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RESEARCH ARTICLE

The effect of cognitive behavioral consultation on marital quality among women

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ABSTRACT

Background: Marital quality reflects the individual's total evaluation of marital relationship. The present study was carried out to examine the effect of cognitive behavioral consultation on marital quality among women. **Aims and Objectives:** The present study was a randomized clinical two-group trial which was carried out using a pre-test and post-test design on 198 qualified women who had referred to the selected healthcare centers in Hamadan in 2016. **Materials and Methods:** The intervention participants received four 2-h sessions of cognitive behavioral consultation. Demographic information questionnaire and marital quality scale were completed by the two groups before and after the intervention. To analyze the collected data, independent samples *t*-test, covariance analysis, or change analysis were employed using SPSS 21.0 software. **Results:** The mean age in the control group and the intervention group was 23.58 ± 7.54 and 35.04 ± 7.91 years, respectively. Covariance analysis was utilized to examine the marital quality scores. In this analysis, after the variables of age, marital quality score of agreement and satisfaction before the intervention and income status were modified, the total marital quality score experienced a significant change in all dimensions ($P < 0.05$), and the mean scores increased remarkably. Moreover, according to the cutoff point of the dimensions, the scores of all dimensions increased remarkably and the proportion of individuals with high marital quality before and after the intervention changed significantly ($P < 0.05$). **Conclusion:** Due to the role of sexual relations in stabilizing marriage, cognitive behavioral consultation was effective in improving marital quality, especially after agreement, and can be used in healthcare centers to improve the relationship between couples and reduce divorce statistics.

KEY WORDS: Cognitive Behavioral Consultation; Marital Quality; Women

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INTRODUCTION

Marital quality is one of the variables that is studied in positive psychology and its role in interpersonal relationships, especially in marital relations, is remarkable. According to Marx, "quality of marital relations is the result of methods through which married individuals systematically organize

this triangle." Quality of marital relations and the level of happiness depend on how wife and husband interact with one another and cope with stressful situations of life.[1,2] The second approach belongs to Fincham and Bradbury. According to this approach, marital quality reflects the individual's total evaluation of the marital relation. The third approach is Marx's theory, which is a combined approach from Lewis and Spanier approach and Bowen systematic approach. Marx has a systematic attitude toward individual and the individual's relationship with spouse and others. He explains his theoretical framework this way that a married person has three angles including inner angel, spouse angle, and effective person. The first angel is the inner angel that includes the individual's personality with his efforts, motivations, and different energies, which form as a result of his experience during life. The second angle is the relationship with spouse. In addition, the third angle is any outside concentration point except for the spouse. In other words, the discussion is about triangles. In general, Marx believes that marital quality is the result of the methods through which married individuals systematically organize themselves within this triangle (three angles).[3,4] Sex education is one of the factors affecting the improvement of the relationship between couples and enhancement of marital quality. Lack of enough information about sex and improper attitudes toward this issue in families and couples are among the major problems that today's society is faced with, which leads to the collapse of the family. In this regard, marital counseling as a specialized consultation can convey to the couples, the information necessary to create a favorable sexual life, so that the couples can utilize this information to evolve and complete their marriage. In this regard, due to their awareness about sexual issues and constant contact with the community, midwives play a significant role in making sure about the couples' satisfaction about marital life, whereby a step toward creating a healthy society will be taken.[5,6] Statistics indicates that 50% of couples experience sexual dysfunction in some stages of their lives; however, a few undergo consultation or treatment. By providing sex education and consultation, sexual problems can fade away gradually, and unawareness will be replaced with complete awareness. Marital consultation with prevention of sexual dysfunction and diseases is one of the most effective methods of teaching health to individuals and couples. Sexual counseling plays a significant role in family health, a decrease in sexual violence in the family, preventing sexually transmitted diseases, a positive attitude to sexual relations, sexual pleasure, a decrease in conflict in the family, and gaining pleasurable sexual experience and thus sexual satisfaction. Consultation is a process that helps healthy sexual development, sexual health, interpersonal relationships and affection, intimacy, body image, and gender roles. Sexual counseling is related to cognitive domain (information and knowledge), affection domain (feelings, values, and attitudes), and behavioral domain (communication skills and decision-making).[7] Cognitive behavioral therapy is today's most popular and widely used model of psychotherapy, and clinical studies have proved its efficiency in different populations and for various problems. This approach is characterized by short-term and problem-focused cognitive behavioral intervention strategies that are retrieved from science and cognitive and learning theories.[8,9] In cognitive behavioral approach, the individual learns to fight against his negative attitudes toward sexual issues and improve his interpersonal relationships by utilizing his problem-solving ability. Moreover, this approach helps to promote and maintain good physical and mental feelings among the couples.[10] Cognitive behavioral consultation approach is one of the most common methods in treating sexual dysfunctions. The term "cognitive behavioral consultation" is used to refer to an approach in which it is necessary to cope with overt and cognitive components of behavior. Although traditional behavior therapies are still uniquely important, it is believed that intervention is supposed to cause a change in cognitive aspects of behavior. Most programs that are designed to treat sexual dysfunctions also use behavioral approach and are based on this premise that cognitive change brings about behavioral change, too.[10] This approach is created by combining behavior therapy approach and cognitive approach either in the form of cognitive therapy or the framework of cognitive psychology and basic cognitive science. In cognitive behavioral therapy, strengths of behavior therapy and cognitive therapy, i.e., objectivism, evaluation, and assessment on the one hand and the role of memory in reconstructing and interpreting data on the other hand are collected and unified as an entity. Nowadays, this approach involves relatively different theories and attitudes. Unlike other forms of behavior therapies, cognitive behavioral methods directly deal with thoughts and feelings that are overtly significant in all psychological disorders. Cognitive behavioral therapy fills in the gap that is felt by most merely behavioral methods and dynamic psychotherapy.[11] One of the main components of therapy in this method is presenting sexual knowledge and information related to sexual response cycle, anatomy, and sexual techniques.[12] Therefore, due to the importance of sexual relationships and their effect on family and society health and presentation of educational and counseling programs in healthcare centers, the present study was aimed at examining the effect of cognitive behavioral consultation on marital quality among women referring to healthcare centers in Hamadan.

MATERIALS AND METHODS

The present study was carried out as a randomized clinical trial including an intervention group (n = 99) and a control group (n = 99) with a pre-test and post-test on qualified

women referring to the selected healthcare centers of Hamadan. The sample size was calculated using the formula $n=\frac{\left(Z_{1-\frac{\alpha}{2}}+Z_{1-\beta}\right)^2\left(S^2_1+S^2_2\right)}{(d)^2}$, where S is standard deviation and indices 1 and 2 were, respectively, related to the intervention and control groups which were equal and 16.1, according to referenced,[13] was equal to 10 and Z indicated percentile of normal distribution which was calculated for indices 0.975 and 0.80. Based on this information, the sample size was determined to be 82 in each group, and the final sample size became 198 due to the given loss of 20%.

Study Inclusion Criteria

The following criteria were included in the study:
1. Married women with an age range of 15–45 (reproductive age)
2. Literacy
3. Passage of 6 months from the beginning of married life
4. Hamadan residency
5. No background of remarkable physical and psychological diseases such as psychotic disorders such as schizophrenia and severe depression that need special medicine or diet and prevent filling out the questionnaires
6. An age difference of 10 years between the couples, and
7. Addiction to drugs and alcoholic drinks.

Study Exclusion Criteria

The following criteria were excluded from the study:
1. Pregnancy during the study and
2. Unwillingness to continue the cooperation.

Six health centers were randomly divided into a control group and an intervention one.[14,15] Therefore, the relationship between the two groups was completely omitted. In so doing, three pairs of health centers (each pair consisted of 2 near centers that were similar in social, economic, cultural, and geographical terms) were randomly selected (the social class of the pair centers was assigned; one pair from the uptown, one from the middle, and one from the downtown). From among the three selected pair centers, one was assigned to the intervention group and one to the control group. In other words, 3 centers were selected as the control group and 3 as the intervention group. The sample size in each center was chosen to be 28 individuals, and due to the probable loss of 20%, 33 individuals were selected in each center, and the total sample size became 33 × 6 = 198. It should be noted that the participants of each center were invited through a public invitation of participating in the research (the inclusion criteria were included in the invitation) which was stuck on the clinics' bulletin. After the qualified women referred to the clinics, the participants were selected through a table of random numbers. All of the participants were emphatically informed that participation in the study was completely voluntary and that was able to quit it in any stage without any restrictions. At the beginning of the study, all of the participants took a pre-test. In the pre-test, the participants of both groups filled out the informed consent form, the demographic information questionnaire, and the marital quality scale. The demographic information questionnaire included age, education level, job, spouse age, spouse education level, spouse job, family income level, marriage duration, number of pregnancies, number of children, and addiction background of the couple. Marital quality was measured using the marital quality standard questionnaire. This questionnaire includes 14 questions and aims to evaluate marital quality from different aspects (agreement, satisfaction, and solidarity). It was devised by Busby, Crane, Larson, and Christensen. This 14-question scale is scored through a 6-point Likert scale ranging from 0 to 5; completely agree is scored as 5 and completely disagree as 0. The tool consists of three subscales: Agreement, satisfaction, and solidarity, of which a total of marital quality scores and high scores indicate higher marital quality indicator. The subscale of agreement consists of items 1–6 with a scale range of 5 = I always agree, 4 = I almost always agree, 3 = I sometimes agree, 2 = I often disagree, 1 = I almost always disagree, and 0 = I always disagree. The subscale of satisfaction includes the items 7–11 with a scale range of 1 = always, 2 = most of the time, 3 = most often, 4 = sometimes, 5 = hardly ever, and 6 = never. The subscale of solidarity consists of items 12–14. Item 12 was scored using scales 1 = every day, 2 = almost every day, 3 = sometimes, 4 = almost sometimes, 5 = hardly ever, and 6 = never, and the items 13 and 14 were scored using scales 0 = never, 2 = less than once a month, 3 = once or twice a month, 4 = once or twice a week, 5 = once a day, and 6 = more. To obtain the scores related to each dimension, the total scores of questions relevant to that dimension were added up, and to calculate the total score of the questionnaire, the total scores of all questions were added up. Higher scores indicated higher marital quality and vice versa. The instrument of the present study was a standard questionnaire whose validity and reliability were measured in the previous studies.[16] After the primary assessments, the intervention group was provided with consultation, while the control group received no intervention. The target consultation was provided in the form of cognitive behavioral counseling sessions over four 2-h sessions for 4 weeks.[17] Each session involved questions and answers, lecturing, group discussion (in groups of maximum 10 individuals), and presentation of teaching slides. To provide the consultation, cognitive therapeutic method was used, and each session included.

Session 1: Identifying inefficient beliefs and explaining negative thoughts regarding sexual satisfaction and marital quality Psychological training: Examining the cognitive behavioral model and introducing cognitive distortion regarding sexual dissatisfaction and unfavorable marital quality Homework: Revising cognitive distortion
Session 2: Examining the homework Psychological training: Examining the methods to fight against cognitive distortion Homework: Practising identification of cognitive distortion using thoughts recording sheets
Session 3: Examining the homework Psychological Training: Introducing coping and preventing methods of behaviors and thoughts leading to sexual dissatisfaction Homework: Cognitive reconstructing, completing the sheets of recording thoughts, practising coping, and preventing inappropriate behaviors and thoughts
Session 4: Examining the homework Psychological training: Discussing and examining the factors, preventing approaches, returning from sexual dissatisfaction, increasing sexual satisfaction, and improving marital quality Homework: Practising and preventing approaches to deal with return

The sessions were held in the training class, and the intervention participants were informed about the date of attending the sessions through phone call. Moreover, 1 day before the sessions, the individuals were reminded about the sessions to prevent sample loss as much as possible. Consultation was provided by 3 midwifery MSC graduates/students who had participated in cognitive behavioral courses held by a clinical psychologist. Moreover, the trainers agreed over a uniform teaching method. After the 4th session finished, both groups took the post-test in which the data of marital quality were measured again. It should be noted that, after the study ended, a session of teaching about sexual issues was held for the control group, and they were provided with educational CDs and booklets. To analyze the collected data, independent samples *t*-test and covariance analysis or change analysis was utilized. All of the tests were carried out at a confidence level of 95%.

RESULTS

According to the results of the present study, the average age in the control group was 32.58 ± 7.54 years, and in the intervention group, 35.04 ± 7.91; the two groups were not homogenous in this regard. However, the two groups were homogenous in terms of spouse age (37.23 ± 8.01 vs. 39.13 ± 7.18 years), marriage duration (8.95 ± 7.67 vs. 8.49 ± 6.99 years), and number of children (1.53 ± 0.96 vs. 1.74 ± 0.86), moreover, other demographic characteristics such as the couples' education level and their addiction to drugs (P < 0.05) [Table 1]. Covariance analysis was used to examine marital quality scores. In this analysis, after the variables of age, marital quality score of agreement and satisfaction before the intervention and income status were modified, marital quality scores were compared in the two groups. Tables of variance analysis and regression coefficients are presented. The value of determination coefficient was calculated as 0.85. After the intervention, significant difference was observed between the two groups in terms of all dimensions and total marital quality ($P < 0.05$) and the mean scores of the dimensions increased remarkably [Table 2]. According to the determined cutoff points based on marital quality scale, all dimensions and total marital quality, a limited number of the women had a suitable level of marital quality before the intervention. After the intervention, however, marital quality scores increased, and a significant difference was observed between the two groups regarding all dimensions ($P < 0.05$) [Table 3].

Table 1: Comparing some demographic characteristics in the two groups

Variable	*n* (%)		
	Control group	Intervention group	*P*
Education level			
Primary	11 (11.1)	8 (8.1)	0.060
Secondary	16 (16.2)	10 (10.1)	
Under diploma	28 (28.3)	26 (26.3)	
Diploma	35 (35.4)	33 (33.3)	
University	9 (9.1)	22 (22.2)	
Spouse education level			
Primary	10 (10.1)	3 (7.1)	0.050
Secondary	17 (17.2)	14 (14.1)	
Under diploma	27 (27.3)	19 (19.2)	
Diploma	37 (37.4)	36 (36.4)	
University	8 (8.1)	23 (23.2)	
Spouse addiction			
Yes	21 (21.2)	26 (26.3)	0.404
No	78 (78.8)	73 (73.7)	
Addiction			
Yes	1 (1)	1 (1)	1
No	98 (99)	98 (98)	
Income status			
<1,000,000	46 (55.4)	40 (40.4)	<0.001
>1,000,000	53 (11.1)	59 (59.6)	

DISCUSSION

The present study was conducted to examine the effect of cognitive behavioral consultation on marital quality among women. The results indicated that cognitive behavioral consultation led to an increase in total marital quality and all its dimensions (solidarity, satisfaction, and agreement). The individuals had a low marital quality before the intervention; however, after the intervention, the scores rose remarkably and the consultation had been effective in improving

Table 2: Comparing the mean scores of different dimensions of marital quality of the women before and after the intervention in the two groups

Different dimensions of marital life	Group	Before intervention				After intervention				*P*
		Mean	SD	Minimum	Maximum	Mean	SD	Minimum	Maximum	
Agreement	Control	11.18	3.41	3	19	11.09	2.94	4	19	0.603
	Intervention	15.56	4.94	3	28	25.11	3.32	9	30	<0.001
	P (independent *t*-test)	<0.001				<0.001				
Satisfaction	Control	7.60	1	2.57	7.46	17	1	3.04	7.60	0.489
	Intervention	9.89	8	2.13	16.53	18	1	4.35	9.89	<0.001
	P (Independent *t*-test)	<0.001				<0.001				
Solidarity	Control	7.64	2.73	1	14	7.49	2.96	1	14	0.382
	Intervention	8.1	2.89	1	16	15.90	2.54	9	20	<0.001
	P (Independent *t*-test)	<0.001				0.199				
Total	Control	26.41	6.37	9	45	26.05	5.99	9	64	0.261
	Intervention	33.60	9.93	6	67	57.54	5.94	34	69	<0.001
	P (Independent *t*-test)	<0.001				<0.001				

SD: Standard deviation

Table 3: Frequency distribution of suitable marital quality based on cutoff point before and after the intervention in both groups

Dimensions of married life	Intervention group, *n* (%)		Control group, *n* (%)	
	Before intervention	After intervention	Before intervention	After intervention
Agreement	14 (100)	88 (100)	0 (0)	0 (0)
Satisfaction	20 (95.2)	1 (4.8)	91 (97.8)	2 (2.2)
Solidarity	22 (57.9)	16 (42.1)	97 (86.6)	15 (13.4)
Total	7 (14.3)	0 (0)	94 (98)	0 (0)

marital relationships. This means that cognitive behavioral consultation of sexual issues led to an increase in the total score and dimensions of marital quality in the intervention group. The results of the study carried out by Young and Carlson showed that cognitive behavioral marital consultation can affect the quality of the individuals' marriage, which is in line with the results of the present study.[18] During the sessions of the present study, the couples were taught to solve their sexual and marital problems with the help of their husbands, and the spouses participate in the treatment. When the problem is considered as a joint issue, a single individual is not considered as the cause, the couples become aware of their roles in emergence of the problem, they stop blaming one another, and there will be less argument between them. Numerous indices are used to show marital quality. Perry proposed satisfaction with marriage, spending time together, management of conflicts, prediction of divorce possibility, and frequency of conflicts between the couples as marital quality indices.[19] Satisfaction with sexual relationships is an important factor in marital relationships. Individuals with high satisfaction with their sexual relationship with their spouse have a remarkably higher quality of life, express higher love and interest to their spouse, and have higher levels of agreement, solidarity, and satisfaction in their marital relationships.[20] The studies carried out by Mangeli *et al*. and Khajeh *et al*. indicated the usefulness of sexual counseling on improving marital relationships and satisfaction.[21,22] Regarding marital satisfaction and improvement of marital quality in dimensions of solidarity and agreement, the wife's and husband's understanding of one another's behavior is significant. Cognitive behavioral therapy tries to change incorrect attitude toward spouse and wrong myths about marital relationships and create skills to establish more effective communication and problem solving.[23] In a study, Akbarzadeh *et al*. indicated that cognitive behavioral education of the couples is effective in family performance and the subscales of problem solving, communication, roles, emotional companionship, emotional involvement, and behavior control among divorce applicant.[2] Cognitive foundations of cognitive behavioral therapy of couples

highlight the couples' mutual understanding of one another and consider understanding as an inseparable part of change in couples. Finally, the philosophical foundation of this understanding is that change in behavior alone is not enough to correct inefficient interactions, rather there should be an emphasis on how individuals think in their relationships and their incompatible behavioral patterns.[24] Veshki *et al*, in their study carried out on 30 women referring to counseling centers in Qom, and utilized a researcher-designed marital quality questionnaire and 6 sessions of sex education. They showed that the intervention could improve marital quality and its dimensions. They showed that the intervention could improve marital quality and its dimensions.[25] Due to the role of sexual relations in consolidating marital relationships and its quality, marital consultation leads to an increase in sexual satisfaction, and the women participating in the educational program reached a higher sexual pleasure and expressed more passion and affection in their marital relationships.[25] The results of the study carried out by Salimi and Fatehizadeh also showed that sex education by cognitive behavioral method enhances the married women's knowledge, self-expression, and sexual intimacy, which is in line with the results of the present study.[26] With regard to the significance of the results, it can be stated that the cognitive behavioral sex consultation used in the present study could improve all dimensions of marital relationships by emphasizing cognitive dimensions of sex consultation such as pinpointing and challenging the common sexual wrong beliefs through group discussion, determination and improvement of attitude toward sexual activity, presentation of realities and importance of satisfying sexual desires, the role of sexual relation in general relationships, and quality dimensions of marital relationships. In the cultural context of Iran, women and men have limited and incorrect knowledge and do not have access to reliable sources. Moreover, they have a lot of incompatible and illogical thoughts, beliefs, attitudes, and understanding of sexual issues which affect the couples' sexual relation. In cognitive behavioral approach, attention is paid to sex education that Iranian couples need and do not obtain by a reliable method.[27,28] According to the mentioned issues, it is determined that, in the culture of Iranian society, paying attention to cognitive factors is highly important to resolve sexual problems, dysfunction, and dissatisfaction and neglecting them leads to a decrease in therapeutic purposes. Cognitive-behavioral family therapy training causes the couples to be equipped with skills necessary for marital life and generalizes these teachings to other levels of marital and social levels of life. In cognitive behavioral method, according to the culture of our society and since an extensive range of treatment techniques and methods is used, it can be effectively employed as an extensive method to treat behavioral problems and positively change couples. Sampling with larger size from various clinics of the city was strength of the present study, and failure to follow them after the study was one of the limitations of the present study. Due to the effectiveness of the method used in the present study, it is suggested that techniques of this approach are utilized by family and marriage counselors to increase sexual satisfaction and solve marital conflicts and improve marital quality of the couples' life. Moreover, the applicable drills and skills of this method in the form of educational sessions, workshop, videos, and pamphlets are employed to prevent marital problems.

CONCLUSION

Due to the role of sexual relations in consolidating marital life, cognitive behavioral consultation was effective in improving marital quality, especially after agreement, and it can be employed in healthcare centers to improve the couples' relationship and reduce divorce statistics.

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