for the variable "Aggression."

The mean difference of -3.58725 indicates that, on average, the non-user group has slightly lower aggression scores compared to the user group. However, this difference is not statistically significant, as the p-value is greater than the significance level.

The confidence intervals provide a range of plausible values for the true difference in means. Since the confidence intervals include zero in both cases (assuming equal variances and not assuming equal variances), it further supports the conclusion that there is no significant difference in aggression scores between the two groups.

In conclusion, based on the results and a significance level of 0.5, there is no evidence of a significant difference in aggression scores between the two groups, assuming both equal variances and unequal variances.

Chapter 6: Conclusion

It was concluded that there was no significant different in the Aggression of users and non-users which was shown in the results as tables. There was no significant difference in Quality of Life considering all the four domains of the Substance users and non-users.

Limitations

Further analysis and interpretation would benefit from considering the limitations of the study, such as sample representativeness, potential confounding variables, and the reliability and validity of the quality-of-life measures used. Additionally, a more comprehensive understanding of substance use patterns, duration, and severity would provide valuable context for interpreting the findings.
Further research with larger and more diverse samples would provide additional insights into the relationship between substance use and quality of life in these domains.

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