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The Effectiveness of Marital Therapy based on Acceptance and Commitment on Couples' Marital Satisfaction and Quality of Life

Abdollah Omidi[1], Ensieh Talighi[2]

[1] Associate Professor, Department of Clinical Psychology, School of Medicine, Kashan University of Medical Sciences, Kashan, Iran
[2] Department of Clinical Psychology, School of Psychology, Islamic Azad University, Science and Research Branch, Tehran (Isfahan), Iran

Quantitative Study

Abstract

Background: The present study assessed the effectiveness of acceptance and commitment therapy (ACT) for couples on couples' quality of life (QOL), emotional regulation, marital satisfaction, general health, and mindfulness.

Methods: This semi-experimental study was performed on 50 couples selected from among 150 couples referring to Zehn Agah Clinic, Bonyad-e Shahid Centre, and the counseling center of Kargarnezhad Hospital in Kashan, Iran, in 2015. The subjects were divided into 2 equal groups including ACT and treatment as usual (TAU). The first group received psychological treatment while the second did not receive any intervention. QOL was assessed in both groups using the Short Form-12 (SF-12) and the ENRICH marital satisfaction questionnaire during pretest and posttest.

Results: A significant differences was observed in the mean scores of marital satisfaction and QOL between the two groups ($P < 0.001$).

Conclusion: It can be concluded that ACT for couples can enhance marital satisfaction and QOL. It appears that ACT for couples is an effective intervention for the treatment of clients with marital problems.

Keywords: Acceptance and commitment therapy (ACT), Marital satisfaction, Quality of life (QOL)

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Introduction

Interpersonal problems are defined as those issues that are repeated frequently in referred interpersonal relationships and which occur because of maladaptive coping responses and behaviors (Gehart, 2012). These behaviors and reactions are learned in childhood and may include demission, blaming, attacking, or aggression. Although these behaviors have adaptive performance in some living conditions, they are often problematic. For example, it is possible for children to remain calm through avoiding their angry, domineering, and controlling parents, but the persistence of these coping behaviors leads to more pain and suffering in adult

Corresponding Author:
Ensieh Talighi
Email: talighi@gmail.com

relationships. Individuals usually learn adaptive behaviors by watching their parents and other family members deal with pain (Gehart, 2012). It is also possible to have aggressive behavior when criticized by others. Evidently, all coping strategies are not learned through modeling. When people are motivated in interpersonal relationships, they may show a response which provides them with a rather short-term relief and usually because this response has already been reinforced, it is possible to be repeated frequently. These compromising behaviors may bring peace in the short-term, but may cause serious damage to relationships in the long-term (Schumacher, 2005). Marital satisfaction is the level of interest of the couple in each other and their positive attitude toward being married which is dependent on factors such as personality problems, relationship with the partner, conflict resolution, financial management, leisure activities, sex, children, friends, and relatives, and religious orientation (Ameri, 2003).

On the other hand, quality of life (QOL) is the most important factor affected by family atmosphere. The World Health Organization (WHO) defines QOL as individuals' perceptions of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, and standards. QOL means a good physical and mental condition, which consist of two elements. These elements are the ability to cope with everyday tasks (at the biopsychosocial level) and the patient's satisfaction with his activities at all levels as well as control over the disease and symptoms connected with the treatment method being applied. The body and mind are not separate. This means that all psychological benefits resulting from the relationship improvement are accompanied with physical benefits (World Health Organization, Division of Mental Health, 1996).

Moreover, several recent papers have reported the important role of familial relationships in somatic health, especially chronic pain. Marital satisfaction is a mental state that reflects the perceived benefits and costs of marriage to a particular person. The operant formulation of physical health, in particular chronic pain, emphasizes the importance of contingent reinforcement in the maintenance of behaviors. The social environment of the patients has been assigned a significant role in this process. Researchers have noted the relationship of numerous somatic problems, such as bodily image, eating disorders, stress related diseases, cardiovascular problems, tension, and migraine headache, with marital satisfaction (Eaker et al., 2007).

There are different approaches in the field of couple therapy, each of which has shown its effectiveness in certain cases. Nevertheless, each approach has strengths and weaknesses, which have been further investigated in studies and clinical trials, and this in turn, has caused the growth and formation of new approaches (Schumacher, &Leonard, 2005).

Acceptance and commitment therapy (ACT) for couples is an evidence-based behavioral intervention that uses acceptance and mindfulness strategies with commitment and behavior-change strategies in order to increase psychological flexibility. Initially, this model was called comprehensive distancing. ACT is rooted in the philosophical theory of functional contextualism and based on a research program regarding language and cognition, is called relational frame theory (RFT). The objective of this model is the creation of psychological flexibility in couples (Gehart, 2012). The therapeutic processes include acceptance, defusion, self-as-context, present moment, values, and committed action. While traditional behavioral couples therapy focused on change, the basic state of ACT for couples (in this study) aims to create a balance between change and acceptance, and a compassionate relationship in couples. This relationship may exist between members of a family, in a couple, and even in interpersonal communication (Hayes & Strosahl, 2010). Couples therapy

usually lasts between 10 to 14 sessions and teaching adaptive coping strategies is the goal of the treatment (Gehart, 2012).

Methods

The present quasi-experimental study was conducted on individuals who referred to the Zehn Agah Clinic, Bonyad-e Shahid Centre, and counseling center of Kargarnezhad Hospital in Kashan, Iran, due to relationship problems and who had no intention to divorce. From among the 150 cases which were referred as a couple, 50 couples who had the inclusion criteria were selected through simple random sampling and were divided into 2 groups of 25 couples (intervention and control group). The intervention group was treated based on ACT for couples and the control group underwent treatment as usual (TAU). It should be noted that the intervention group included 50 individuals (25 couples) and it was difficult to shape a group of 50 individuals; therefore, every 5 couples were assigned to a small group and the collected data were aggregated.

The therapy program process instructions were adjusted based on two books; "Acceptance and Commitment Therapy for Interpersonal Problems" (Gehart, 2012) and "Mindfulness and Acceptance in Couple and Family Therapy". The program consisted of 10 weekly sessions, each session lasting approximately 90 minutes (McKay, Lev, Skeen, & Hayes, 2012).

Marital Satisfaction: Marital satisfaction was measured using the ENRICH marital satisfaction index. The original test consists of 115 questions that have been prepared in various forms due to its length. The questionnaire was designed by Olson, et al., and then, the 47-item form was created. The ENRICH inventory is a multidimensional marital satisfaction measurement that includes 12 subscales. These subscales were developed through a series of theoretical and empirical analyses (Olson, et al., 1983). These subscales consist of personality issues, marital communication, conflict resolution, financial management, leisure activities, sexual relationships, marriage and children, relatives, friends, and religious orientation. In Iran, Soleymanian and Navabinejad (1994) calculated the internal consistency of the ENRICH inventory and reported it as higher than 0.7 for the subscales. Furthermore, test-retest reliability of the questionnaire was acceptable with an average of 0.86 within 4 weeks. Mahdavian (1997) obtained a reliability of 0.94 for women and 0.94 for men using Pearson correlation coefficient and test-retest.

Quality of Life: The quality of life (QOL) variable was measured using the 12-item Short Form (SF-12). In this tool, the minimum and maximum possible score for each dimension of QOL and QOL in general is between 0 and 100. This means that a score of 100 is the best QOL score and a score of 0 is the worst QOL score. The SF-12 was designed in order to be used by the British Health Institute in 1988 and was standardized in 1990. Most of the questions on the SF-12 were gained from tools that were used in 1970 and 1980. This tool includes the 8 subscales of physical functioning, physical role, bodily pain, general health, vitality, social function, emotional role, and mental health. Studies have shown that the correlations among physical, somatic, and mental health in the general population and patients in different countries were 0.80-0.85 (World Health Organization, 2005). Content validity of SF-12 has been investigated in a large-scale health study and the results have shown that the majority of the components of the SF-12 measure health. Empirical validity of the subscales of the SF-12 was reported as 0.80-0.90 in studies on mental and physical health (Omidi, Mohammadkhani, Mohammadi, Zargar, 2013).

Results

Data analysis was performed using SPSS software (version 13, SPSS Inc., Chicago, IL, USA). Descriptive statistics was used to examine differences in demographic

characteristics at baseline between the intervention group and the control group. The multivariate analysis of covariance (MANCOVA) was used to compare multiple variables. Statistical indicators of the two groups in terms of demographic characteristics show that there is no significant difference between the two groups (Tables 1, 2, and 3).

Table 1. Demographic characteristics of the subjects

		Mean ± SD
Age (year)	Intervention group	25.70 ± 5.77
	Control group	24.85 ±2.39
		No (%)
Age (years)	20-25	10 (12.5)
	26-30	16 (20.0)
	> 30	24 (65.5)
Level of education	Diploma	14 (44.0)
	University	36 (56.0)

Levene's test was used to confirm homogeneity assumption of variances between groups. MANCOVA was used to test the hypothesis and to identify significant differences between the intervention and control groups in terms of the dependent variables. Significant differences were observed between the groups in marital satisfaction and QOL scores.

The results of multivariate analysis of variance (MANOVA) showed a significant difference between the intervention and control groups in posttest in terms of mean QOL (P > 0.001). Therefore, in this study, the effectiveness of marital therapy based on ACT was confirmed on marital satisfaction. In this study, effect size and statistical power of marital therapy based on ACT on the subscales of marital satisfaction was 0.197 and 0.889, respectively. To understand the difference, MANCOVA was performed and the results are listed in table 4.

According to the contents of table 4, there was a significant difference between the intervention and control groups in posttest in terms of marital satisfaction (P > 0.001). Accordingly, it can be stated that all aspects of marital satisfaction have improved in the intervention group.

The results of MANOVA on mean QOL scores showed that there is a significant difference between the two groups in posttest in terms of the dependent variables related to QOL (P > 0.001). Therefore, the effectiveness of marital therapy based on ACT was confirmed on QOL.

According to the contents of table 5, there was a significant difference between the intervention and control groups in posttest in terms of QOL for all subscales except physical functioning (P > 0.001). Thus, the effectiveness of marital therapy based on ACT was confirmed on the QOL of couples.

Discussion

The aim of this research was to determine the effectiveness of marital therapy based on ACT on couples' marital satisfaction and QOL. Patterns of interaction between spouses can affect how satisfied they are with their marriage. The pattern that is most often related to marital dissatisfaction is one of

Table 2. The mean and standard deviation of marital satisfaction subscale scores of experimental and control groups in pretest and posttest

Variables	Intervention group (Mean ± SD)		Control group (Mean ± SD)	
	Pretest	Posttest	Pretest	Posttest
Personality issues	3.120 ± 0.824	3.652 ± 0.840	3.632 ± 0.739	3.656 ± 0.907
Marital relationship	2.928 ± 0.667	3.664 ± 0.768	3.440 ± 0.892	3.616 ± 0.891
Conflict resolution	3.052 ± 0.758	3.512 ± 0.809	3.572 ± 0.708	3.504 ± 0.838
Financial management	3.352 ± 0.766	3.984 ± 0.604	3.712 ± 0.822	3.756 ± 0.728
Leisure activities	3.256 ± 0.700	3.696 ± 0.650	3.748 ± 0.707	3.676 ± 0.714
Sexual relationships	3.536 ± 0.673	3.856 ± 0.676	3.608 ± 0.798	3.640 ± 0.666
Marriage and children	2.848 ± 1.196	3.116 ± 1.275	3.064 ± 1.165	2.936 ± 1.149
Relatives and friends	3.276 ± 0.684	3.632 ± 0.703	3.628 ± 0.680	3.504 ± 0.572
Religious orientation	3.984 ± 0.568	4.328 ± 0.596	4.068 ± 0.661	4.056 ± 0.791
Overall satisfaction	41.260 ± 8.980	49.420 ± 9.188	47.88 ± 9.290	46.98 ± 9.580

Table 3. The mean and standard deviation of quality of life subscale scores of experimental and control groups in pre-test, post-test

Variables	Intervention group (Mean ± SD)		Control group (Mean ± SD)	
	Pretest	Posttest	Pretest	Posttest
Emotional health	46.700 ± 21.443	31.200 ± 15.205	43.200 ± 5.264	36.400 ± 23.453
General health	58.000 ± 21.093	63.140 ± 22.345	66.000 ± 22.452	67.500 ± 22.160
Physical function	39.200 ± 39.646	9.000 ± 18.736	28.500 ± 35.718	19.500 ± 25.897
Physical pain	70.500 ± 27.980	79.000 ± 29.606	77.000 ± 27.590	79.000 ± 27.830
Physical role	32.000 ± 44.904	17.500 ± 32.308	29.000 ± 40.520	24.000 ± 38.119
Social function	34.500 ± 25.500	25.400 ± 22.879	25.700 ± 26.515	30.500 ± 27.798
Emotional role	46.000 ± 43.846	20.000 ± 36.422	34.000 ± 39.693	28.000 ± 40.608
Vitality	49.100 ± 19.939	63.200 ± 19.737	53.400 ± 22.822	60.800 ± 21.077

demand/withdrawal and especially impulsive behavior. On the other hand, bodily complaints and somatic problems are common among these couples (Eaker et al., 2007). Therefore, in this research, couples received training on coping behaviors and schemes identification, appropriate behaviors and mindfulness techniques, and etcetera, and expected an increase in marital satisfaction. According to the findings, it seems that couples, who had conflicts and experienced intense emotions in their relationship, responded better to this treatment. During the treatment sessions, it was clear that when they were aware of their emotions, thoughts, and physical sensations in times of sadness and anger, they were able to tolerate their negative emotions and manage their behavior, enhance their ability to have dialogues and modify their relationship, speak and listen about disagreements and problems, use problem-solving techniques, and improve their relationship and marital satisfaction. The research findings were consistent with the results of the study by Morshedi, Davarniya, Zahrakar, Mahmudi, & Shakarami (2016), in which the effect of ACT on couple burnout, sleep problems, sexual complaints, fatigue, anxiety, and depression wasassessed. In this study, the participants showed great equal improvement in the rates of depression, anxiety, performance problems, QOL, life satisfaction, and general clinical conditions. Furthermore, effectiveness of marital therapy based on ACT on couples' QOL showed that QOL dimensions in the intervention group, in comparison with the control group, had a significant increase from pre-test to posttest. Hence, it can be concluded that intervention sessions based on ACT were effective on the QOL of couples. This finding is consistent with the results of the study by Morshedi et al. (2016). A study on the effectiveness of acceptance and coping strategies on improved performance and QOL in a sample of 32 patients showed that treatment based on ACT significantly improved perceivedfunctional ability associated with pain, pain intensity, discomfort of pain, and QOL (Ghomian & Shairi, 2014). The results of a study on the effectiveness of ACT on QOL improvement among obese individuals showed that ACT caused a significant increase in QOL, reduction in psychological anxiety, BMI, and concerns endurance, and an increase in psychological flexibility against obesity after 3 months (Lillis & Kendra, 2014).

Table 4. Results of multivariate analysis of covariance on mean marital satisfaction scores in the intervention and control groups at posttest

Stattistical test	Value	F	Hypothesis df	Error df	Size effect	Statistical power	P-value
Pillai's trace	0.197	2.535	8	83	0.197	0.889	< 0.001
Wilks' lambda	0.803	2.535	8	83	0.197	0.889	< 0.001
Hotelling's trace	0.245	2.535	8	83	0.197	0.889	< 0.001
Roy's largest root	0.245	2.535	8	83	0.197	0.889	< 0.001

df: Degrees of freedom

Table 5. Results of multivariate analysis of variance on mean quality of life scores in the intervention and control groups at posttest

Statistical test	Value	F	Hypothesis df	Error df	Size effect	Statistical power	P-value
Pillai's trace	0.197	2.538	8	83	0.197	0.889	< 0.001
Wilks' lambda	0.803	2.538	8	83	0.197	0.889	< 0.001
Hotelling's trace	0.245	2.538	8	83	0.197	0.889	< 0.001
Roy's largest root	0.245	2.538	8	83	0.197	0.889	< 0.001

df: Degrees of freedom

Conclusion

The present study showed that marital therapy based on ACT is effective on the improvement of QOL and marital satisfaction. Moreover, its effectiveness was significant due to its shorter duration compared with other marital therapy methods.

Conflict of Interests

Authors have no conflict of interests.

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