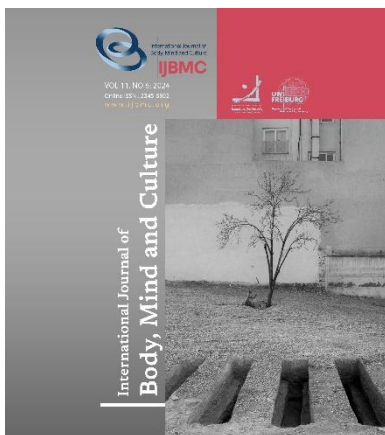


Article type:
Original Research

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Article history:

Received 21 July 2024
Revised 14 October 2024
Accepted 24 October 2024
Published online 10 December 2024

How to cite this article:

Nasiri Nasrabadi, F. (2024). Comparative Effectiveness of Acceptance and Commitment Therapy and Short-Term Psychodynamic Psychotherapy on Sexual Intimacy and Marital Silence in Women with Marital Burnout. *International Journal of Body, Mind and Culture*, 11(6), 266-279.



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Comparative Effectiveness of Acceptance and Commitment Therapy and Short-Term Psychodynamic Psychotherapy on Sexual Intimacy and Marital Silence in Women with Marital Burnout

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ABSTRACT

Objective: This study compared the effectiveness of ACT and short-term psychodynamic psychotherapy in improving sexual intimacy and reducing marital silence among women experiencing marital burnout.

Methods and Materials: In a quasi-experimental design with pre-test, post-test, and follow-up, 45 married women meeting criteria for marital burnout were selected through purposive sampling and randomly assigned to three groups: ACT (n = 15), short-term psychodynamic psychotherapy (n = 15), and a wait-list control group (n = 15). The intervention groups received eight weekly 90-minute sessions based on standard ACT and short-term psychodynamic protocols. All participants completed validated measures of sexual intimacy and marital silence at pre-test, post-test, and eight-week follow-up. Data were analyzed using repeated-measures ANOVA and ANCOVA, controlling for baseline scores.

Findings: Both ACT and short-term psychodynamic psychotherapy produced significant improvements in sexual intimacy and reductions in marital silence compared with the control group at post-test ($p < .01$). These gains were largely maintained at follow-up. Between the two active treatments, ACT showed slightly greater effects on reducing marital silence, whereas improvements in sexual intimacy were comparable across approaches. Effect sizes for both interventions were in the moderate-to-large range.

Conclusion: ACT and short-term psychodynamic psychotherapy are both effective for enhancing sexual intimacy and reducing marital silence in women with marital burnout, with ACT showing a relative advantage for breaking maladaptive patterns of silence. Integrating these approaches into couple-focused services may improve relational outcomes for distressed women.

Keywords: Acceptance and Commitment Therapy, Short-Term Psychodynamic Psychotherapy, Sexual Intimacy, Marital Silence, Marital Burnout.

Introduction

Marital relationships are still one of the most important sources of emotional support, identity, and social stability for adults—yet they are increasingly threatened by chronic dissatisfaction, emotional distance, and “quiet” relationship breakdown. Marital burnout is one of the central constructs used to explain this gradual erosion of marital quality. It has been defined as a state of intense physical, emotional, and psychological exhaustion, accompanied by feelings of failure, disappointment, and a progressive loss of intimacy and warmth toward one’s spouse (Pines, 2013). In burnout, positive emotions fade and are gradually replaced by detachment and resentment, making divorce or “living together apart” more likely. Recent work in Iranian samples shows that marital burnout is not a marginal phenomenon; in a large health-center sample of married women (N = 936), mean scores on Pines’s Marital Burnout Scale were in the moderate range, and burnout was significantly associated with marital dissatisfaction, longer marriage duration, and constrained marital choice (e.g., mandatory marriage) (Nejatian et al., 2021). Structural equation–modeling studies similarly frame marital burnout as a key outcome of chronic unmet expectations and emotional disillusionment in intimate relationships (Minoosepehr et al., 2022).

Sexual intimacy is one of the relational domains most strongly linked to marital satisfaction and burnout. Sexual intimacy includes not only sexual intercourse but also affectionate touch, mutual desire, and the experience of emotional closeness in erotic interactions. A recent qualitative study of married men and women in Iran highlighted how declines in sexual intimacy often emerge from a complex interplay of sex-drive mismatch, emotional disconnection, sexual dissatisfaction, restrictive sexual stereotypes, and “sexual nostalgia” for previous satisfying experiences (Azimi et al., 2025). These disruptions in sexual intimacy were perceived by participants as both a consequence and a driver of marital conflict, psychological distress, and a sense of being “trapped in a loveless marriage.” In line with broader international data, sexual dissatisfaction has been estimated to contribute to a substantial proportion of divorces and extramarital affairs and is repeatedly shown to covary with lower marital satisfaction and

greater relationship instability (Azimi et al., 2025; Nezhad & Shameli, 2017). Thus, understanding how to restore sexual intimacy is central to preventing or reducing marital burnout, particularly among women, who often bear a disproportionate emotional and caregiving load in heterosexual marriages (Nejatian et al., 2021).

Alongside diminished sexual intimacy, many distressed couples fall into a pattern of “marital silence,” in which partners increasingly avoid vulnerable conversations and emotionally withdraw from one another. In the empirical literature, these dynamics are often captured by the demand–withdraw communication pattern: one partner pressures or demands discussion of a relationship issue while the other avoids, becomes silent, or disengages (Papp et al., 2009; Zarei et al., 2025). Diary-based research has shown that demand–withdraw interactions during marital conflict are consistently associated with more anger, sadness, and hostility, less affection and support, and lower levels of conflict resolution—even after controlling for overall marital satisfaction (Papp et al., 2009). A large meta-analysis of 74 studies (N = 14,255) reported a moderate overall association between demand–withdraw and negative individual, relational, and communicative outcomes, with the strongest correlations observed for relationship outcomes such as satisfaction and stability (Schrodt et al., 2014).

Recent work has started to examine demand–withdraw patterns specifically in the sexual domain. In an observational study of couples discussing sexual conflicts, higher levels of demand–withdraw communication during sexual discussions predicted lower concurrent sexual and relationship satisfaction and higher sexual distress (Rosen et al., 2024). Over time, couples showing more demand–withdraw during sexual conflict also reported declines in relationship satisfaction at 12-month follow-up. These findings support the idea that “marital silence” is not simply a benign communication style but a relational process tightly linked to sexual disconnection, emotional alienation, and—in the longer term—marital burnout. Together, the literatures on marital burnout, sexual intimacy, and demand–withdraw communication support a cascading model in which unresolved conflict and avoidance undermine intimacy, increase emotional

exhaustion, and heighten the risk of relationship dissolution.

Women appear to be particularly vulnerable to this cascade. Cross-sectional and longitudinal data indicate that women frequently report higher burnout scores than men, a pattern often attributed to greater role overload, higher initial relational expectations, and more intense psychological consequences of unmet emotional needs (Nejatian et al., 2021; Pines, 2013). Iranian studies, for example, have shown that women who have limited autonomy in selecting their spouse, who juggle multiple caregiving and occupational roles, and who lack spousal support in domestic tasks experience higher levels of marital burnout and report more frequent thoughts of emotional divorce (Nejatian et al., 2021). At the same time, qualitative findings suggest that women's sexual motivation is especially sensitive to perceived emotional injustice, disrespect, and chronic conflict, which can lead to avoidance of sexual contact as a form of self-protection (Azimi et al., 2025). These gendered patterns underscore the need for interventions that directly address both emotional and sexual aspects of the relationship, as well as the silent withdrawal that often follows repeated relational injuries.

Acceptance and Commitment Therapy (ACT) has emerged as a promising contextual-behavioral approach for treating relational and sexual difficulties. ACT aims to increase psychological flexibility—defined as the ability to stay in mindful contact with uncomfortable internal experiences while behaving in ways that are guided by deeply held values (Hayes et al., 2011). In couple and sexual health contexts, ACT interventions typically focus on helping partners notice and “defuse” from rigid thoughts (e.g., “If my desire is low, the relationship is doomed”), reduce experiential avoidance of intimacy-related emotions (shame, fear of rejection), clarify shared relational values, and take committed action toward closeness even in the presence of unresolved pain. A randomized trial with Iranian couples demonstrated that ACT-based couple therapy significantly increased sexual satisfaction relative to a control condition, with effects attributed to greater emotional acceptance and value-guided behavior (Flaherty et al., 2024). Among postmenopausal women, ACT has been shown to improve sexual function, marital satisfaction, and quality of life, suggesting its relevance for women facing multiple biological and psychosocial

stressors (Ghasemi et al., 2025). Most recently, Najibzadegan et al., (2024) found that ACT significantly increased marital intimacy and forgiveness while reducing marital burnout among women affected by their husbands' extramarital relationships, with gains maintained at follow-up. Collectively, these studies support ACT as an intervention that directly targets the avoidance and cognitive fusion processes that maintain sexual distance, marital silence, and burnout.

Short-term psychodynamic therapy (STPT), in contrast, is rooted in psychodynamic theory and emphasizes the role of unconscious conflicts, early attachment experiences, and defensive processes in current relational patterns. In intensive or short-term dynamic psychotherapy, therapists focus on helping patients become aware of repetitive maladaptive relational templates, interpret defensive avoidance (including emotional withdrawal and sexual inhibition), and work through ambivalence and guilt in the therapeutic relationship (Leichsenring et al., 2004; O'Neal et al., 2014). A recent clinical trial with depressed women found that intensive short-term dynamic psychotherapy produced significant improvements in both marital satisfaction and sexual function compared to a wait-list control group (Ziapour et al., 2023). In a more directly related sample, Khodadad et al., (2025) reported that short-term psychodynamic therapy reduced marital burnout and improved negative meta-emotions in betrayed women, using Pines's Couple Burnout Measure as the primary outcome. These findings suggest that STPT can address not only individual symptoms but also entrenched relational patterns, including those rooted in infidelity, resentment, and long-standing communication breakdown.

Conceptually, ACT and short-term psychodynamic therapy both aim to transform rigid, self-defeating responses to emotional pain, but they do so via different primary mechanisms. ACT works “from the outside in,” by altering how clients relate to thoughts and feelings and encouraging value-consistent behaviors even when fear, shame, or anger are present. In the context of sexual intimacy and marital silence, this might involve helping women notice and accept feelings of vulnerability during sexual contact, clarify what kind of intimate relationship they want to build, and take small steps toward open communication with their partner. Short-term psychodynamic therapy, by contrast, works “from the

inside out,” by uncovering and interpreting recurrent relational themes (e.g., expecting rejection, equating desire with moral failure) that underlie withdrawal or sexual shutdown. Intensively processing these patterns in therapy may enable women to experience anger and longing more directly, reduce defensive silence, and reengage emotionally and sexually with their spouse (Khodadad et al., 2025; Ziapour et al., 2023).

Despite the growing evidence base for both approaches, there is a notable gap in the literature. Existing ACT studies have typically examined either sexual satisfaction or marital burnout in isolation and have rarely focused specifically on women experiencing marital burnout, sexual intimacy problems, and marital silence simultaneously (Ghasemi et al., 2025; Najibzadegan et al., 2024). Studies of short-term psychodynamic therapy, meanwhile, have largely been conducted either in psychiatric populations (e.g., depression, chronic illness) or in women facing specific relational crises such as infidelity, without directly targeting sexual intimacy or communication silence as primary outcomes (Khodadad et al., 2025; Ziapour et al., 2023). To date, no controlled study has directly compared the effectiveness of ACT and short-term psychodynamic therapy on sexual intimacy and marital silence in women experiencing marital burnout.

The present study aims to address this gap by comparing the effectiveness of Acceptance and Commitment Therapy and short-term psychodynamic therapy in improving sexual intimacy and reducing marital silence among women suffering from marital burnout. Given evidence that ACT enhances intimacy and reduces burnout by increasing psychological flexibility, and that short-term psychodynamic therapy reduces burnout by resolving underlying emotional conflicts, this comparative investigation can clarify whether one approach is superior—or whether each offers distinct benefits—for women caught in the intersection of marital burnout, sexual disconnection, and silent withdrawal. Ultimately, such knowledge can inform more precise treatment recommendations and contribute to the development of integrative interventions for marital burnout in women.

Methods and Materials

Study Design

This study employed a quasi-experimental design with three parallel groups and repeated measurements at three time points (pre-test, post-test, and follow-up). The three groups consisted of (a) an Acceptance and Commitment Therapy (ACT) group, (b) a short-term psychodynamic therapy (STPT) group, and (c) a wait-list control group receiving no active treatment during the study period. The independent variable was type of intervention (ACT, STPT, control), and the primary dependent variables were sexual intimacy and marital silence. Marital burnout was used as an inclusion criterion and was also monitored descriptively across the study to ensure that participants were drawn from a clinically relevant population of women with elevated marital burnout. The overall aim of the design was to compare the effectiveness and durability of ACT and STPT in changing sexual intimacy and marital silence, relative to natural change in a control group.

Participants and Sampling

The statistical population comprised married women referring to counseling and family health centers in a large metropolitan city in Iran during the study period. Using purposive–convenience sampling, women who reported difficulties related to marital burnout, reduced sexual intimacy, and communication problems were initially approached. After a brief screening interview and completion of the marital burnout measure, eligible women were invited to participate in the study.

Inclusion criteria were: (1) being legally married and living with one’s spouse for at least two years; (2) age between 25 and 50 years; (3) obtaining a score above a predetermined cut-off on the Couple Burnout Measure (indicating at least moderate marital burnout); (4) self-reported problems in sexual intimacy (e.g., reduced interest, avoidance, dissatisfaction) and tendencies toward silence or avoidance in marital communication; and (5) willingness to attend weekly group therapy sessions and complete all assessments. Exclusion criteria were: (1) current diagnosis of a severe psychiatric disorder (e.g., psychotic disorder, bipolar I disorder) or substance dependence; (2) current engagement in another structured psychological treatment targeting marital or sexual issues; (3) pregnancy or acute medical conditions that could markedly affect sexual functioning;

and (4) ongoing severe marital violence or a current process of legal divorce, for which more intensive or specialized services would be indicated.

Based on previous intervention research in similar domains and power analyses for repeated-measures designs with three groups, a minimum of 12–15 participants per group was considered adequate to detect medium effect sizes with power of .80 and $\alpha = .05$. To account for possible attrition, 60 women were initially screened. Of these, 48 met inclusion criteria and agreed to participate. After pre-testing, three participants withdrew before the start of treatment (due to scheduling difficulties), leaving a final sample of 45 women. These 45 participants were randomly allocated to three groups of equal size ($n = 15$ per group: ACT, STPT, control).

Random allocation was carried out using a simple randomization procedure. After pre-test assessment, each eligible participant was assigned a numerical code. A random numbers table was used by a researcher not involved in the interventions to assign codes to the three groups, thereby minimizing allocation bias. The three groups were tested to ensure that they did not significantly differ at baseline in age, duration of marriage, sexual intimacy, marital silence, or burnout scores. Demographic characteristics (age, education, occupation, number of children, duration of marriage) were summarized descriptively for each group.

Measures

Marital Burnout: Marital burnout was assessed using the Couple Burnout Measure (CBM), adapted from Pines's burnout scale for marital relationships. The CBM consists of items that assess physical exhaustion (e.g., feeling tired and drained), emotional exhaustion (e.g., feeling discouraged and hopeless about the relationship), and psychological exhaustion (e.g., feeling trapped and stuck in the marriage). Items are rated on a Likert-type scale, with higher total scores indicating higher levels of marital burnout. The CBM has demonstrated good internal consistency and validity in Iranian samples of married women and was used both to screen participants and to describe the severity of marital burnout in the sample.

Sexual Intimacy: Sexual intimacy was measured by a standardized sexual intimacy questionnaire designed to assess frequency and quality of sexual interactions, mutual desire, emotional closeness in sexual encounters,

and the ability to communicate sexual needs and boundaries. The instrument includes items rated on a multi-point Likert scale (e.g., from "very rarely" to "very often" or from "strongly disagree" to "strongly agree"), generating a total score in which higher scores reflect greater sexual intimacy. The scale has been previously validated in Iranian populations of married women, showing satisfactory internal consistency and construct validity. In the present study, Cronbach's alpha was calculated for the overall sample at pre-test to ensure adequate reliability.

Marital Silence: Marital silence was assessed using a self-report marital silence questionnaire, which evaluates tendencies to withhold feelings, avoid discussing problems, reduce emotional sharing, and withdraw from communication with the spouse. Items tap dimensions such as fear of conflict, hopelessness about being understood, and deliberate or habitual avoidance of intimate conversations. Responses are scored on a Likert scale, and higher scores indicate more pronounced marital silence. The questionnaire has been developed and used in prior Iranian studies on "silent divorce" and marital communication, with evidence of acceptable reliability and content validity. In the current sample, internal consistency was again evaluated at pre-test.

Demographic Information: A brief demographic form was administered to collect data on age, educational level, employment status, duration of marriage, number of children, history of psychological or marital counseling, and use of psychiatric medication. These variables were used to describe the sample and to check baseline equivalence between groups.

Intervention Protocols

Acceptance and Commitment Therapy (ACT) Group: Participants in the ACT group received eight weekly sessions of group-based Acceptance and Commitment Therapy. Each session lasted approximately 90 minutes and was conducted by a clinical psychologist trained and supervised in ACT. Group size ranged from 8 to 10 women to allow for interaction while maintaining sufficient time for individual processing.

The ACT protocol was structured around the six core ACT processes, with specific emphasis on issues related to marital burnout, sexual intimacy, and silence. Early sessions focused on psychoeducation about marital burnout and experiential avoidance, helping participants

identify the ways in which they avoided difficult thoughts and feelings (e.g., shame, fear of rejection, anger) by withdrawing from sex or conversations with their spouse. Mindfulness exercises were introduced to cultivate present-moment awareness of internal experiences without immediate judgment or avoidance.

Subsequent sessions targeted cognitive defusion, helping participants “step back” from rigid, self-critical, or catastrophic thoughts (e.g., “I am undesirable,” “If I speak up, everything will get worse”) through metaphors, exercises, and experiential techniques. Values clarification was a central component: participants explored personal and relational values related to intimacy, respect, emotional honesty, and partnership, distinguishing these from the “struggle” with internal experiences. Based on clarified values, women were encouraged to set small, realistic behavioral goals (committed actions), such as initiating a caring conversation with their spouse, expressing a sexual preference, or spending dedicated time together.

Throughout the sessions, the therapist explicitly linked psychological flexibility to changes in sexual intimacy and marital silence, highlighting how acceptance and values-based action could support more open communication and more meaningful sexual engagement even in the presence of unresolved pain. Homework assignments included mindfulness practice, values-based behavior experiments, and brief written reflections on barriers and progress. The final session focused on consolidating learning, planning for setbacks, and creating individualized maintenance plans.

Short-Term Psychodynamic Therapy (STPT) Group: Participants in the STPT group received eight weekly sessions of group-based short-term psychodynamic therapy, with each session lasting approximately 90 minutes. The group was led by a clinical psychologist with training and supervision in psychodynamic approaches, particularly time-limited dynamic psychotherapy.

The STPT protocol was designed to identify and work through central conflictual relationship themes contributing to marital burnout, sexual disconnection, and silence. In initial sessions, the therapist invited participants to describe the history of their marital relationship, focusing on patterns of closeness and distance, conflicts around sexuality, and instances of silence or withdrawal. Particular attention was paid to

recurring feelings (e.g., being unappreciated, rejected, controlled) and to typical ways of coping (e.g., compliance, avoidance, passive anger).

The therapist actively explored links between these current relational patterns and earlier attachment experiences or significant relationships (e.g., with parents or previous partners), helping women recognize how old expectations and defensive styles (such as intellectualization, denial, or turning anger against the self) might be shaping their current marriage. Transference phenomena within the group were also addressed; for example, when a participant related to the therapist as critical or rejecting, this was used as an opportunity to understand her expectations of others and how these might play out with her spouse.

Over the middle sessions, the focus shifted toward confronting and processing ambivalence (e.g., simultaneous love and resentment), unexpressed anger, guilt, and fears associated with asserting needs for emotional and sexual intimacy. The therapist encouraged participants to move from silent withdrawal to more direct expression of feelings in the group, modeling and reinforcing honest but respectful communication. As women gained insight into the roots of their marital burnout and silence, they were supported to experiment with new ways of relating to their spouses, such as expressing anger without attacking, sharing vulnerability instead of shutting down, or initiating discussions about sexual needs. The final sessions were devoted to integrating these insights, reflecting on shifts in self-perception and marital interactions, and planning how to maintain changes after therapy ended.

Wait-List Control Group: Participants in the wait-list control group did not receive any structured psychological intervention during the eight-week study period, beyond any routine services they might access on their own. They were, however, informed that they would be offered the opportunity to participate in one of the intervention protocols after the completion of follow-up assessments, as an ethical consideration. The control group completed the same pre-test, post-test, and follow-up assessments as the two intervention groups.

Procedure

After obtaining ethical approval, the researcher contacted counseling and family health centers and obtained permission to recruit participants. Posters and

brief announcements described the study as a program for women experiencing marital fatigue, reduced intimacy, and communication difficulties. Women who expressed interest were screened individually for eligibility criteria, and those who met the criteria completed the pre-test battery (marital burnout, sexual intimacy, marital silence, and demographic form) after providing written informed consent.

Following pre-test, participants were randomly allocated to the ACT, STPT, or control group as described previously. The ACT and STPT groups then began their respective eight-session programs, conducted weekly in separate rooms and times to prevent contamination between interventions. Attendance was recorded each session. If a participant missed more than two sessions, her data were noted for possible sensitivity analyses, but she remained in the intent-to-treat dataset if she completed the assessment points.

Immediately after the final session (week 8), all three groups (including the wait-list control) completed the post-test battery of sexual intimacy and marital silence questionnaires, as well as the marital burnout measure. Approximately eight weeks after the end of treatment (week 16), participants in all groups were contacted and invited for follow-up assessment using the same instruments. To maximize retention, follow-up assessments were scheduled flexibly, and reminder calls were made.

Assessments were administered by research assistants who were not involved in delivering the therapies and were blind to participants' group assignments as much as possible (particularly at pre-test and post-test). Participants completed questionnaires anonymously using coded identifiers to ensure confidentiality.

Data Analysis

Data were analyzed using statistical software (e.g., SPSS). Prior to hypothesis testing, data were screened for outliers, missing values, and adherence to assumptions. Cases with excessive missing data (e.g., more than 20% of items on a given scale) were excluded from that analysis. For sporadic missing responses, mean substitution within the individual's scale scores was considered if the amount of missing data was small.

Normality, homogeneity of variance, and sphericity (for repeated-measures analyses) were evaluated using graphical methods and formal tests (e.g., Shapiro-Wilk, Levene's test, Mauchly's test).

Descriptive statistics (means, standard deviations) for sexual intimacy and marital silence were calculated for each group at pre-test, post-test, and follow-up. To examine the effectiveness of the interventions over time, mixed-design repeated-measures ANOVAs were conducted separately for sexual intimacy and marital silence, with time (pre, post, follow-up) as the within-subject factor and group (ACT, STPT, control) as the between-subject factor. Significant time \times group interactions were followed up with simple effects tests and pairwise comparisons, using Bonferroni correction where appropriate.

Additionally, ANCOVAs were conducted on post-test and follow-up scores for sexual intimacy and marital silence, with pre-test scores entered as covariates, to control for baseline differences and to estimate adjusted group means. Effect sizes were reported using partial eta squared (η^2) for omnibus tests and Cohen's *d* for pairwise comparisons. The level of statistical significance was set at $\alpha = .05$ (two-tailed).

Ethical Considerations

The study protocol was approved by the ethics committee of the relevant university. All participants were informed about the objectives of the study, the voluntary nature of participation, and their right to withdraw at any time without penalty. Written informed consent was obtained prior to data collection. Confidentiality was ensured by using code numbers instead of names and by storing all data in locked files accessible only to the research team. Given the sensitivity of marital and sexual topics, participants were reminded that they could skip any questions that made them uncomfortable, and they were provided with information about additional counseling resources if participation raised distress. After completion of the follow-up assessments, women in the wait-list control group were offered the opportunity to receive one of the intervention programs free of charge.

Findings and Results

Of the 45 women who entered the trial (ACT: $n = 15$; STPT: $n = 15$; control: $n = 15$), 42 completed the post-test (ACT: $n = 14$; STPT: $n = 14$; control: $n = 14$) and 40 completed the follow-up (ACT: $n = 13$; STPT: $n = 14$; control: $n = 13$). Missing data at post-test and follow-up were mainly due to scheduling conflicts and relocation; no participant reported dropping out because of dissatisfaction with treatment. Because attrition was low and similar across the three groups, analyses were conducted using an intent-to-treat (Schrodt et al.) approach with last observation carried forward (LOCF) for participants missing one time point. Completer-only analyses produced the same pattern of significant results; therefore, ITT results are reported.

Inspection of histograms, Q-Q plots, skewness, and kurtosis indicated that sexual intimacy and marital silence scores were approximately normally distributed at all three time points. Levene's tests confirmed homogeneity of variances across groups at pre-test ($p > .05$). For repeated-measures analyses, Mauchly's test of sphericity was non-significant for both outcomes ($p > .05$), so unadjusted F statistics are reported. Table 1 summarizes the demographic characteristics of the three groups. One-way ANOVAs and χ^2 tests indicated no significant baseline differences between groups with respect to age, duration of marriage, education, employment status, or number of children (all $p > .10$).

Table 1

Demographic Characteristics of Participants by Group (N = 45)

Variable	Category	ACT (n = 15)	STPT (n = 15)	Control (n = 15)
Age (years)	M (SD)	36.00 (5.80)	35.67 (6.10)	35.33 (5.90)
Duration of marriage	M (SD)	11.27 (5.10)	10.93 (4.80)	11.00 (5.00)
Education	High school or less	4	5	5
	Diploma/Associate	4	3	3
	Bachelor's	5	5	4
	Master's or higher	2	2	3
Employment status	Homemaker	7	6	7
	Employed (full/part-time)	8	9	8
Children	Yes	12	12	11
	No	3	3	4

Means and standard deviations for sexual intimacy and marital silence at pre-test, post-test, and follow-up are presented in Table 2. At pre-test, all three groups reported low to moderate sexual intimacy and high

marital silence, consistent with the inclusion criterion of marital burnout. At post-test and follow-up, both ACT and STPT groups showed large improvements, whereas the control group showed minimal change.

Table 2

Means and Standard Deviations of Sexual Intimacy and Marital Silence by Group and Time (N = 45)

Outcome	Group	Pre-test M (SD)	Post-test M (SD)	Follow-up M (SD)
Sexual intimacy (higher = greater intimacy)	ACT	33.47 (5.92)	52.31 (6.08)	50.69 (6.34)
	STPT	34.13 (6.10)	48.53 (6.72)	47.11 (6.89)
	Control	32.80 (5.74)	34.09 (5.91)	34.46 (6.15)
Marital silence (higher = more silence)	ACT	41.73 (6.24)	24.38 (5.89)	25.31 (6.02)
	STPT	42.20 (6.51)	28.07 (6.31)	28.85 (6.44)
	Control	40.93 (6.02)	39.64 (6.19)	38.92 (6.05)

Descriptively, both active treatments produced large increases in sexual intimacy and marked reductions in marital silence from pre-test to post-test, with gains largely maintained at 8-week follow-up. The control group remained relatively stable over time. A 3 (group:

ACT, STPT, control) \times 3 (time: pre-test, post-test, follow-up) mixed-design repeated-measures ANOVA was conducted on sexual intimacy scores. **Main effect of time:** $F(2, 84) = 63.42$, $p < .001$, $\eta p^2 = .60$ \rightarrow Overall, sexual intimacy changed significantly across

time. **Time × group interaction:** $F(4, 84) = 24.97, p < .001, \eta^2 = .54$ → The pattern of change over time differed across the three groups. **Main effect of group**

at pre-test: $F(2, 42) = 0.34, p = .714$ → Groups did not differ significantly at baseline. The ANOVA results for sexual intimacy are summarized in Table 3.

Table 3

Mixed Repeated-Measures ANOVA for Sexual Intimacy (N = 45)

Effect	df	F	p	η^2
Time	2, 84	63.42	<.001	.60
Group	2, 42	0.34	.714	.02
Time × Group	4, 84	24.97	<.001	.54

Separate one-way ANOVAs were conducted on post-test and follow-up sexual intimacy scores.

Post-test: $F(2, 42) = 19.61, p < .001, \eta^2 = .48$. Bonferroni-adjusted pairwise comparisons: ACT vs. Control: ACT significantly higher ($p < .001$; Cohen's $d \approx 2.95$). STPT vs. Control: STPT significantly higher ($p < .001$; $d \approx 2.31$). ACT vs. STPT: ACT > STPT, small-to-moderate effect, ns after correction ($p = .087$; $d \approx 0.60$).

Follow-up: $F(2, 42) = 15.27, p < .001, \eta^2 = .42$. Bonferroni-adjusted pairwise comparisons: ACT vs. Control: ACT significantly higher ($p < .001$; $d \approx 2.70$); STPT vs. Control: STPT significantly higher ($p < .001$; $d \approx 2.04$); and ACT vs. STPT: ACT > STPT, but ns after correction ($p = .154$; $d \approx 0.52$)

ANCOVA Controlling for Baseline

To adjust for minor baseline variability, an ANCOVA was run on post-test sexual intimacy scores with pre-test sexual intimacy as a covariate. Overall model: $F(3, 41) = 39.12, p < .001, \eta^2 = .74$. Group effect (controlling for pre-test): $F(2, 41) = 27.08, p < .001, \eta^2 = .57$. Adjusted

means showed both ACT and STPT groups had significantly higher sexual intimacy than the control group ($p < .001$), with no significant difference between ACT and STPT ($p > .05$). Both ACT and STPT produced large and sustained improvements in sexual intimacy relative to the control group. Although ACT tended to yield slightly higher scores than STPT, the difference between the two active treatments was not statistically robust. A similar 3 (group) × 3 (time) mixed-design repeated-measures ANOVA was conducted for marital silence.

Repeated-Measures ANOVA

Main effect of time: $F(2, 84) = 49.05, p < .001, \eta^2 = .54$ → Overall, marital silence changed significantly across time. **Time × group interaction:** $F(4, 84) = 26.18, p < .001, \eta^2 = .56$ → The pattern of change across time differed among the three groups. **Main effect of group at pre-test:** $F(2, 42) = 0.26, p = .772$ → No significant baseline differences in marital silence. ANOVA results for marital silence are shown in Table 4.

Table 4

Mixed Repeated-Measures ANOVA for Marital Silence (N = 45)

Effect	df	F	p	η^2
Time	2, 84	49.05	<.001	.54
Group	2, 42	0.26	.772	.01
Time × Group	4, 84	26.18	<.001	.56

Between-Group Comparisons at Post-test and Follow-up

One-way ANOVAs on post-test and follow-up marital silence scores further clarified the interaction. Post-test: $F(2, 42) = 27.36, p < .001, \eta^2 = .57$. Bonferroni-adjusted pairwise comparisons: ACT vs. Control: ACT significantly lower silence (better outcome) ($p < .001$; $d \approx 2.62$); STPT vs. Control: STPT significantly lower silence ($p < .001$; $d \approx 1.96$); and ACT vs. STPT: ACT significantly lower

silence than STPT ($p = .041$; $d \approx 0.66$). Follow-up: $F(2, 42) = 19.89, p < .001, \eta^2 = .49$. Bonferroni-adjusted pairwise comparisons: ACT vs. Control: ACT significantly lower silence ($p < .001$; $d \approx 2.39$); STPT vs. Control: STPT significantly lower silence ($p < .001$; $d \approx 1.75$); and ACT vs. STPT: ACT < STPT, marginally significant ($p = .052$; $d \approx 0.58$)

ANCOVA Controlling for Baseline

ANCOVA on post-test marital silence, with pre-test silence as covariate, yielded: Overall model: $F(3, 41) = 42.45, p < .001, \eta^2 = .76$. Group effect (controlling for pre-test): $F(2, 41) = 29.36, p < .001, \eta^2 = .59$. Adjusted post-test means indicated: Both ACT and STPT groups had significantly lower marital silence than the control group ($p < .001$). ACT also showed significantly lower adjusted marital silence than STPT ($p = .038$), confirming ACT's relative advantage after controlling for baseline. Both ACT and STPT significantly reduced marital silence

compared with the control condition. However, ACT showed a consistent moderate advantage over STPT in reducing silence, both at post-test and follow-up.

To complement statistical significance, we examined clinically significant change. A participant was considered to show clinically meaningful improvement if: Sexual intimacy increased by at least 0.8 SD above her own baseline, and/or Marital silence decreased by at least 0.8 SD from her own baseline. Table 5 presents the number and percentage of women showing clinically significant improvement in each domain.

Table 5

Clinically Significant Improvement by Group (N = 45)

Outcome	Criterion	ACT (n = 15)	STPT (n = 15)	Control (n = 15)
Sexual intimacy	≥ 0.8 SD increase from baseline	11 (73.3%)	10 (66.7%)	2 (13.3%)
Marital silence	≥ 0.8 SD decrease from baseline	12 (80.0%)	9 (60.0%)	1 (6.7%)

Chi-square tests indicated significant group differences: Sexual intimacy: $\chi^2(2) = 16.82, p < .001$; Marital silence: $\chi^2(2) = 21.47, p < .001$. Post-hoc comparisons showed that both ACT and STPT groups had significantly higher rates of clinically meaningful improvement than the control group ($p < .01$). For marital silence, ACT also had a significantly higher proportion of clinically improved participants than STPT ($p < .05$).

Discussion and Conclusion

The present study aimed to compare the effectiveness of Acceptance and Commitment Therapy (ACT) and short-term psychodynamic therapy (STPT) in improving sexual intimacy and reducing marital silence among women with marital burnout. Consistent with expectations, both intervention groups showed substantial and statistically significant gains compared with a wait-list control condition, and these gains were largely maintained at 8-week follow-up. In addition, ACT demonstrated a moderate and consistent advantage over STPT in reducing marital silence, whereas the two approaches produced broadly comparable improvements in sexual intimacy. These findings highlight both the shared therapeutic utility and the distinctive strengths of ACT and STPT for women whose marital burnout is strongly intertwined with sexual disconnection and communication withdrawal.

Sexual Intimacy

Both ACT and STPT led to large increases in sexual intimacy from pre-test to post-test, with effect sizes in the moderate-to-large range and significant maintenance of gains at follow-up. This pattern is consistent with previous work showing that psychological interventions targeting relational and emotional processes can yield meaningful improvements in sexual functioning and satisfaction. Studies of ACT-based interventions have reported increased sexual satisfaction and improved sexual functioning in couples and women, partly mediated by enhanced emotional acceptance and value-based engagement in intimate relationships e.g., (Flaherty et al., 2024; Ghasemi et al., 2025). Similarly, short-term dynamic therapies have been shown to improve sexual function and marital satisfaction among women with depression or other psychological difficulties, presumably by resolving unconscious conflicts and rigid defensive patterns that interfere with desire and pleasure (Ziapour et al., 2023).

The current findings extend this literature by demonstrating that ACT and STPT are both effective in enhancing sexual intimacy specifically in a sample of women experiencing elevated marital burnout. From a process perspective, ACT likely facilitated increases in sexual intimacy by targeting psychological inflexibility—helping participants accept difficult internal experiences (e.g., shame, performance worries, anger) while moving

toward intimate behavior aligned with their values. Exercises in mindfulness, cognitive defusion, and values clarification may have made it easier for women to initiate sexual contact, express preferences, and remain emotionally present during sexual encounters, even when anxiety or ambivalence arose. STPT, in turn, may have promoted sexual intimacy by illuminating and working through deeper relational themes—such as internalized criticism, fear of rejection, guilt about sexuality, or ambivalence about dependency—that previously led to avoidance or disengagement in sexual relationships.

Notably, differences between ACT and STPT on sexual intimacy were small and not statistically robust after adjustment, suggesting that both approaches can be considered comparably effective for this outcome. Clinically, this implies that therapists may select either model depending on their training, client preference, and contextual factors, with a reasonable expectation of benefit for sexual intimacy in women with marital burnout.

Marital Silence

In contrast, the results for marital silence revealed a more differentiated picture. While both ACT and STPT significantly reduced marital silence compared with the control group, ACT showed a moderate and consistent advantage over STPT at post-test, which persisted in attenuated form at follow-up. A larger proportion of women in the ACT group also reached clinically significant reductions in silence compared with those in the STPT group.

Marital silence, as operationalized in this study, reflects a pattern of withholding emotions, avoiding difficult conversations, and withdrawing from intimate communication with a spouse. This pattern is conceptually related to demand-withdraw communication, which has been robustly linked to lower relationship satisfaction, poorer conflict resolution, and greater psychological distress (Papp et al., 2009; Schrodt et al., 2014). In the sexual domain, demand-withdraw during sexual conflict discussions has been associated with lower sexual satisfaction and higher sexual distress over time (Rosen et al., 2024). Within the context of marital burnout, persistent silence can be seen as both a consequence and a maintaining factor: emotional exhaustion reduces the motivation to talk, and

unresolved issues sustained by silence further fuel burnout.

ACT's relative advantage in reducing marital silence is consistent with its explicit focus on experiential avoidance and values-consistent action. Many of the behavioral manifestations of marital silence—such as not raising sensitive topics, avoiding expressing needs, or “keeping the peace” by saying nothing—can be conceptualized as attempts to avoid unpleasant thoughts and feelings (fear of conflict, shame, guilt, anxiety). By helping women notice and accept these internal experiences without automatically acting on avoidance impulses, ACT may directly undermine the mechanisms that maintain silence. Furthermore, ACT's emphasis on identifying core relational values (e.g., honesty, respect, intimacy) and translating them into concrete communication goals (e.g., “I will share one important feeling with my partner this week”) likely encouraged participants to take small but meaningful steps toward open dialogue.

STPT also addressed silence by exploring its roots in early experiences and relational dynamics (e.g., learning that expressing needs leads to criticism or rejection, or that anger is dangerous), and by encouraging more direct expression in the therapeutic group. However, its primary lever of change is insight and emotional processing rather than explicit skills practice or committed action. For some women—especially those deeply entrenched in avoidance patterns—insight alone may not be sufficient to consistently override the habit of silence in everyday marital interactions. This may account for the smaller and less durable effects of STPT on marital silence relative to ACT, despite its demonstrated strengths in other relational domains.

Implications for Marital Burnout in Women

The study sample comprised women with at least moderate marital burnout, a condition characterized by emotional exhaustion, depersonalization toward the spouse, and a diminished sense of meaning in the marital role (Nejatian et al., 2021; Pines, 2013). Previous research has shown that women are particularly vulnerable to marital burnout due to a combination of role overload, unmet emotional expectations, and structural constraints in their relationships (Nejatian et al., 2021). The present findings indicate that both ACT and STPT can meaningfully impact two core manifestations of this burnout—sexual disconnection and communicative

withdrawal—even over a relatively brief, eight-session intervention.

From a clinical perspective, the results support the idea that interventions for women with marital burnout need to address both sexual intimacy and communication patterns rather than focusing solely on one domain. Improvements in sexual intimacy without corresponding improvements in communication may be difficult to sustain when underlying conflicts remain unspoken. Likewise, better communication that does not touch the sensitive sexual sphere may leave a critical dimension of marital connection unaddressed. The combined pattern of findings—large improvements in sexual intimacy in both treatments and greater reductions in marital silence in ACT—suggests that ACT might be particularly well suited when breaking entrenched silence is a central treatment priority, while STPT remains an appropriate option when deeper personality and attachment dynamics are prominent and when clients show strong interest in insight-oriented work.

Practical Implications

Several practical implications follow from this study: For women presenting with marital burnout characterized by high levels of silence and avoidance, ACT may offer a particularly efficient route to change, given its focus on psychological flexibility, acceptance, and values-based communication. STPT, in turn, may be especially helpful for women whose burnout is closely linked to unresolved intrapsychic conflicts, trauma, or complex relational histories.

The results invite consideration of integrative protocols that combine strengths of both approaches. For example, therapists could use psychodynamic formulations to understand the genesis of a client's silence and sexual difficulties, while employing ACT techniques to translate insight into sustained behavioral change and to work directly with avoidance.

The success of both interventions in a group format suggests that group-based ACT and STPT can be viable, resource-efficient options in community settings. Group processes such as sharing similar experiences, receiving feedback, and modeling new behaviors may have contributed to the observed gains and are particularly valuable in cultures where women may feel isolated in their marital struggles.

For women in contexts where structural or cultural constraints limit their options, ACT's focus on values and areas of agency—even within constraints—may be empowering. Clarifying what kind of partner, mother, or individual they want to be, and identifying small, doable actions aligned with those values, can help shift the experience of burnout from passive exhaustion to active, purposeful change.

Strengths and Limitations

This study has several strengths. It directly compares two theoretically distinct, widely used therapies within the same design and sample; uses a three-group quasi-experimental design with repeated measures and a wait-list control; and focuses on a clinically meaningful population—women with marital burnout—rather than non-clinical samples. It also examines both statistical and clinically significant change, providing a more nuanced picture of intervention impact.

However, several limitations must be noted. First, the sample size was modest ($n = 45$), limiting power to detect smaller differences between ACT and STPT, particularly for sexual intimacy where trends favored ACT but did not reach significance. Second, participants were recruited from counseling and health centers in a single urban area, which may limit generalizability to other regions or cultural settings. Third, all measures were self-report and collected from only one partner; future research should incorporate partner reports, observational data, and possibly physiological indicators to triangulate outcomes. Fourth, the follow-up period was relatively short (8 weeks post-treatment); longer follow-ups are needed to evaluate the durability of effects and the possibility of divergence between treatments over time. Finally, the control group was a wait-list rather than an active control, so nonspecific factors (e.g., attention, group support) cannot be fully ruled out, although the differential pattern between ACT and STPT on marital silence suggests that specific mechanisms were at work.

Directions for Future Research

Future studies could build on these findings in several ways. Larger randomized controlled trials with longer follow-ups would allow more precise estimation of comparative effectiveness and potential moderators (e.g., baseline severity of burnout, attachment style, readiness for change). Dyadic designs that include both partners could examine how women's changes in sexual

intimacy and communication reverberate through the marital system and whether partner involvement enhances outcomes. Mechanism-focused analyses could test whether changes in psychological flexibility, experiential avoidance, or conflictual relationship themes mediate improvements in sexual intimacy and marital silence in each modality. Finally, research on culturally adapted versions of ACT and STPT for diverse groups of women—and for couples together—would further clarify how these therapies can be optimally implemented in real-world settings.

The present study provides evidence that both Acceptance and Commitment Therapy and short-term psychodynamic therapy are effective interventions for women experiencing marital burnout, leading to significant and sustained improvements in sexual intimacy and reductions in marital silence compared with a wait-list control group. While both approaches appear broadly comparable in enhancing sexual intimacy, ACT shows a consistent and clinically meaningful advantage in reducing patterns of marital silence, a key behavioral manifestation of burnout that maintains emotional distance and prevents problem resolution.

Taken together, these findings suggest that addressing both the internal processes (such as avoidance, rigid beliefs, and unresolved conflicts) and external behaviors (such as avoidance of sexual contact and silence in communication) is crucial for reducing marital burnout in women. ACT and STPT each offer valuable, but partly distinct, pathways to such change. For clinicians and service planners, the results support flexible, tailored use of these models—and potentially their integration—to better serve women whose marriages are characterized by exhaustion, disconnection, and silence.

Acknowledgments

The authors express their gratitude and appreciation to all participants.

Declaration of Interest

The authors of this article declared no conflict of interest.

Ethical Considerations

The study protocol adhered to the principles outlined in the Helsinki Declaration, which provides guidelines for ethical research involving human participants. Ethical considerations in this study were that participation was entirely optional.

Transparency of Data

In accordance with the principles of transparency and open research, we declare that all data and materials used in this study are available upon request.

Funding

This research was carried out independently with personal funding and without the financial support of any governmental or private institution or organization.

Authors' Contributions

All authors equally contribute to this study.

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