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Research Paper

The Effect of Acceptance and Commitment-based Therapy on Self-Compassion, Quality of Life and Marital Commitment of Women Who Filed for Divorce

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ABSTRACT

Objective: The objective of the present study was to investigate the effect of acceptance and commitment therapy on self-compassion, quality of life, and marital commitment of women who filed for divorce.

Methods: The research method was quasi-experimental with a pretest-posttest and follow-up design. The population included all women who filed for divorce, either referring or were referred to the psychological and counseling centers under the supervision of the Welfare Organization in Neishabour. The sample was selected purposively. Then, 30 women were randomly assigned to the experimental and the control groups (i.e., each group included 15 participants). Data collection instruments included Neff's Self-Compassion Scale (2003), the World Health Organization's short form of Quality of Life Scale (1989), and Adams and Jones' Marital Commitment Questionnaire (1997). Data analysis was performed through repeated measure analysis using SPSS software (version 25).

Results: The results showed that acceptance and commitment-based therapy had a positive effect on self-compassion, quality of life, and marital commitment of the women applying for divorce. In addition, the effectiveness of acceptance and commitment-based therapy was sustained in terms of self-compassion, quality of life, and marital commitment.

Conclusion: As a result, this treatment can be used by psychologists and clinical counselors to offer psychological interventions on self-compassion, quality of life, and marital commitment of women who filed for divorce.

1. Introduction

Marriage is a commitment with love and responsibility for peace, happiness, and the transformation of family relationships. In addition, choosing a partner for marriage is a turning point and personal success (Gilman, 2022). Marriage has many benefits both for women and men (Huang et al., 2020). For instance, it reduces stress and increases happiness (Chen & Chen, 2021). However, divorce is a social phenomenon that severely affects the lives of individuals (Oldham, 2021). It is a complex phenomenon viewed from different psychological, social, and cultural aspects. The prevalence of divorce has increased in recent decades in the world (Sands et al., 2017). Including a range of negative consequences, divorce puts the

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families' level of mental health at risk (Raley & Sweeney, 2020). In recent years, this phenomenon has become an important social problem; it is increasing daily. It has led to disintegration, which has many negative consequences, including emotional and psychological problems for family members, various crimes, and the homelessness of many children. According to the reported statistics in Iran, 519250 marriages and 171246 divorces were registered in 2020.

Moreover, in the first six months of 2021, 127318 marriages and 34659 divorces were reported. Therefore, the ratio of marriage to divorce is more than three to one (Iran, 2022). These statistics show that divorce is a fundamental issue that must be attended to. Divorce seems very difficult for individuals, especially women, who find it a major problem in their future relationships (Sbarra & Whisman, 2022). Therefore, it can be stated that women suffer from divorce more than men due to after-divorce circumstances. In fact, after divorce, women suffer from various psychological, emotional, communication, and social problems and injuries, including the reduction of self-compassion, quality of life, and marital commitment (Parker et al., 2022).

Compassion signifies warmth and acceptance of unpleasant aspects of oneself and life. Self-compassion can be defined as being aware of one's suffering and having a comforting and compassionate attitude towards oneself when things go wrong (Di Fabio & Saklofske, 2021). Self-compassion is one of the most important components of mental health; it enables individuals to achieve happiness and psychological well-being through learning and performing related skills (Tóth-Király & Neff, 2021). Furthermore, quality of life is the level of physical, psychological, and social well-being that individuals perceive. It shows individuals' satisfaction level with the gifts of life (Dumith et al., 2022). The World Health Organization defines the quality of life as an individual's perception of his position regarding cultural context, values, and individual goals (Atanasova & Karashtranova, 2016). Quality of life is a multifaceted and complex concept; however, it is definable and measurable. In studies on quality of life, there are two conceptual and objective approaches (Bhatti et al., 2017). These approaches are mostly used separately and rarely are used in combination. Quality of life is perceived in terms of conceptual dimensions, which include people's assessment of their life situation and are measured by conceptual indicators. Importantly, the conceptual quality of life is the cumulative level of satisfaction with different areas of life. Moreover, according to Kaplan & Hays (2022), quality of life includes the acceptance of self, purpose in life, personal growth, environmental control, autonomy, and positive relationships with others (Uysal & Sirgy, 2019). The concept of quality of life is deeply rooted in the way we think about health.

Furthermore, marital commitment is the strongest and the most stable predictor of the quality and stability of the marital relationship (Bilal et al., 2021). Lifelong commitment to marriage, fidelity to one's spouse, strong moral values, respect for one's spouse as the best friend, and commitment to sexual fidelity are the characteristics of satisfactory marriages over the age of 20 (Ellen Byrd, 2009). Marital commitment is a conjecture in which people have long-term views on their marriage, try for their relationship, take steps to maintain, strengthen, and bond their union, and stay with their spouse even when marriage is not rewarding (Stets & Hammons, 2002). Although commitment or intention to continue a relationship is often considered a general construct, it is explicitly divided into three types (Adams & Jones, 1997). These three types of commitment include: a) commitment to the spouse (i.e., personal commitment which is based on the desire to remain in the relationship), b) commitment to marriage (i.e., moral commitment related to social or religious obligations of integration and responsibility) and c) compulsory commitment (i.e., trapping in a relationship due to the costs and the problems involved in terminating the relationship) (Adams & Jones, 1997; Burgoyne et al., 2010).

In a study titled "Marital commitment and quality of life in fertile and infertile couples," Shahhossiani Tajik, Sayyadi, and Taheri (2019) found that marital commitment had a significant relationship with the couples' quality of marital life. In addition, Dasht-e Bozorgi, Asgari, and Asgari (2018) investigated the effect of self-compassion-based intervention on loneliness and emotional regulation of women affected by marital infidelity. He showed that self-compassion-based intervention reduced loneliness and increased emotional regulation in women affected by marital infidelity. This effect was consistent after one month.

Psychological interventions are used to improve and enrich marital relationships. Acceptance and commitment-based therapy was developed in the 80s by Hayes (2002). *Psychological flexibility* is a process during which an individual makes momentary contact with the present moment. Accordingly, he commits to moving through the path of his life values (Bai et al., 2020; Hayes & Lillis, 2012). This model of therapy helps individuals design functional plans and implement them by accepting their inner thoughts and

being aware of their personal values (Burckhardt et al., 2017). This type of therapeutic intervention aims to change the individual's relationship with his inner experiences and create a non-judgmental view towards various life issues (Köhle et al., 2015).

The theoretical and experimental literature shows that acceptance and commitment-based therapy has positive effects on marital compatibility, interpersonal intimacy, frustration and the quality of couple's interactions, the reduction of stress, tension, and depression caused by marital infidelity, compatibility, sexual satisfaction, forgiveness and marital adjustment, marital separation, attachment problems, and marital dissatisfaction (HONARPARVARAN, 2014; Wiebe, 2016).

Since couples' conflicts have deep and destructive personal, social, economic, parental, and legal consequences (Michalitsianos, 2014), the necessity of conducting this study is more clear. On the one hand, the significance of this research study is clarified by providing information on marital problems and family issues. On the other hand, it fosters the application of communication theories in improving the mental health and the marital life of couples who are referred to courts, technical family counseling centers, Education ministry counseling centers, welfare organizations, and divorce prevention centers.

The occurrence of divorce seems very annoying for people, especially women who consider divorce as a fundamental problem in their future relationships. Therefore, it can be stated that women suffer more from divorce. In addition, due to after-divorce conditions, women would face many problems, including anxiety (Hald et al., 2022; Shazia, 2019), stress (Srinivasan et al., 2020), depression (Anderson et al., 2003; Nahar, 2020), lower adjustment and self-esteem, and less happiness (Bereket, 2015). Therefore, it is necessary to perform psychological interventions to increase the quality of life of women seeking divorce. Thus, the objective of this research study was to investigate the effect of acceptance and commitment-based therapy on self-compassion, quality of life, and marital commitment of women who filed for divorce.

2. Materials and Methods

The present study was applied in terms of purpose and quasi-experimental with a pretest-posttest design with a control group. It also included a two-month follow-up phase. The population included all women who filed for divorce, either referring or were referred to the psychological and counseling centers under the supervision of the Welfare Organization in Neishabour in 2021. The sample was selected purposively (based on the participants' low scores in Self-Compassion, Quality of Life, and Marital Commitment questionnaires). Then, 15 women were randomly assigned to the experimental group and 15 to the control group. The sample size was determined by Cohen's table. In fact, at a 95% confidence level, the effect size of .50 and test power of .80, 15 individuals were determined for each group. The inclusion criteria included filing for consensual divorce, having at least a diploma, spending more than two years of married life, being 20-50 years old, not participating in other treatment programs at the same time, not receiving individual counseling or medication, and declaring satisfaction with participating in treatment sessions during the research study. The exclusion criteria included the deficiency in the returned questionnaires and more than two absent sessions during therapy sessions.

The experimental group was provided with the intervention during eight sessions (a 90-minute session per week) using the principles of acceptance and commitment-based therapy by the researcher at Afarinesh Counseling Center in Neishabur. Moreover, the control group did not receive any intervention. The summary of the training sessions is presented in Table 1. The treatment protocol of acceptance and commitment-based therapy (ACT) was developed and implemented based on the theoretical foundations of this approach and the ACT manual written by Efret, and Forsite (2007, Translated by Faizi et al., 2017.:

Table 1. Summary of the content of the treatment sessions of acceptance and commitment-based therapy focusing on self-compassion, quality of life and marital commitment of women who filed for divorce

Session	Objective	Strategies	Intervention
1	Individual evaluations	Interview, assessment of the contradiction	Planning and combining individual evaluations
2	Examining the costs of the relationships	Examining the costs of members' avoidance and contradictions, and creating creative frustration	Chinese Finger Trap metaphor and tug of war practice with the spouse
3	Mindfulness and acceptance	Introducing mindfulness and acceptance	Acceptance of thoughts and feelings
4	Cognitive impairment	Derealization of negative communicative thoughts of couples	Practicing bus driver, and practicing thoughts on sheets

5	Observation of thoughts	Creating compassion and observer point of view towards oneself and one's spouse	Practicing acceptance, and practicing thoughts on tree leaves
6	Choosing value paths/ recognizing obstacles in life	Helping the clients in recognizing the valuable paths in life, examining the value worksheet and discussing obstacles	Practicing wishes, and practicing obituaries, worksheet on committed action, and bus driver worksheet review
7	Creating flexible patterns of behavior and communication as a context	Introducing consent, creating options and responses, and confronting members to their experience as a context	Committed action worksheet and Chess Board metaphor
8	Acceptance and committed actions	Examining satisfaction in the context of committed action	Committed action

Data analysis was performed through SPSS software (version 25). Despite the follow-up test, repeated measure analysis was used to compare the differences between the experimental and the control groups in terms of self-compassion, quality of life and marital commitment of women. The reported descriptive statistics included mean and standard deviation, and p <.05 was considered significant in the analysis. In this research study, ethical considerations including observance of scientific honesty and trustworthiness, conscious consent to participate in the study, observance of the participants' right to remain anonymous and the confidentiality of their data were considered.

Instruments

1. Self-compassion Scale: This 26-item scale was developed by Neff (2003) to measure self-compassion. It includes the six subscales of self-kindness, self-judgment, common humanity, isolation, mindfulness, and over-identification in a 5-point Likert scale ranging from rarely to almost always. About scoring, some items and subscales are inverse, and a higher score indicates more self-compassion. The psychometric properties of the scale have been confirmed in different studies. The correlation coefficient of the six factors of this scale and self-compassion (total scale) was confirmed at the significance level of .001 (Neff, 2003). Khosravi, Sadeghi, and Yabandeh (2014) standardized this scale in Iran. Through exploratory factor analysis, the structure of the six-factor scale was confirmed, and the six factors were obtained. In addition, the total scale's validity was obtained through Cronbach's alpha coefficient of.86. It is worth mentioning that the Persian form of the scale, similar to the Latin short-form, includes 26 items in the Likert scale, which range from 1 (almost never) to 5 (almost always). It similarly examines the six subscales (i.e., self-kindness, self-judgment, common humanity, isolation, mindfulness, and over-identification). Furthermore, the total score in the six subscales shows the overall level of self-compassion.

2. Short Form-36 Health Survey: SF-36 was designed to measure physical and mental health based on 8 health concepts: physical and social functioning, role limitations due to physical and emotional problems, mental health, vitality, bodily pain, and general health perception.3-4-5- The scale was constructed to be suitable for use by anyone, irrespective of demographics or disease, and contains 36 items that are rated on 2 to 6 ordered categories.5 SF-36 is often considered a measure of HRQoL,6 due to the definitions of health and HRQoL being inconsistent but largely overlapping.7. SF-36 is conceptualized as a hierarchical 2-level structure where the 2 constructs of physical and mental health (component summary scores), mediated through the 8 health concepts (subscales), drive the item responses.3-4-5. Although this theory is largely consistent across studies, its empirical representations vary, which has resulted in various scoring methods and disparate association schemes linking the constructs, subscales, and items together. 8-9. The scale's reliability was confirmed in the study by Bunevicius (2017). Also, the internal consistency was adequate for all (Cronbach $\alpha \geq .728$) but Social Functioning (Cronbach $\alpha = .527$) and General Health (Cronbach $\alpha = .693$) subscales. The scale's validity was confirmed in the study by LoMartire, Äng, Gerdle, & Vixner (2020). The scale-level indices unanimously supported an acceptable two-tier model fit {RMSEA: 0.041 (90% confidence interval [CI] 0.041-0.042); SRMSR: 0.038; TLI: 0.971; CFI: 0.976). In Iran, Nejat et al (2006) examined the reliability through the test-retest method with a three-week interval. They turned out to be 70respectively.

3. Marital Commitment Questionnaire: This questionnaire was developed by Adams and Jones (1997) to measure three dimensions of marital commitment (i.e., personal commitment, moral commitment, and structural commitment). This questionnaire contains 44 items. The general range of individuals' scores is between 1 and 127; a higher score indicates the high overall commitment of couples (Namani, 2017). To examine the reliability and validity of the questionnaire, Adams and Jones (1997) administered it in six different studies investigating 417 married individuals, 347 single individuals, and 46 divorced individuals. In these studies, the correlation between each item and the total score of the questionnaire was high and significant. In general, the dimensions of this questionnaire enjoyed the most experimental and theoretical support (Mohammadi et al., 2014).

3. Results

Each experimental and control group included 15 women with bachelor's or master's degrees. The groups were homogeneous; there were little differences in terms of the groups' level of education. Among the 30 participants, 10 were employed in governmental organizations, 5 were employed in non-governmental organizations, and 15 were housewives. In addition, women were in the age range of 30 to 40 years. In addition, the mean age and the standard deviation of the control group were 35.73 years and 2.1, respectively, and the mean age and the standard deviation of the experimental group were 36.24 and 1.75, respectively.

Table 2. Mean and standard deviation of self-compassion, quality of life, and marital commitment of the experimental and the control groups' women who filed for divorce

Variables	Group	Number	Pretest		posttest		Follow-up	
			M	SD	M	SD	M	SD
self-compassion	Acceptance and commitment	15	92.53	5.53	100.73	7.07	101.93	6.47
	Control	15	92.20	6.16	93.07	5.6	92.53	5.99
quality of life	Acceptance and commitment	15	86	6.96	89.93	5.39	90.27	5.62
	Control	15	87.07	7.25	86.6	6.68	86.33	6.58
marital commitment	Acceptance and commitment	15	134.07	19.29	138.53	18.87	140.87	18.21
	Control	15	132.67	18.13s	132.4	17.88	131.8	18.56

As Table 2 shows, there were differences between the experimental and the control groups' means of pretest, post-test, and follow-up regarding self-compassion, quality of life, and marital commitment.

The result of the Shapiro-Wilk test for the experimental group in self-compassion was not significant (Z=0.98, P=0.80). The result of the Shapiro-Wilk test for the control group in self-compassion was not significant (Z=0.92, P=0.19).

The result of the Shapiro-Wilk test for the experimental group in quality of life marital commitment was not significant (Z=0.96, P=0.64). The result of the Shapiro-Wilk test for the control group in quality of life marital commitment was not significant (Z=0.90, P=0.09).

Thus, the condition of the normal distribution of the scores was established. In addition, the results of Levine's test indicated the homogeneity of the error variances in the two groups (experimental group in self-compassion, F=0.011, P=0.71; control group in self-compassion, F=0.28, P=0.49;). The result of the Shapiro-Wilk test for the control group's quality of life marital commitment was insignificant (F=0.003, P=0.99). The result of the Shapiro-Wilk test for the experimental group's quality of life marital commitment was not significant (F=0.084, P=0.79). Moreover, the results of Mauchly's test of sphericity showed that the condition of equality of variance/ covariance matrices and the assumption of sphericity were not met for the marital commitment variable. Therefore, Greenhouse-Geisser correction was used.

Table 3. Results of within-group variance analysis with repeated measures of self-compassion, quality of life, and marital commitment of women who filed for divorce

Variables	Tests	Source	Sum of the squares	df	Mean of the squares	F	Sig.	Eta square	Effect size
Self-compassion	Greenhouse-Geisser	Time	443.47	2	221.73	22.78	.0001	.45	1
		Group* Time	347.47	2	173.73	17.85	.0001	.39	1
		Error	545.07	56	9.73				
Quality of life	Greenhouse-Geisser	Time	61.27	1.16	52.73	5.98	.02	.18	.7
		Group* Time	111.8	1.16	96.23	10.91	.0001	.28	.92
		Error	286.93	32.53	8.82				
Marital commitment	Sphericity	Time	139.62	2	69.81	51.05	٠.0001	.65	1
		Group* Time	224.47	2	112.23	82.07	.0001	.75	1
		Error	76.58	56	1.37				

The results of within-group variance analysis with repeated measures (see Table 3) showed that acceptance and commitment-based therapy was effective in terms of self-compassion, quality of life and marital commitment of women who filed for divorce.

According to the results of the Bonferroni test in Table 5, there was a significant difference between the pretest and the post-test of the experimental group regarding self-compassion, quality of life, and marital commitment of the women who filed for divorce (P < 0.05).

However, there was no significant difference between the post-test and the follow-up scores (P < 0.05). In other words, acceptance and commitment-based therapy was effective in terms of self-compassion of women who filed for divorce; there was a significant difference in their self-compassion scores after the treatment. However, it did not have a sustained effect in the follow-up phase (P < 0.05).

Table 4. Bonferroni post hoc test results comparing the variables of self-compassion, quality of life, and marital commitment in the experimental group's women who filed for divorce

Variables	Phases	Posttest	Follow-up
Self-compassion	Pretest	8.20**	9.40**
	Posttest	-----	1.20
Quality of life	Pretest	3.93**	4.27*
	Posttest	-------	.33
Marital commitment	Pretest	4.46**	6.80**
	Posttest	------	2.33

**P<٠.05 ،* P<٠01

As it is evident in Table 5, the between-group effect was significant in terms of self-compassion (P < 0.05); however, it was not significant in terms of quality of life and marital commitment (P < 0.05). In other words, there was a significant difference between the participants of the experimental and the control groups in terms of self-compassion (P < 0.05). However, there was no significant difference between the groups in terms of quality of life and marital commitment (P < 0.05).

Table 5. The results of the between-group significance test of acceptance and commitment-based therapy considering the variables of self-compassion, quality of life, and marital commitment of women who filed for divorce

Variables	Source	Sum of the squares	df	Mean of the squares	F	Sig.	Eta square	Effect size
Self-compassion	Intercept	820822.5	1	820822.5	8707.01	.0001	1	1
	Group membership	1756.9	1	756.9	8.03	.01	.22	.78
	Error	2629.628	28	94.27				
Quality of life	Intercept	692216.1	1	692216.1	6044.05	.0001	1	1
	Group membership	96.1	1	96.1	.84	.37	.03	.14
	Error	3206.8	28	114.53				
Marital commitment	Intercept	1641600.28	1	1641600.28	1603.84	.0001	.98	1
	Group membership	688.9	1	688.9	.67	.42	.02	.12
	Error	28659.16	28	1023.54				

4. Discussion and Conclusion

The objective of the current study was to investigate the effectiveness of acceptance and commitment-based therapy in terms of self-compassion, quality of life, and marital commitment of women who filed for divorce. The results showed that acceptance and commitment-based therapy had a positive effect on self-compassion, quality of life, and marital commitment of women who filed for divorce. These results are consistent with those of Wiebe, Johnson, Burgess-Moser, Dalgleish, Lafontaine, and Tasca (2016) and Honarparvaran (2014) studies.

These findings can be explained by referring to the fact that following the theoretical foundations of acceptance and commitment-based therapy (Hayes & Lillis, 2012), the therapist helped the participating members improve themselves and their behavioral, cognitive, and emotional dimensions. He also makes them aware of the contents and how they function. During this investigation, the members concluded that they had many ineffective functions, such as using verbal and non-verbal harassers, not paying attention, not managing emotions, and not expressing emotions constructively, which not only disturbed their psychological security but also made their partner dissatisfied with their marital life (Gillard et al., 2018). Through such knowledge and insight, the members and the therapist focused on each of these non-constructive behaviors and designed and implemented acceptance and commitment-based programs to correct them. By reducing the frequency and severity of these behaviors, the intimacy of couples and their satisfaction with the life process increased to a great extent. In addition, another dimension that could provide the basis for increasing self-compassion, quality of life, and marital commitment was the fact that when the members focused on their inner selves, a set of irrational thoughts was identified. The

therapist, accompanied by the members, focused on the unrealistic nature of these thoughts; after analyzing and questioning them, he allowed the members to replace them with more positive and constructive thoughts. He avoided relying on them continuously. Such a process gradually reduced the effectiveness of these thoughts and provided the grounds for increasing self-compassion, quality of life, and marital commitment.

Acceptance and commitment-based therapy improves the quality of marital relationships by strengthening the ability of couples to manage their inner emotions and committing them to address their marital needs and desires. Kalangoochan Atiq and Sarai (2016) showed that acceptance and commitment-based therapy increase the couples' ability to face life challenges by increasing their awareness of their performance and creating marital goals based on intrapersonal and family values. It assists them in taking care of their plans in life and adapting to marital conditions through perseverance. In sum, in the present study, the therapist helped the members focus on themselves and analyze and evaluate their role in life. After this analysis, the members realized the fact that all their behaviors were due to their own choices and were completely under their own control. Such an insight motivated the members to be more aware of their choices and face different life challenges more freely (Hayes et al., 2011). When the members realized the powers of freedom, control, and discretion, they recognized that they could solve any problem and cope with and adapt to any situation in life. In addition to strengthening their self-efficacy, the formation of such a transformation improved the members' ability to adapt to different conditions and strengthened their performance in handling their tasks in different life dimensions (Hayes & Lillis, 2012).

As a result, this treatment can be used in psychological interventions considering self-compassion, quality of life, and marital commitment of women who filed for divorce by psychologists, counselors, and clinicians. This study investigated the women who filed for divorce in Neishabur. Thus, generalization of the findings should be done with caution. Further research studies are suggested to replicate this study with longer sessions in other cities and cultures. The results of the present study showed that acceptance and commitment-based therapy was effective in increasing self-compassion, quality of life, and marital commitment of women who filed for divorce.

5. Ethical Considerations

Compliance with ethical guidelines

All ethical principles were considered in this article. The participants were informed about the objective of the research and its implementation phases. They were also assured about the confidentiality of their information and were allowed to leave the study whenever they wished. Moreover, if they desired, the research results would be available to them.

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Authors' contributions

All authors participated in the design, implementation and writing of all sections of the present study.

Conflicts of interest

The authors declare that there is no conflict of interest in this article.

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