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Comparing Meaning Therapy and Quality of Life Therapy for Improving Parent–Adolescent Interaction in Maladjusted Students

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ABSTRACT

Objective: This study compared the effectiveness of meaning therapy and quality of life therapy in improving parent-adolescent interaction among maladjusted students.

Methods and Materials: A quasi-experimental pretest-posttest control-group design with a two-month follow-up was conducted with 48 male adolescents aged 16-18 years who were referred to Tehran Department of Education counseling centers in 2025. Participants were purposively recruited and randomly assigned to meaning therapy, quality of life therapy, or control groups (n = 16 each). Parent-adolescent interaction was assessed with the Parent-Child Relationship Questionnaire. Data were analyzed using mixed-design ANOVA and Bonferroni post hoc tests.

Findings: The time × group interaction was significant, $F = 5.78$, $p < .001$, partial $\eta^2 = .216$. Both meaning therapy and quality of life therapy produced significant improvements compared with the control group. The adjusted posttest mean difference was 5.94 points for meaning therapy versus control ($p = .017$) and 8.52 points for quality of life therapy versus control ($p < .001$), while the two intervention groups did not differ significantly ($p = .622$). Improvements remained stable at the two-month follow-up.

Conclusion: Meaning therapy and quality of life therapy were both effective in strengthening parent-adolescent interaction in maladjusted students, with no evidence that either intervention was superior. The findings support their use as school- and family-oriented psychological interventions for adolescents experiencing adjustment difficulties.

Keywords: Meaning Therapy, Quality of Life Therapy, Parent-Adolescent Interaction, Maladjustment, Adolescents.

Introduction

Adolescence is a developmental period in which growing autonomy, identity exploration, and expanding social roles reshape the parent-child relationship. Conflict may become more frequent, but emotional availability, respect, and supportive communication remain central to adolescents' psychological adjustment and emotion regulation (Smetana & Rote, 2019; Morris et al., 2017). Recent evidence also indicates that the quality of parent-child relationships is closely associated with adolescents' self-worth and broader adaptive functioning (Abedi Barzi, 2025).

For adolescents experiencing maladjustment, strained family communication can amplify behavioral, emotional, and school-related difficulties. Interventions that strengthen family intimacy, communication, and emotional regulation may therefore reduce risk while increasing resilience. Family-centered intervention research has shown that changes in emotional regulation and parental support can produce sustained improvements in adolescent anger, resilience, and family intimacy (Sepehrianazar & Chitsaz, 2025).

Meaning therapy is rooted in existential and logotherapeutic traditions that emphasize personal meaning, responsibility, value clarification, and constructive attitudes toward unavoidable difficulty. Frankl's formulation proposes that a sense of meaning can organize behavior and sustain psychological functioning even in adverse circumstances (Frankl, 2006). Empirical syntheses of existential therapies have reported beneficial effects on meaning, psychological symptoms, and self-efficacy (Vos et al., 2015), and research on meaning in life supports its association with adaptive well-being and purposeful functioning (Steger et al., 2006). For maladjusted adolescents, strengthening values and purposeful action may help shift family interactions from impulsive conflict toward more reflective and responsible communication.

Quality of life therapy (QOLT) takes a complementary route by systematically improving satisfaction across important life domains and by helping clients modify circumstances, attitudes, standards, priorities, and satisfaction in other areas. The approach integrates positive psychology with cognitive-behavioral strategies and is designed to increase well-being while reducing distress (Frisch, 2013; Frisch, 2016). Its focus on needs, goals, competence, and relationships is also consistent with motivational models that emphasize autonomy, competence, and relatedness as basic psychological needs (Deci & Ryan, 2000). In adolescents, such changes may improve family communication by reducing rigid appraisals, increasing realistic goal setting, and broadening sources of satisfaction and support.

Although both approaches are theoretically relevant to adolescent adjustment, direct comparative evidence regarding parent-adolescent interaction remains limited. The present study therefore compared meaning therapy and quality of life therapy in maladjusted students and examined whether gains were sustained two months after treatment. It was hypothesized that both interventions would improve parent-adolescent interaction relative to a control condition; the comparative analysis was exploratory because the two approaches may act through different but complementary mechanisms.

Methods and Materials

Research Design and Participants

The study used a quasi-experimental pretest-posttest design with a control group and a two-month follow-up. The target population comprised maladjusted male adolescents aged 16-18 years referred to counseling centers of the Tehran Department of Education during the first half of 2025. Following preliminary screening, 48 eligible students were selected purposively and randomly assigned to three equal groups: meaning therapy (n = 16), quality of life therapy (n = 16), and

control (n = 16). All 48 participants completed the posttest and follow-up assessments.

Eligibility required current enrollment in upper-secondary school, age 16-18 years, evidence of maladjustment on the California Test of Personality social-adjustment section, confirmation by a school counselor or psychologist, adequate cognitive ability to participate in group work, and written parental/guardian consent together with adolescent assent. Exclusion criteria included severe psychiatric disorder, unstable psychiatric medication, concurrent psychotherapy, absence from more than two sessions, withdrawal of consent, or incomplete assessment across study stages.

Measures

California Test of Personality. The California Test of Personality was originally developed by Thorpe, Clark, and Tiegs and revised in 1953 (Thorpe et al., 1953). The instrument assesses personal and social adjustment across age-appropriate forms. The high-school form was used for screening, with the social-adjustment domain serving to identify students with maladjustment. In the present sample, Cronbach's alpha for the administered section was .84.

Parent-Child Relationship Questionnaire. Parent-adolescent interaction was assessed with the 24-item Parent-Child Relationship Questionnaire associated with the work of Fine, Moreland, and Schwebel (Fine et al., 1983). The measure assesses positive affect, trust, respect, anger, and perceived similarity in the relationship with parents, using a 7-point response format with reverse scoring for designated items. Higher total scores indicate a more positive relationship. Internal consistency in the present study was .83.

Interventions

The meaning therapy program consisted of ten structured group sessions emphasizing values clarification, purposeful goal setting, responsibility, experiential and attitudinal values, and translation of personally meaningful goals into daily action. The progression of sessions is summarized in Table 1.

Table 1.

Summary of the Meaning Therapy Program

Session	Core content	Between-session assignment
1	Orientation; existential themes; introduction to meaning analysis; values-awareness exercise.	Begin identifying creative values.
2	Review; personal values worksheet; alternative occupations and satisfying achievements.	Complete creative values; begin experiential values.
3	Review personal values; recent events; positive persons; artistic experiences; relational meaning.	Complete experiential values; begin attitudinal values.
4	Wise quotations; taking a position; "my obituary" exercise; value prioritization.	Complete attitudinal values and construct a value hierarchy.
5	Expand the value hierarchy; goal setting; examine goals from alternative perspectives.	Formulate realistic short-, medium-, and long-term goals.
6	Analyze goals for consistency with values; identify barriers and revise goals.	Apply goal-analysis procedure to personal goals.
7	Set new goals for neglected values; connect values with daily choices.	Develop action steps for neglected values.
8	Goal-achievement planning; anticipate obstacles and alternative plans.	Implement a goal plan and record progress.
9	Identify strengths and limitations; revise plans using personal resources.	Integrate strengths and limitations into goal plans.
10	Review change; consolidate insight and goals; relapse-prevention and motivation enhancement.	Posttest and continuation plan.

Quality of life therapy was delivered in nine structured sessions based on QOLT principles, including the CASIO framework (Circumstances, Attitudes, Standards, Importance/Priorities, and satisfaction in Other areas), cognitive restructuring, realistic standards, self-respect, family communication, and maintenance planning (Frisch, 2013; Frisch, 2016). The program is summarized in Table 2.

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Table 2.

Summary of the Quality of Life Therapy Program

Session	Goal and content	Between-session assignment
1	Orientation; group rules; treatment rationale; discussion of maladjustment and life satisfaction.	Baseline assessment and personal goals.
2	Review; identify problem life domains; introduce strategies for reducing maladjustment and improving relationships.	Identify situations that intensify maladjustment.
3	Introduce CASIO; focus on changing circumstances (C); strengths, resources, and attainable environmental changes.	Apply circumstance-change strategies at home.
4	Changing attitudes (A); identify automatic thoughts, assumptions, and core beliefs affecting parent-adolescent interaction.	Daily stress/thought record and alternative appraisals.
5	Changing standards (S); reduce perfectionistic expectations; emphasize realistic "good enough" standards.	Revise unrealistic standards and relationship goals.
6	Changing priorities/importance (I) and increasing satisfaction in other areas (O); "happiness pie" and "egg basket" exercises.	Rebalance time and attention across life domains.
7	Self-respect, helping others, emotional support, and effective family communication skills.	Practice one communication skill with parents and record the outcome.
8	Family satisfaction; problem solving; creativity in relationship repair; applying CASIO to family situations.	Use CASIO on a real family conflict and reflect on the process.
9	Consolidation of CASIO; maintenance and relapse prevention; future plan.	Posttest and continued practice plan.

Procedure and Ethical Considerations

After administrative coordination with the participating education counseling centers, eligible adolescents and their parents received an explanation of study aims, procedures, confidentiality, voluntary participation, and the right to withdraw without penalty. Written parental or guardian consent and adolescent assent were obtained before enrollment. The experimental groups received their respective group interventions, while the control group received no study psychotherapy during the intervention period. All groups completed the outcome measure at pretest, posttest, and 60-day follow-up. No identifying information was included in the analysis dataset.

Statistical Analysis

Data were analyzed in SPSS version 26. Descriptive statistics were calculated for all study stages. Mixed-design analysis of variance evaluated the effects of time, group, and the time × group interaction. Normality, homogeneity of variance, homogeneity of covariance matrices, and sphericity were examined before inferential analysis. Greenhouse-Geisser corrections were used when sphericity was violated. Significant omnibus effects were followed by Bonferroni-adjusted pairwise comparisons. Statistical significance was set at $p < .05$, and partial eta squared was reported as an effect-size estimate.

Findings and Results

The final sample included 48 male adolescents: 16 in meaning therapy, 16 in quality of life therapy, and 16 in the control group. Mean ages were 17.43 ± 1.45, 17.63 ± 1.02, and 17.47 ± 0.94 years, respectively. Descriptive results for parent-adolescent interaction are shown in Table 3. Both intervention groups increased from pretest to posttest and maintained most of the gain at follow-up, whereas the control group remained stable.

Table 3.

Parent-Adolescent Interaction Scores Across Assessment Stages

Group	Pretest M ± SD	Posttest M ± SD	Follow-up M ± SD
Control	59.13 ± 14.93	58.47 ± 14.72	58.87 ± 14.28
Meaning therapy	60.40 ± 16.21	67.33 ± 15.80	67.13 ± 15.70
Quality of life therapy	59.27 ± 13.45	66.93 ± 19.34	66.87 ± 19.78

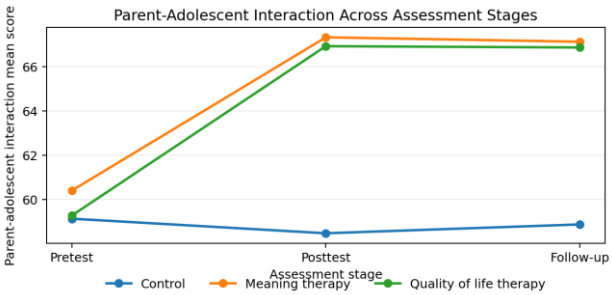

Figure 1.

Mean Parent-Adolescent Interaction Scores by Group and Assessment Stage

egrees

The pattern is also illustrated in Figure 1. The trajectories show parallel improvement in the two treatment conditions and minimal change in the control group. Assumption testing supported use of the mixed model. Levene's tests were nonsignificant at pretest, posttest, and follow-up; Box's M was also nonsignificant. Because Mauchly's test indicated a

As shown in Table 4, the main effect of time was significant, $F = 18.59$, $p < .001$, partial $\eta^2 = .307$, and the time × group interaction was significant, $F = 5.78$, $p < .001$, partial $\eta^2 = .216$. The between-group main effect was not significant when averaged across all time points, indicating that the principal evidence for treatment efficacy was the differential pattern of change over time rather than a static overall group difference.

Table 4.

Mixed Repeated-Measures ANOVA for Parent-Adolescent Interaction

Effect	SS	df	MS	F	p	Partial η^2
Group	270.93	2	135.47	0.838	.440	.038
Time	580.84	1.69	344.46	18.59	< .001	.307
Time × Group	361.16	3.37	107.09	5.78	< .001	.216

Bonferroni-adjusted between-group comparisons at posttest are presented in Table 5. Meaning therapy produced a significantly higher adjusted posttest mean than the control condition (mean difference = 5.94, $p = .017$), and quality of life therapy also outperformed the control condition (mean difference = 8.52, $p < .001$). The two active interventions did not differ significantly (mean difference = -2.58, $p = .622$).

Table 5.

Bonferroni Comparisons of Adjusted Posttest Means

Comparison	Adjusted mean 1	Adjusted mean 2	Mean difference	p
Meaning therapy vs. Control	47.16	41.22	5.94	.017
Quality of life therapy vs. Control	49.75	41.22	8.52	< .001
Meaning therapy vs. Quality of life therapy	47.16	49.75	-2.58	.622

Within-group pairwise comparisons are summarized in Table 6. Both intervention groups improved significantly from pretest to posttest and from pretest to follow-up, while posttest-to-follow-up differences were nonsignificant. No time comparison was significant in the control group, supporting the durability of the treatment gains over the two-month follow-up.

Table 6.

Bonferroni Pairwise Comparisons Across Time Within Each Group

Group	Comparison	Mean difference	p
Meaning therapy	Pretest - Posttest	-5.87	.006
Meaning therapy	Pretest - Follow-up	-5.53	.011
Meaning therapy	Posttest - Follow-up	0.33	.718
Quality of life therapy	Pretest - Posttest	-8.27	< .001
Quality of life therapy	Pretest - Follow-up	-7.13	< .001
Quality of life therapy	Posttest - Follow-up	1.13	.392

Control	Pretest - Posttest	0.87	.520
Control	Pretest - Follow-up	-0.47	.713
Control	Posttest - Follow-up	-1.33	.223

Discussion and Conclusion

The study found that meaning therapy and quality of life therapy both improved parent-adolescent interaction in maladjusted students, and these gains remained evident at the two-month follow-up. The absence of a significant difference between the two active conditions suggests that the interventions reached a similar relational outcome through distinct therapeutic routes. This overall pattern is compatible with evidence that family-oriented psychological interventions can strengthen family intimacy and relational functioning in adolescents (Sepehrianazar & Chitsaz, 2025).

The effect of meaning therapy can be understood through its emphasis on values, responsibility, purpose, and the freedom to choose one's attitude toward difficult circumstances. Adolescents who clarify personally meaningful values may be better able to pause before reacting, connect immediate conflict with longer-term goals, and adopt more responsible communication within the family. Frankl's logotherapeutic perspective (Frankl, 2006) and contemporary evidence on meaning-centered and existential therapies (Vos et al., 2015) support the plausibility of this pathway. A stronger sense of meaning may also increase perceived coherence and agency, constructs closely related to adaptive functioning (Steger et al., 2006).

Quality of life therapy may have improved parent-adolescent interaction by a different mechanism. The CASIO framework encourages clients to examine circumstances, attitudes, standards, priorities, and satisfaction across life domains rather than interpreting family conflict as a single fixed problem. Cognitive reframing, realistic standards, and deliberate redistribution of attention toward supportive or rewarding domains can reduce emotional escalation and create more opportunities for constructive interaction (Frisch, 2013; Frisch, 2016). The focus on competence, autonomy, and relatedness is also consistent with self-determination theory (Deci & Ryan, 2000), suggesting that relational improvement may occur when adolescents experience greater agency and more supportive interpersonal connection.

The similar magnitude of improvement across the two interventions is therefore clinically interpretable rather than contradictory. Parent-adolescent interaction is a multidetermined outcome. Meaning therapy primarily strengthens motivational and existential resources, whereas QOLT targets appraisals, standards, goals, and satisfaction across daily life. Both pathways can ultimately increase respectful communication, emotional regulation, and willingness to cooperate. The finding is also consistent with evidence that supportive parent-child relationships are strongly linked with adolescent self-worth and adjustment (Abedi Barzi, 2025) and that parenting processes shape emotion regulation across development (Morris et al., 2017).

The follow-up results are important because posttest gains remained stable rather than disappearing after treatment ended. Meaning therapy may support maintenance by anchoring behavior in enduring values and goals, while QOLT explicitly includes maintenance, relapse prevention, and repeated use of the CASIO framework in daily situations. For school counseling services, this suggests that either intervention can be selected according to counselor competence, adolescent preference, and the dominant formulation of the problem rather than on an assumption that one approach is universally superior.

Several limitations should be considered. The sample was small, consisted only of male adolescents, and was recruited from education counseling centers in Tehran, which limits generalizability. The study relied primarily on adolescent self-report of the parent-child relationship and did not include parent reports or

observational measures. The follow-up period was limited to two months. Future studies should use larger and gender-diverse samples, include multi-informant and observational assessment, extend follow-up, and examine mediators such as meaning in life, emotion regulation, self-efficacy, and family communication to clarify how each intervention produces change.

Both meaning therapy and quality of life therapy produced meaningful and durable improvements in parent-adolescent interaction among maladjusted students, whereas the control group showed no comparable change. Neither intervention demonstrated superiority. The findings support the use of structured meaning-centered and quality-of-life-focused programs as complementary options for school counselors and psychologists seeking to strengthen family relationships and adolescent adjustment.

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Declaration of Interest

The authors declared no conflict of interest.

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Data Availability

De-identified study data may be made available by the corresponding author upon reasonable request, subject to ethical and institutional requirements.

Authors' Contributions

All authors contributed to the conception, implementation, analysis, interpretation, and preparation of the manuscript and approved the final version.

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