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Differences of Sexual satisfaction, dysfunctional relationship beliefs and dyadic adjustment among addicts under methadone treatment and withdrawal applicants

Soheila Shaei Arani*, Fatemeh Azartash Shandy

Abstract--- *PURPOSE: This study was conducted to compare withdrawal applicants (untreated) with patients who were under methadone maintenance treatment for at least 6-month to investigate sexual satisfaction, dyadic adjustment and dysfunctional relationship beliefs. METHODS: The population included addicts referring to addiction treatment centers in Shiraz and their wives in 2013. A sample of 74 addicts admitted to these centers, together with their spouses participated in the study. Data was collected through questionnaires of spanier revised dyadic adjustment, Larson sexual satisfaction, and relationship beliefs inventory (RBI). Then, the data was analyzed via t-tests. RESULTS: The partner's dysfunctional relationship beliefs were observed more in the drug abusers (untreated) group than the group under methadone maintenance treatment. Also differences in destructive disagreement and sexual perfectionism as two subscales of dysfunctional relationship beliefs, as well as differences in agreement and satisfaction as two subscales of dyadic adjustment were significant between the groups. DISCUSSION: According to the results, it is essential to hold long-term courses for training relationship techniques to couples and to use special techniques for correction of cognitive errors among addicts.*

Keywords--- *Sexual Satisfaction, Relationship Beliefs, Dyadic Adjustment.*

I. INTRODUCTION

Drug use has a long history and has appeared since ancient times in diverse forms for various reasons. But "drug addiction" as a peculiar predicament is a relatively new phenomenon emerged since the late 18th and early 19th centuries (1). The phenomenon of drug or substance abuse and addiction is the result of the interaction among several factors. All addiction experts and specialists agree that drug abuse cannot be considered as a mere physical, psychological or social problem, and its emergence should be noticed as the consequence of the interaction of several problems. Institutions and network of an addict's interactions are psycho-social concepts that should be thought as a factor influencing the occurrence of addiction; family is a critical institute (2).

Addiction can be come off during four stages: pre-intention, intention, action and maintenance (3). Previous studies have identified many reasons and factors for trying to quit addicts, which drive a person to move into one stage and the next stages. Passing into each stage and continuing treatment leads to changes in economic, familial, social, individual, etc. aspects of an addict.

Methadone treatment is recommended to help patients and reduce their social health problems. Centers for treatment

Soheila Shaei Arani, Master of Clinical Psychology, Shiraz University, Iran. * Corresponding Author: Email: arani.2548@gmail.com*
Phone number: +98 913 260 3806
Fatemeh Azartash Shandy, Department of Psychology, Central Tehran Branch, Islamic Azad University, Tehran, Iran.

with methadone directly and indirectly affect the prognosis of addiction. Methadone is an industrial substance that has the same physiological and analgesic features as opium. Though, it is not considered intoxicating and it is easier to stop using than opium and heroin. Methadone is administrated to patients orally and in a controlled way in some centers (4).

Despite various treatments, many addicts, particularly heroin users, are unable to reach the state of persistent abstinence and if there is no protective treatment, the rest of their lives will revolve around the supply and consumption of drugs. To date, MMT has been recognized as the most successful approach in addiction treatment, reducing drug use, reducing criminal behavior and legal detention, reducing mortality, increasing occupational function, reducing AIDS, hepatitis, and other infectious diseases such as tuberculosis which is resistant to treatment (50% of injecting drug users in New York are HIV positive and AIDS virus vectors, but this percentage was almost zero among those who were under MMT treatment since 1978, exactly three years before the onset of AIDS). Patients treated with MMT, even if they are AIDS virus vector, are very unlikely to infect others (5).

Much research has been done on the relationship between drug use and psychological, social and behavioral troubles. There is a significant difference in the psychosis (6) and neuroticism level of Eysenck's personality system (7) between drug addicts and normal people; the level is higher in drug addicts. Drugs such as heroin, cocaine, amphetamines, alcohol, and nicotine release dopamine into the nervous system (8). Therefore, it can be assumed that the release of dopamine in the neural pathways of the activation system is closely linked to the emotional states resulting from the use of the drugs mentioned above (9). Thus, due to the activity and sensitivity of the behavioral activation system and deficient behavioral inhibition system among the drug users, there is an increase in the person's uncontrolled behaviors. This includes sexual behaviors that in most cases lead to the partner's sexual dissatisfaction.

The quality and the way couples communicate with each other are of the most effective and momentous variables in sexual satisfaction. Numerous studies have confirmed a significant relationship between sexual satisfaction and satisfaction with marital interactions and relations (10).

Drugs impact sexual function in several ways. For example, decreased or increased libido, impotence, and premature or late ejaculation are known as the most common effects. Some patients initially tend to the use of drugs for some of their side effects such as delayed ejaculation and increased eroticism. In more advanced stages, impotence is usually the last impact of drug abuse on eroticism so that even after quitting addiction, sexual desire, sexual power and premature ejaculation does not easily return to its previous normal state and in some cases it lasts up to months or years.

In addition to warming the marital relations and spouses' vitality, sexual satisfaction can prevent disorders and diseases associated with it. For example, a positive relationship between sexual satisfaction and reduced heart attack and reduced migraine headaches, symptoms of premenstrual syndrome and chronic arthritis have been reported among men and women, respectively (11).

Clinical findings show that about 70% of addicts are married (12); therefore, sexual and dyadic issues can be one of the most serious risk for addicts' lives. This may lead to the feeble solidarity and more conflicts at the family level, and problems such as divorce, rape, the unstable relations outside the home, running away, and various other psychological and social risks against the children at the social level. Previously, many studies have introduced diverse types of social crimes, including addiction as a disease for which preparation and susceptibility are provided first within the family system and then in the community. Hence, regardless of all other individual and social troubles and problems, the importance of the issue can be pondered according to an alternative perspective: addiction disrupts the structure of the family system and arouses the tendency to this type of crime, as well as numerous mental and training disorders.

In addition to knowledge, experience and the use of medicine, motivation to continue a healthy life is a necessity to cope with addiction. Such a motivation is mostly related to family and spouse. Therefore, having a healthy family relations

can help a person to come off. The lack of such relations causes a vicious cycle and continues the process of addiction. For this reason, recognizing the problems caused by addiction that affect the quality of married life and the efforts to eliminate them is of a great importance. Increasing the knowledge addicts' spouse, awareness of the importance of sexual relations and dyadic quality, and discovering the cause of the damage to relations will significantly help rehabilitate different aspects of addicts' life and improve the quality of his/her personal, familial and social life.

According to the studies, while desirable sexual function is an agent for consolidating family and culture, sexual dysfunction is closely linked to social problems such as crime, rape, mental illness, and divorce. Moreover, nervousness, abdominal and back pain, inability to concentrate and even to do daily activities are other consequences of failure to satisfy sexual instinct (13). Therefore, sexual satisfaction acts like an operator for having successful and satisfying dyadic relations. In religious societies, marriage is the only social system that provides an opportunity for satisfying sexual needs (14).

Studies also reveal that marriage makes individuals healthy and vital and the lack of marital adjustment after marriage not only adversely affect the psycho-social actions of couple, but also the growth and development of children and adolescents in the family (15). In Iran, marital conflicts and divorce are acute damages to society and researchers have evaluated divorce as one of the most severe psychological pressures and have ranked it as one of the most stressful life events. (16). Sadeghi (2000) found that 82% of women were not sexually satisfied and 4.61% of them had applied for a divorce because of sexual dissatisfaction. He also found that 74% of men were dissatisfied with their sexual relations due to frigidity and lack of their wives affection, and 10% of men had applied for a divorce due to sexual dissatisfaction (17). Bentium also attributes the failure of 50% of marriages to sexual dissatisfaction (18). Therefore, the importance and role of sex in having a satisfying married life is clear.

Although sexual dysfunction and problems are critical problems of opioid and industrial drug abusers, there are very few studies on this issue in Iran and other countries. Hanbury, Cohen, and Stimmel (2000) explain the lack of research by patients feeling ashamed of expressing their sexual problems to addiction therapists and not reporting it. Addiction therapists also regard it a private matter and are less willing to interview their patients about it (19). On the other hand, issues such as negative perceptions of couples, having inflexible standards, personal prejudices and misunderstandings result in dissatisfaction with and failure of positive aspects of marriage. Marital problems and the lack of adjustment are rooted in partners' irrational thoughts. If such thoughts are modified, marital conflicts will also disappear (20). Primarily, failure to communicate is the most common complaint of divorced couples. To learn more about people's behaviors, we need to explore individuals' actions behind the scenes and go beyond their spontaneous thoughts and look for their fundamental beliefs. Fortunately, some of these beliefs are not so deep and can be easily identified (21).

Dysfunctional beliefs are the main cause of many social disputes, especially relation conflicts (22, 23, 24, 25, 26, 27). Such beliefs actually mean the existence of misconceptions that do not correspond to reality about oneself and the world. According to Ellis (2001), no event can inherently cause mental disorder in humans since all stimuli and events are conceptualized and interpreted in the mind, and accordingly, maladaptation and emotional problems are actually due to the way through which the information resulting from stimuli and events is processed and interpreted; ineffective thoughts and beliefs underlie that information as well(28).

Dyadic life is an area where irrational and dysfunctional thoughts are penetrated in and emerged. Although many experts believe that marriage is one of the universal foundations and deeply affects the lives of human beings, it is not protected from various harms. For example, studies (29) have shown that many spouses have difficulty with establishing and maintaining friendly and intimate relations with each other since they expect to gain benefits from marriage in general,

and from the spouse in specific. In other words, their expectations of a marital relationship have become wider and in many cases more irrational so that it has even led to frustration with married life.

In many cultures, marital relations are perceived as the primary source of support and affection (30), and spouses are expected to show an exclusive relationship, honesty, affection, intimacy and support. Almost all couples report high levels of satisfaction at the beginning of their married life (31), it decreases over time. Divorce is the most valid indicator of this dissatisfaction and perturbation (32). On the other hand, 85-91% of people who are getting divorced had positive ideas and unrealistic and ineffective predictions at the beginning of the marital relationship and believe that the probability of divorce is zero for them (33).

Undoubtedly, to behave within the framework of relations is significantly influenced by cognitive agents. This is because people with a set of expectations and beliefs about each other gradually reach a point where indifference, frustration and distastefulness dominate their relations. Accordingly, identifying and measuring these ideas and beliefs and reflecting on them will be beneficial to settle spouses' emotional and behavioral troubles (28).

Irrational beliefs in marital relations are classified in different ways. For example, according to Beck (1976), some specific and unique beliefs of couples are: 1) selective experiences (to focus on a small part of a negative event), 2) exaggerated generalizations (perceiving any negative incident as an absolute failure), 3) labeling negatively (insisting on negative and malicious reasons in the spouse's behavior and speech), 4) personalization (attributing all problems to him/herself disabilities) 5) Hasty judgments (without having good reason to judge, reading and predicting each other's thoughts), 6) all or nothing thinking, and 7) magnification (exaggerating matters and mistakes) (34). According to Burns (1992), some of the dysfunctional beliefs of spouses in marital relations include being righteous, blaming the partner, considering themselves as a victim, humiliation, expectation and helplessness (35).

McCrady, Epstein, and Cell (36) also identified two relationship styles in the interactions of addicted couples: demand-withdrawal style and high-level emotion expression style. Demand-withdrawal interactions are a particular type of negative relationship style in addicted families through which one spouse pursues and demands while the other spouse puts a distance, defends, and withdraws. This type of interaction is common in addicted spouses and the non-addicted spouse criticizes and demands change from the withdrawn addicted spouse, leading to a demand-withdrawal cycle.

This cycle may perpetuate the problem of consumption and also lead to more marital stress and dissatisfaction for both spouses. Subsequently, stress and dissatisfaction become a prelude to more consumption. Expressed emotion is also a form of negative relationship that has drawn plenty of attention in the literature of addiction and family (37) and probably represents an important prelude to drug use. Stress expression in addicted families is defined as a combination of criticism, hostility, and excessive emotional conflict toward the addicted spouse. Compared with lower expressed emotion, highly expressed emotion (among addicts' spouses) is associated with lower dyadic satisfaction, higher recurrence rate, and shorter recurrence time after treatment. Criticism and frustration of the non-addicted spouse may lead to more marital stress and eventually more drug use by the addicted side. Successively, a more severe addictive problem may lead to more expressed excitement and, equally, a greater likelihood of recurrence. Certain problems, such as sexual dissatisfaction and dysfunction, might be seen as sources of stress and a trigger for drug use. Also, any interaction that leads to negative emotions with stress is likely to contribute to the persistence of drug abuse (34). Here is some empirical evidence:

Hanbari et al. (2000) studied impaired sexual function among 50 male patients treated with methadone maintenance and showed that 33% of the subjects suffer severe sexual dysfunction and 50% of them, even one month after the treatment, still had the disorder. This problem was seen among 71% of heroin users (38).

Tatari, Farnia, Faqih and Nasiri (2010) studied 177 opioid patients and showed significant sexual disorders in 70% of the clients (39). Babakhanian et al. (2011) conducted a study on sexual dysfunction in men with opioid abuse who were

under methadone maintenance treatment. Their results revealed the prevalence of sexual dysfunction and improvement of some components of sexual function during the treatment (40). Chun, Hao, Ruan, Cassell, Chen, Xin et al. (2008) measured the effect of methadone on risky sexual behaviors for 557 heroin users in China. The data showed a positive and short-term impact of methadone on high-risk behaviors (41); however, more research is needed to examine the long-term impacts.

Sadeghi (2001) conducted a field study using the Jones questionnaire and concluded that drug addicts suffer more cognitive distortions than non-addicts. He confirmed the influence of drugs on irrational thinking and dysfunctional attitudes of addicts (42).).

The results of Aziz Mohammadi (2007) showed that the scores of dysfunctional thinking are significantly different between the two groups of normal and (opium and heroin) addicted people. His findings also showed that there is a significant relationship between the scores of personality traits, dysfunctional thinking and duration of substance use in both groups of opium and heroin addicts. This relationship was more severe in the heroin addict group (66%) who had used drug for more than two years (43).

Lotfabadi (1996) has studied the personality traits of addicts from a clinical perspective and reported that addicts have traits such as introversion and neurosis so that their attitude to the environment changes and their thinking in settling everyday problems gets inefficient. Research conducted in the country suggest that the personality traits of drug addicts have always been affected by substance abuse. This negatively changes their attitudes toward the environment and makes them ineffective thinkers in solving personal and daily problems (44).

Research hypotheses

1. There is a difference in sexual satisfaction between the group of substance abusers (withdrawal applicants) and the group of maintenance treatment.

2. There is a difference in dyadic adjustment between the group of substance abusers (withdrawal applicants) and the group of maintenance treatment.

3. There is a difference in dyadic adjustment of a spouse between the group of substance abusers (withdrawal applicants) and the group with maintenance treatment.

4. There is a difference in dysfunctional relationship beliefs of the addict between the group of substance abusers (withdrawal applicants) and the group with maintenance treatment.

5. There is a difference in dysfunctional relationship beliefs of the spouse between the group of substance abusers (withdrawal applicants) and the group with maintenance treatment.

The present study aimed at investigating the level of sexual satisfaction of addicts attempting to give up, or in other words, the level of satisfaction with their sexual activity and definition of their sexual efficiency, as well as dyadic adjustment and dysfunctional relationship beliefs.

II. Population, Sample and Sampling Method

The statistical population includes all addicts attempting to give up by methadone maintenance method in Shiraz in 2013. The sample consists 74 (29 withdrawal applicants and 45 under treatment subjects) married people with their spouses referring to “Neshat Amin” and “Iman” drug treatment centers in Shiraz.

Subjects were selected using available sampling method and data was collected via a questionnaire.

Reading/writing literacy and visual and auditory ability to complete the questionnaires were the inclusion criteria. Moreover, individuals in the treatment group should have at least 6 months of non-return maintenance treatment for

effectiveness of the treatment. Exclusion criteria included chronic physical or mental illness and being over 60 years old, since the sexual ability can be greatly changed under the influence of these two factors.

Research instruments

Relationship Beliefs Inventory (RBI)

The inventory includes a 40-item questionnaire developed by Edelson and Epstein (1982) to measure irrational beliefs about marital relations (45). Cronbach's alpha coefficient for this scale is estimated from 0.72 to 0.81 and each sub-scale has a significant relationship with marital scales (46). The Persian version was translated and validated by Mazaheri and Pouretemadi (2003) (47). James, Huntley, and Hems (2002) reported an alpha coefficient of 0.58 to 0.83 for the five subscales (48). In the study by Heidari et al. (2005), internal consistency of the sub-scales was obtained from 0.47 to 0.70 (20). This scale includes 5 areas for irrational relationship beliefs:

1. Believing in destructive disagreement means disagreement is harmful (questions 1, 6, 11, 16, 21, 26, 31, 36).

2. Expecting the discovery of thoughts means expecting the spouse to understand the feelings, thoughts and needs of the spouse without expressing them (questions 2, 7, 12, 17, 22, 27, 32, 37).

3. Believing in the spouse immutability means belief in the immutability of the spouse's behaviors and their repetition in the future (questions 3, 8, 13, 18, 23, 28, 33, 38).

4. Believing in sexual perfectionism means expecting the spouse to have full sexual intercourse regardless of the spouse's status and needs (questions 4, 9, 14, 19, 24, 29, 34, 39).

5. Believing in gender differences means to have expectations from the spouse without considering the cognitive and physiological differences between men and women or congenital differences as the cause of differences (questions 5, 10, 15, 20, 25, 30, 35, 40).

RBI is a Likert scale and the subjects express their opinion about each item as 0: totally wrong, 1: wrong, 2: probably wrong, 3: probably correct, 4: correct, 5 totally correct.

The score of every sub-scale is calculated by adding the scores of all of the relevant items. Then, the total score of relationship beliefs is calculated by adding the score of 5 sub-scales. It should be noted that questions 2, 7, 9, 13, 16, 18, 25, 28, 29, 31, 33, 34 and 36 are scored in reverse. A higher score on this scale indicates more irrational relationship beliefs.

Larson Sexual Satisfaction Questionnaire:

This questionnaire includes 25 questions. Respondents reply as: never, rarely, sometimes, most of the time and always. Every item is given one to five points according to the selected option. Questions 4, 5, 6, 7, 8, 11, 14, 15, 18, 20, 24, 25 get the reverse score. In Iran, Moshkbid and Shams Mofreheh (2001) used this questionnaire and determined its scientific validity through the content validity and examined the reliability by retest method which was confirmed with a correlation coefficient of 0.98 (49).

Revised Dyadic Adjustment Scale (RDAS):

This questionnaire was developed by Busby et al. (1995) (48). The original form of this scale was developed by Spinner (1976) based on the theory of Lewis and Spinner (1979) on the quality of marital relations (50, 51). After proposing their theory of marital quality, Fincham and Bradbury (1987) introduced this questionnaire as a suitable instrument for assessing marital quality (52). RDAS is a 14-item questionnaire based on the original 32-item Spinner questionnaire, which is scored as 0 to 5: completely positive answer gets a score of 5 and a completely opposite answer gets a 0 score. It should be noted that questions 7, 8, 9 and 10 of this questionnaire get a reverse score. The instrument

consists of three sub-scales of agreement (questions 1 to 6), satisfaction (questions 7 to 10), and solidarity (questions 11 to 14). The total scores indicate a higher marital quality.

The three-factor structure and validity of the questionnaire were confirmed by confirmatory factor analysis in the United States. Using Cronbach's alpha, the reliability of the questionnaire was obtained from 0.80 to 0.90 in a study by Hatlist and Miller (2005) (53). Issainejad (2009) examined the validity and reliability of the questionnaire and confirmed its structural validity through confirmatory factor analysis. Using Cronbach's alpha method, the reliability of the factors was respectively obtained 0.91, 0.89 and 0.86 for satisfaction, agreement and solidarity, and 0.92 for the whole questionnaire.

Research design

This is a causal-comparative research in terms of design and t-test was applied as the statistical method.

Procedure

One hundred married people referring to two drug treatment centers “Neshat Amin” and “Iman” were selected by availability sampling. First, the subjects were informed about the research topic, satisfied to participate and were assured of the data confidentiality and of using the information of the questionnaires only for the present study. Then, a questionnaires containing three scales related to the research variables were distributed. The spouses were also given a questionnaire of relationship beliefs and dyadic adjustment. Then, the necessary explanations were provided to complete the questionnaires. Out of about 100 pairs of questionnaires distributed, 74 questionnaires were completed and returned.

III. RESEARCH FINDINGS

Research hypotheses testing

Hypothesis 1: There is a difference in sexual satisfaction between the group of substance abusers (withdrawal applicants) and the group of maintenance treatment.

Hypothesis 2: There is a difference in dyadic adjustment between the group of substance abusers (withdrawal applicants) and the group of maintenance treatment.

Hypothesis 3: There is a difference in dyadic adjustment of a spouse between the group of substance abusers (withdrawal applicants) and the group with maintenance treatment.

Hypothesis 4: There is a difference in dysfunctional relationship beliefs of the addict between the group of substance abusers (withdrawal applicants) and the group with maintenance treatment.

Hypothesis 5: There is a difference in dysfunctional relationship beliefs of the spouse between the group of substance abusers (withdrawal applicants) and the group with maintenance treatment.

Tables 1 and 2 display the t-test results of sexual satisfaction, dyadic adjustment, dyadic adjustment of the spouse, relationship beliefs and relationship beliefs of the spouse for the two independent groups of substance abusers (withdrawal applicants) and maintenance treatment.

Table 1- Descriptive data for the scores of drug abusers (withdrawal applicants) and subjects under maintenance treatment

Group / Scores	Withdrawal applicant			Under maintenance treatment		
		SD	N M	N	M	SD
Sexual adjustment	29	92.62	9.413	45	98.51	14.858
Dysfunctional relationship beliefs	29	142.17	18.079	45	140.58	5.370
Destructive disagreement	29	30.31	5.751	45	28.16	3.586
Thought discovery expectation	29	30.28	3.586	45	30.71	4.906

Spouse immutability	29	22.34	6.493	45	22.82	3.804
Sexual perfectionism	29	30.86	4.051	45	29.29	4.906
Gender differences	29	28.38	6.144	45	29.60	3.887
Dyadic adjustment	29	55.48	8.318	45	56.18	8.102
Agreement	29	28.52	7.164	45	30.38	3.810
Satisfaction	29	10.59	3.942	45	9.93	3.922
Solidarity	29	16.38	2.859	45	15.87	4.635
Spouse dysfunctional relationship beliefs	29	136.97	8.073	45	131.80	13.295
Destructive disagreement	29	27.69	1.671	45	25.36	3.191
Thought discovery expectation	29	30.34	2.676	45	30.29	5.307
Spouse immutability	29	20.03	4.785	45	21.18	3.985
Sexual perfectionism	29	28.17	4.089	45	25.09	4.781
Gender differences	29	30.72	2.789	45	29.89	4.816
Spouse dyadic adjustment	29	53.62	8.695	45	54.49	4.737
Agreement	29	25.93	6.290	45	30.38	5.105
Satisfaction	29	13.03	4.127	45	9.09	3.239
solidarity	29	14.66	4.768	45	15.02	3.340

Table 2- t-test results for independent groups of drug abusers (withdrawal applicant) and subjects under maintenance treatment

	T	Sig
Sexual satisfaction	-1.901	0.061
Dyadic adjustment	-0.357	0.723
Spouse dyadic adjustment	-0.555	0.580
dysfunctional relationship beliefs	0.557	0.580
Spouse dysfunctional relationship beliefs	2.301	0.024

According to the tables, the difference in the dysfunctional relationship beliefs of the spouse is significant at the level of 0.05 between the two groups, but the difference in the other variables mentioned in the hypotheses is not meaningful. Table 3 shows the t-test results of the subscales of dyadic adjustment and addicts' relationship beliefs for the two groups.

Table 3- t-test results for dyadic adjustment and addict's relationship beliefs subscales among drug abusers (withdrawal applicant) and subjects under maintenance treatment

		T	Sig
Dysfunctional cognitive beliefs	Destructive disagreement	1.988	0.051
	Thought discovery expectation	-0.414	0.680
	Spouse immutability	-0.399	0.691
	Sexual perfectionism	1.438	0.155
	Gender differences	-1.048	0.298
Dyadic adjustment	Agreement	-1.455	0.150
	satisfaction	0.698	0.488
	solidarity	0.533	0.596

As can be seen, the difference in the sub-scales of the variables mentioned in the hypotheses is not significant between the two groups.

Table 4 shows the t-test results for the sub-scales of dyadic adjustment and the relationship beliefs of the spouse.

Table 4- t-test results for dyadic adjustment and spouse's relationship beliefs among drug abusers (withdrawal applicant) and subjects under maintenance treatment

		T	Sig
Dysfunctional cognitive beliefs	Destructive disagreement	3.625	0.001
	Thought discovery expectation	0.053	0.958
	Spouse immutability	-1.113	0.269
	Sexual perfectionism	2.862	0.006

	Gender differences	0.846	0.400
Dyadic adjustment	Agreement	-3.337	0.001
	Satisfaction	4.589	0.000
	Solidarity	-0.390	0.698

According to Table 4, the difference in the variables of destructive disagreement and sexual perfectionism as the sub-scales of dysfunctional relationship beliefs, as well as agreement and satisfaction as the sub-scales of dyadic adjustment is significant at the significance level of 0.01 between the two groups. However, the difference in the other sub-scales is not significant.

IV. Discussion and Conclusion

The result of testing the first hypothesis "There is a difference in sexual satisfaction between the group of substance abusers (withdrawal applicants) and the group of maintenance treatment" indicates that sexual satisfaction is not significantly different between the two groups; thus, it was rejected. This is inconsistent with the findings of Babakhanian et al. (2011) who showed that erectile function score, sexual intercourse status and sexual desire improve during the treatment. Chan et al. (2008) also have confirmed a positive and short-term effect of methadone on improving risky sexual behavior. To explain our finding, it can be said that the lack of significant improvement in sexual satisfaction in the treatment group might be the result of long-term negative effects of drug use on addicts' libido which can be the major agent of insufficient sexual desire and dissatisfaction. It needs more treatments such as the use of medication and even the involvement of the patient and the spouse in psychological interventions (Babakhanian et al., 2011). Rahmani et al. also acknowledged that even after quitting addiction, the sexual ability may not fully return, so that in the case of alcoholics, organ damage from long-term alcohol use may lead to erectile dysfunction.

However, in the present study, sexual satisfaction score was examined and not sexual function. Therefore, it is concluded that sexual satisfaction is a quality separate from sexual function, sexual self-efficacy, sexual desire and sexual pleasure. Sexual satisfaction is a mental concept of the quality of a sexual relationship that may or may not be consistent with the degree of efficiency and quality of sexual function.

The Larson (1998) Sexual Satisfaction Scale measures sexual satisfaction, which includes both sexual partners behavior (54). More than half of the questions on this scale concern one's mentality. So, the spouse sexual behavior plays a significant role in the formation of sexual satisfaction and this is a bilateral that depends on the quality of the relationship and the individual's mental perception of the relationship. It can be said that if a person's sexual function is weak or aggressive and of low quality for a long time, his/her and the spouse's mentality and beliefs will change. As a result, the spouse's sexual behaviors will also change and a wrong relationship will be formed. This should be modified by correcting the mentality and beliefs of the individual oneself and his/her spouse along with treating sexual disorders and improving function (which occurs during addiction treatment) in order to raise the spouse' accountability.

Results of testing the second and third hypotheses "There is a difference in dyadic adjustment between the group of substance abusers (withdrawal applicants) and the group of maintenance treatment" and "There is a difference in dyadic adjustment of a spouse between the group of substance abusers (withdrawal applicants) and the group with maintenance treatment" suggest that there is no significant difference between the two groups in terms of dyadic satisfaction, neither in the individuals themselves nor in their spouses. Therefore, the second and third hypotheses were rejected. To explain this finding, it can be said that there are many factors that affect predicting dyadic adjustment. They include: age of marriage, economic and social status, duration of marriage, number of children, birth date of the first child, age gap between couples, personality traits, family background, family relations, etc. Since other factors affecting marital satisfaction have not been controlled in this study, the difference in each of them may have influenced the lack of significance.

Results of testing the fourth hypothesis "There is a difference in dysfunctional relationship beliefs of the addict between the group of substance abusers (withdrawal applicants) and the group with maintenance treatment" indicate that there is no difference between the two groups in terms of dysfunctional relationship beliefs; thus, it was rejected. This finding is inconsistent with the results found by Sadeghi (2001), Lotfabadi (1996) and Aziz Mohammadi (2007) who state that cognitive beliefs and irrational thoughts and dysfunctional attitudes of addicts are more than normal people. To explain our finding, it can be said that the treated group was not a sample of normal people, but they were addicts attempting to give up. Although they are not currently addicted to drugs, they have been addicted for many years and their cognitive distortions have been appeared over a long period of time. Therefore, they do not meet our expectations for a significant reduction in dysfunctional beliefs. In addition, relationship beliefs are a type of cognitive beliefs rooted in cognitive schemas and the process of education and growth in a particular cultural environment with specific ideas and beliefs; so, they can be easily changed without special training. On the other hand, dysfunctional beliefs trigger individuals to use drugs, and as Zeinali et al. (2007) showed an addict is impaired in terms of cognition (beliefs, thoughts and judgments). Hence, it can be expected that those who are currently addicted or once they were addicted to drugs generally suffer from cognitive distortions and dysfunctional beliefs.

Results of testing the fifth hypothesis "There is a difference in dysfunctional relationship beliefs of the spouse between the group of substance abusers (withdrawal applicants) and the group with maintenance treatment" reveal a significant difference in the relationship beliefs of the spouse in the two groups; thus it is confirmed. To explain, it can be said that one of critical issues in developing relationship and correcting dysfunctional beliefs is to help couples understand that relationship is a set of skills that can be learned. This learning takes place in part during major life changes and while trying to disregard the issues caused by misconception. Therefore, quitting addiction and positive changes in addicts is a strong factor that might correct spouses' misconceptions about dysfunctional beliefs. This is because the personality and moral development of addicts under treatment proves the evidence rejecting the dysfunctional beliefs of their spouses. However, group workshops and training workshops are still needed to make major changes and fundamental corrections.

The limitations of this study include the cross-sectional nature of the research and the lack of a control group. Further, due to the limited sample, the study was done only on men. It is suggested to study women as well, because due to the critical role of women in the family and marital relations, understanding the sexual and marital issues of addicted women and better planning for their treatment is of a great importance.

Providing information through the mass media about the types of addictive substances and the destructive effect of drugs on sexual abilities and efficiency, educating and warning the public of the consequences of drug addiction with emphasis on the adverse effects on family and marital relations might be helpful in preventing the problems mentioned in this study. Furthermore, developing programs for training proper methods of establishing intimate sexual relations between spouses, instructing healthy relations to an addict's sexual partner, informing couples of the effects of drugs on their marital relations should be comprehensively included at the treatment centers.

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