

Abstract

Objective: The present study was aimed at comparing the effectiveness of medicinal and cognitive-behavioral rehabilitation approaches in the adjustment ratio of the families seeking rehabilitation. In this study, a quasi-experimental research design with pretest-posttest and control group was employed. **Method:** The statistical population of this study included all patients presented to Tehran rehabilitation centers in 2014. The search sample consisted of 30 participants who were selected through purposive sampling and were selectively assigned into three 10-participant groups. The two experimental groups were treated by medicinal and cognitive-behavioral rehabilitation approaches, and the control group awaited the treatment. Twelve weeks after the intervention, all the participants were evaluated through Spanier Dyadic Adjustment Scale (1976). **Results:** The results of the data analysis indicated that both treatment approaches were effective in the individuals' adjustment ratio ($P < 0.001$) whereas cognitive-behavioral approach was more effective than the medicinal one. **Conclusion:** Psychological treatments are effective methods for treatment of disorders and can replace medicinal therapies.

Keywords: cognitive-behavioral treatment approach, medicinal treatment approach, rehabilitation volunteers

On the Comparison of the Effectiveness of Medicinal and Cognitive-Behavioral Rehabilitation Approaches in the Adjustment of Spouses in Volunteer Families for Abstinence

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Introduction

Addiction to drugs is one of the most important problematic issues of the present age, which has become widespread globally. This problem devastates millions of lives and destroys national macro capitals to fight and treat it. A large number of people are added to this disaster every day and, accordingly, its complications, including physical, mental, familial, cultural, economic, and social disorders result in the elimination of the cultural boundaries of the community and endangers human mental and economic health. Due to its numerous cultural and geographical location and neighboring two major narcotics-producing countries, Iran is in a very critical and sensitive condition. Therefore, the individuals suffering from addiction cause serious economic and cultural damages to society every day (Mousavi, Dowlatshahi, & Noori Khajavi, 2009). Because it reduces quality of life, mortality and ethics, and increased criminal behavior (Hollinghurst et al., 2010; Morton, Snowden, Gopold, & Guymer, 2012), addiction is one of the most important issues related to health Psychiatric disorders. Addiction has had devastating effects on physical, psychological, social, and family domains as well as social communication (Astals et al., 2009; Roberts, Roberts, & Oxine, 2007).

On the other hand, family is the main institution of society, thereby, the establishment of a healthy and proper relationship among its members is the most important factor in its health and stability. In fact, family is the smallest component of the community. A social community composed of healthy families is certainly healthy, and the main condition for the health of families is the members. In a healthy family, the main goals are to improve the status of the community, the family, and its people (Satir, 1990; Translated by Birashk, 2011). One of the factors that causes problems, tension, and conflict in the family is the existence of turbulent relationships among the members of addicted families. Addiction is a disease that affects family relationships (Hendriks, Scheea, & Blankena, 2011). Govanloo (2004) states that men's addiction causes women to be discouraged in life and have less affection; therefore, it reduces their emotional relationships with their husbands, limits their communication patterns in their relationship, and leads to the intensification of incompatibilities among couples. The majority of families also react promptly to the problem of their spouses or children's addiction, and call for immediate treatment, but they usually fail. The role of families in the affected person's addiction abstinence is of crucial importance, because if the patient and his/her family do not get disappointed with the treatment and continue the treatment, the likelihood of success in the treatment is very high. Families should know that there is no definitive treatment for addiction and the relapse into drug use always happens, but the likelihood of relapse decreases over time and with the modification of the lifestyle (Abar, Carter, & Winsler, 2009). Monshe'ea (1999) studied the addicts' families in terms of scale (solving the communication problem, roles

and emotional response, emotional engagement, behavior control, and general efficiency). The results were representative of the availability of inefficiency and the problem (s) in the functioning of families with addicted member(s). Therefore, since addiction is a very dreadful social phenomenon, it affects not only the addict's personal life, but also his/her relatives and family members (as cited in Ghahsareh, Dervizeh, & Pourshahriari, 2008).

Hence, drug addicts' relatives use a variety of therapies, such as medication, psychoanalysis, cognitive behavioral therapy, group therapy, etc. By means of these therapies and to save the affected person from this disaster, families hope to act successfully in addiction abstinence of their family members. In the national conferences on drug treatment from research to practice in 2005, 2006, and 2007, the research findings on the effectiveness of different treatment methods represent inconsistent and sometimes contradictory results. Perhaps the only commonality of these pieces of research has been their emphasis on these two points: 1) Psychotherapy is more effective than medication alone and 2) Psychotherapy, including behavioral therapy, cognitive therapy, group therapy, and so on reflects its beneficial effects in the addiction withdrawal and the survival of addiction treatment compared to non-treatment of the disease (National Conference on Addiction Abstinence Therapy, 2007).

The review of the findings of several recent meta-analysis studies suggests that cognitive-behavioral therapy is effective in the treatment of addicted people in comparison to medicinal therapy (Team, 2004; Butler, Chapman, Forman, Beck, 2006; Turkington et al., 2009). However, a very limited number of studies have been done on the comparison of the efficacy of methadone maintenance treatment and other common treatments, including non-medicinal therapies in psychiatric disorders among populations of drug abusers. Evidence obtained from experimental studies indicates the efficacy of medicinal treatments of opioid dependence and agonist-maintenance treatment, especially methadone maintenance treatment as a common treatment method in most countries (Drummond, 2007). In addition to the effectiveness of methadone therapy in drug use abstinence, some research findings about methadone therapy have referred to the effectiveness of this therapy in the reduction of the duration of abstention, improvement of the psychological status, health, and psychological well-being of patients (Marmani et al., 2007), Beigi, Farahani, Mohammadkhani, & Mohammadi, 2011), the reduction of drug-related crime, the reduction of high-risk behaviors, the mortality due to overdose of substances (Brugal et al., 2005), and the recovery from anxiety and depression (Harvard, 2006; Poornaghash, 2008).

According to the results of related studies, the effectiveness of both cognitive-behavioral and medicinal therapy in drug addicts has been evaluated, but in this regard, the results have been reported to more or less differ from one another. Lotfi Kashani, & Asgari (2009) evaluated the efficacy of cognitive-behavioral therapy, methadone maintenance therapy and congress60 therapy, and found that

cognitive-behavioral therapy was significantly effective in interpersonal variables among addicts and their spouses. Turkington et al. (2009) examined the effectiveness of cognitive-behavioral therapy in the psychological health status of addicts and their families through their random assignment to two groups of cognitive-behavioral therapy with naltrexone and cognitive-behavioral therapy without naltrexone. They reported that cognitive-behavioral therapy along with medicinal therapy were more effective and fruitful. Peles, Schreiber, Naumovsky, & Adelson (2007) also compared the efficacy of medicinal therapy with cognitive-behavioral therapy and advocated the significant effectiveness of cognitive-behavioral therapy compared to medicinal therapy. Beigi et al. (2011) also assessed the compatibility, quality of life, and hope in addicts and concluded that the average scores of participants in treatment sessions in factors of agentic thinking, hope, compatibility, interpersonal relationships, and physical health were significantly higher than those in the individuals not attending the treatment sessions. Similarly, the results of this study in families are important in several aspects. The attention of families to the person in the process of addiction withdrawal helps him/her to get fully aware of his/her heavier responsibility. On the other hand, the patient will be able to make better decisions on not using the drug. On the other hand, families' compassionate attention and emphasis on drug use withdrawal leads to healthy behaviors and a healthy family environment, which ultimately provide the basis for the successful addiction withdrawal.

Therefore, considering the existence of various therapies, addiction not only afflicts the affected individual with terrible difficulties, it also has a great deal of harmful effects on these addicts' families. Such families are constantly looking for and trying to make the addicted member to stop drug use. This way, they sometimes feel skeptical about finding help from the variety of methods they have at their disposal. Therefore, the current study seeks to answer the following research question: Are medicinal methods of addiction treatment and cognitive-behavioral therapy are effective in the adjustment ratio of wives in the families seeking rehabilitation? If yes, which method is more effective?

Method

Population, sample, and sampling method

To conduct the current study, a quasi-experimental research design along with pre-test/post-test and control group was employed. The statistical population of this study included all the patients presented to Tehran rehabilitation centers in 2014. The entry criteria for the inclusion of participants in this research was addiction to one of the narcotic drugs (regardless of type), being married, and willingness to participate in the research. The search sample consisted of 30 participants who were selected through purposive sampling (if desired and volunteered) and were selectively assigned into three 10-participant groups (two experimental and one control groups). All the selected individuals had been recently presented to the centers and their treatment was still at an early stage or

had not begun the treatment yet. It is noteworthy that all the selected participants were male and were placed in the 35-to-50-year-old age range.

Instruments

Dyadic Adjustment Scale (DAS): This scale was developed by Spanier (1976) to measure the adjustment between the husband and wife or any couple who live together. There are 32 items in the scale that are used to assess the marital quality of a husband or wife, or any couple who live together. The factor analysis shows that this scale measures four dimensions of marital relationships, namely dyadic satisfaction, dyadic cohesion, dyadic consensus, and affective expression. The total score of this scale ranges from zero to 151. The scores above the average (101) indicate better adjustment and relations, and the scores below the average indicate a lower degree of adjustment (Sanayi, 2000). Spanier (1976) compared 218 people living with their spouse and 94 divorced women with each other to calculate the criterion validity scale. In this comparison, the mean scores of the two groups were significantly different, which indicated the acceptable criterion validity scale ($p < 0.001$). Significant differences were also found in the subscales. Spanier (1976) reported the reliability of this scale to be equal to 0.96, which indicates the significant internal consistency of the scale. In addition, the internal consistency of the subscales was as follows: dyadic satisfaction 0.94, dyadic cohesion 0.81, dyadic consensus 0.90, and affective expression 0.73 (as cited in Abbasi, 2004). For the investigation of the concurrent validity of this scale, Molazadeh (2002) conducted the simultaneous implementation with Locke – Wallace Marital Adjustment Test with the reliability of 75% and the validity coefficient of 0.90 was obtained. It is noteworthy that he carried out the study on 76 couples similar to the sample couples. Haj Abolzadeh (2002) implemented a study on 15 couples in order to assess the test-retest reliability of this scale within a one-week interval. The correlation coefficient between two series of scores during the two rounds of questionnaire implementation obtained was equal, while these values obtained equaled 0.68, 0.81, 0.77, and 0.78 for the subscales of dyadic satisfaction, dyadic cohesion, dyadic consensus, and affective expression, respectively. The scoring is conducted based on a Likert scale. The items numbered 16, 17, 18, 19, 20, 21, 22, 23, 31, and 3 belong to dyadic satisfaction; the items numbered 24, 25, 26, 27, and 28 pertained to dyadic cohesion; the items numbered 1, 2, 3, 5, 8, 9, 10, 11, 12, 13, 14, and 15 are related to dyadic consensus; and the items numbered 4, 6, 29, and 30 belong to affection expression.

Procedure

The participants in the sessions of cognitive-behavioral group therapy were treated during twelve 45-minute sessions and the methadone treatment group consumed an average of 10 to 20 cc of methadone syrup based on the type of substance consumed, the duration of consumption, and the dosage in line with

the physician's opinion without the researcher's interference. The control group did not receive any medical and psychological treatment and was kept on the waiting list. In order to comply with research ethics, firstly, the required explanations were given to the individuals about the research and their consent was obtained. They were ensured that their participation would be voluntary. A description of the cognitive-behavioral sessions is presented in Table 1.

Table 1: Cognitive-behavioral therapy sessions

<i>Sessions</i>	<i>Title</i>
Session 1	Goals: Introduction and initial communication, mention of the expectations in the treatment process, placement of emphasis on the confidentiality of the sessions.
Session 2	Goals: mention of the signs and symptoms of depression and its relation with drug use and motivation towards treatment
Session 3	Goals: Explanation of the analysis model of behavioral functioning, expression of beliefs and absolute values, attention to the cause of problematicity of beliefs, identification of thoughts and assumptions, presentation of assignments
Session 4	Goals: Review of the assignments of the previous session, assessment of thoughts and challenges with them, introduction of four styles along with errors (negative self-concept, negative central beliefs, cognitive triangle, and rational error), presentation of assignments
Session 5	Goals: Presentation of practical strategies to fill the clients' time, introduction of the table of daily activity records, and disconnection from drug use initiators
Session 6	Goals: Explanation about irrational beliefs relating to drug use and presentation of assignments about internal and external initiators
Session 7	Goals: Review of the assignments of the previous session, evaluation of worries and negative emotions, presentation of assignments
Session 8	Goals: Review of the assignments of the previous session, presentation of a list of cognitive distortions, and explanation about the identification of cognitive distortions
Session 9	Goals: Review of the assignments of the previous session, relaxation training, presentation of assignments on how to review the relaxation method
Session 10	Goals: Teaching coping behavior with craving, presentation of assignments for recording hazardous situations
Session 11	Goals: Training about the bottom-up arrow technique, and presentation of assignments pertaining to the identification of ineffective substance-related assumptions
Session 12	Goals: Review of the assignments of the previous session, review of the dysfunctional thoughts, and explanation about the end of the sessions

Results

The descriptive statistics of the research variables are presented in Table 2 for each group and test type.

Table 2: Descriptive statistics of the research variables for each group and test type

Variable	Test type	Group		Medicinal		Cognitive-Behavioral	
		Mean	SD	Mean	SD	Mean	SD
Dyadic satisfaction	Pretest	1.3	26.11	6.6	25.09	5.2	24.17
	Posttest	1.7	34.5	4.8	28.42	4.8	23.89
Dyadic cohesion	Pretest	2.3	12.1	4.6	14.00	2.2	13.10
	Posttest	5.52	22.5	4.8	16.9	3.8	14.6
Dyadic consensus	Pretest	5.45	30.58	6.6	30.75	4.2	29.41
	Posttest	4.42	40.5	5.8	33.9	5.8	28.55
Affection expression	Pretest	2.17	6.08	2.6	6.5	1.16	7.91
	Posttest	1.85	10.75	1.8	7.9	1.15	7.25
Total adjustment	Pretest	9.54	75.20	8.6	79.14	6.26	78.16
	Posttest	8.15	109.50	7.8	80.9	10.06	78.20

In order to examine the effectiveness of addiction treatment methods in dyadic adjustment components, multivariate covariance analysis should be used. One of the assumptions of using this analysis is the equality of error variances. To this end, the results of Levene's test are presented in Table 3.

Table 3: Results of Levene's test representing the equality of error variances in the three groups

Variable	F	Sig.
Dyadic satisfaction	0.60	0.44
Dyadic cohesion	0.20	0.65
Dyadic consensus	1.72	0.19
Affection expression	1.54	0.16

As it can be observed, the assumption of equality of error variances has been met in all the components ($P > 0.05$). Another assumption of using covariance analysis is the equality of variance-covariance matrix. The results of the test showed that this assumption has also been met ($P > 0.05$; M Box = 2.20). Therefore, multivariate covariance analysis was run and the results showed that the groups were different in the linear combination of the components ($F = 65.31$; $P < 0.001$; Wilks's Lambda = 0.94). To examine the patterns of difference, univariate analysis of covariance was run, as presented in Table 4.

Table 4: Univariate covariance analysis results for examining the patterns of differences

Variable	Mean Square	F	Sig.
Dyadic satisfaction	202.30	14.80	0.0005
Dyadic cohesion	164.40	14.80	0.0005
Dyadic consensus	96.24	5.25	0.01
Affection expression	110.66	10.90	0.001

Bonferroni post hoc test was run to examine patterns of difference. The results showed that there was a significant difference between the control group and both medicinal and cognitive-behavioral group in all components ($P < 0.001$). There was also a significant difference between the medicinal and

cognitive-behavioral methods ($P < 0.05$). According to the descriptive statistics, cognitive-behavioral therapy has been more effective than medicinal therapy.

Discussion and Conclusion

The objective of this study was to compare the effectiveness of medicinal withdrawal and cognitive-behavioral therapy in the adjustment ratio of spouses in volunteer families for rehabilitation. The results of this study showed that both treatments were effective in increasing the adjustment rate of addicts and their spouses. In their study, Beigi et al. (2011) assessed adjustment, quality of life, and hope in addicts and concluded that the mean scores of participants attending the treatment sessions on the three mentioned variables were significantly higher than those in the individuals not attending the treatment sessions. Therefore, the results of this study are consistent with those of the mentioned research. Similarly, Ghasareh et al. (2008) also showed that cognitive-behavioral approach is effective in dyadic adjustment of male addicts' spouses, which is consistent with the findings of this study.

Substance abuse is accompanied by severe devastation of family and social functions; and the consequences of substance abuse are harmful to the individual's social relationships. Anxiety about being seen by the people in the neighborhood, being labeled, the potentially insults directed upon the addicted person, increased irritability, and negative emotions are all factors that disrupt one's social relations. The person is caught in a vicious cycle, that is, the diminution of the relationship with his/her associates leads him/her to the consumption of drugs in order to find a way to fill his/her emotional vacuums. In cognitive-behavioral therapy, the improvement of the relationship between the individual and his/her friends, acquaintances, spouse, and children is emphasized in order to ensure that his/her sources of support are sufficiently rich. Therefore, it is expected that cognitive-behavioral interventions will be effective in the enhancement of social relationships.

Moreover, the findings of this study showed that there is a significant difference between cognitive-behavioral therapy and medicinal therapy, which is consistent with some other research findings in this area (Pournaghas, 2008; Dean, Bell, Christie, & Mattick, 2004; Momenpour, 2010). In addition, this finding supports the finding reported by Lotfi Kashani, & Asgari (2009) in that cognitive-behavioral therapy outweighs medicinal therapy in the interpersonal relationships among addicts and their spouses. This finding is also in line with the research findings reported by Brooki Milan, Kamarzarin, & Zare (2014) who found that cognitive-behavioral therapy is effective in the improvement of coping strategies and mental and physical health of drug dependent patients. In fact, the key concept of the higher effectiveness of cognitive-behavioral therapy and its more positive effect on the improvement of addicts' mood indicators compared to medicinal therapy is the acceptance of reality and the responsibility of what has happened and the change that must take place. Although by taking

medication, an addict feels improvement in his/her mood due to the change in the chemical process of the neurotransmitter, s/he does not feel responsible for the phenomenon, as s/he did not find him/herself responsible for the addiction. In another study, Momeni, Mushtagh, & Pourshbaz (2013) concluded that medicinal intervention was effective in the improvement of the quality of life of opiate addicts under methadone treatment in the short term, but it had little effect on their quality of life in the long run. In the treatment of opioid addiction, as a long-term preservative drug, methadone maintenance therapy is one of the most proven and well-known approaches to the maintenance of abstinence state and relapse prevention. Although methadone treatment is considered as one of the most common and effective approaches, it seems that this treatment alone is not sufficient thereby, other treatments that take the psychological, social, and environmental aspects of patients into account, should also be considered. Among the above-mentioned interventions, cognitive-behavioral therapy is a selective treatment for some psychological disorders since it enjoys some benefits, such as saving time and effort, training social skills, and improvement and promotion of interpersonal relationships. These benefits have led to the widespread application of this method as a selective treatment for drug dependent patients (Brink, & Hassen, 2006). McHugh, Hearon, & Otto (2010) have shown that cognitive-behavioral techniques alone or in combination with medication, play an significant role in the management of anxiety and depression and the relationship with others and increase the patients' satisfaction with life. Also, Sugarman, Nich, & Carroll (2010) reported that cognitive-behavioral interventions improve the individuals' anxiety symptoms, increase tolerance, and promotes the quality of life in patients. Another study conducted by Osilla, Hepner, Muñoz, Woo, & Watkins (2009) has proved that cognitive-behavioral interventions influence all aspects of a person's life, improve communication skills with the environment, and reduce depression. In addition, Drisson & Wahlon (2011, as cited in Momeni et al., 2013) have reported that the effectiveness of cognitive-behavioral therapy leads to all aspects of the person's life and has a significant effect on satisfaction with life.

In this regard, Turkington et al. (2009) examined the effectiveness of cognitive-behavioral therapy in the mental health status of addicts and their families through their random assignment to two groups of cognitive-behavioral therapy with naltrexone and cognitive-behavioral therapy without naltrexone. They reported that cognitive-behavioral therapy along with medicinal therapy were more effective and fruitful. In other words, although cognitive-behavioral therapy has a better efficacy than medicinal treatment in the improvement of addicts and their family adaptation, the combination of cognitive-therapeutic therapy with medicinal therapy can have the best effect on improving the psychological health of individuals who abuse drugs. This is why, addiction treatment centers should choose the appropriate treatment according to the treatment priorities at their disposal. This means that they first prescribe a

combination of medicinal therapy and cognitive-behavioral therapy for the patient, and if for any reason, such as no cooperation by the patient or lack of facilities, they had to choose one of the treatment methods, they can assign a priority to the cognitive-behavioral therapy and eventually use medication as the last priority.

Hence, aside from the fact that addiction is a disease and has severely damaged family relationships, it should be noted that family members also play an important role in the effectiveness of various ways of addiction treatment. They should know that their inappropriate behavior towards the addicted member in the process of withdrawal in the form of placing pressure on him/her may cause the recurrence of the illness or relapse of the substance; however, by their proper conduct, they can prevent these problems. The role of families in the abstinence of the affected person's addiction is of crucial importance because if the patient and his/her family do not get disappointed with the treatment and continue the treatment, the likelihood of success is very high. Families should know that there is no definitive treatment for addiction and the relapse into drug use always happens, but the likelihood of relapse decreases over time and with the modification of the lifestyle.

One of the limitations of this study is that only two therapeutic methods were assessed in terms of increasing the adjustment rate of substance abusers' wives, while there are also other methods for the improvement of mental health in these individuals. There are also other variables, such as family, cultural factors, and psychological variables that may affect the effectiveness of a therapeutic approach. In this study, only the variables of gender, marital status, and age (i.e., demographic variables) were controlled. For this reason, at the end, in order to achieve a safe and conclusive treatment in future research, it is suggested that other therapies be compared with behavioral, cognitive-behavioral, and group therapy methods in addiction treatment. In fact, further studies in this area should address and control more variables so that it would be possible to comment on their effectiveness more precisely and accurately.

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