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# Comparing the effectiveness of Acceptance and Commitment Therapy and Compassion Focused Therapy and Acceptance and Commitment Therapy enriched with Compassion on social adjustment of women with depression and marital conflict

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***Abstract***

**Introduction:** This study aimed to compare the effectiveness of Acceptance and Commitment Therapy (ACT) and Compassion Focused Therapy (CFT) and Compassion Enriched Acceptance and Commitment Therapy on social adjustment of married women with depression and marital conflict.

**Materials and Methods:** The statistical population included married women suffering from depression and marital conflicts who referred to counseling centers in Mashhad city, Iran. The participant (n=60) were selected by purposive sampling and randomly divided into three experimental and control groups. The intervention was performed in eight 90-minute training sessions for the experimental groups and the control group did not receive any intervention. All four groups answered the Adult Bell Form (Social Adjustment) questionnaire before the intervention, at the end of the intervention and 30 days after the intervention. Data were analyzed by univariate analysis of covariance and analysis of variance for repeated measures.

**Results:** There was a significant difference between the mean of pre-test, post-test and follow-up of social adjustment in the group of treatment based on acceptance and commitment, treatment focused on compassion, acceptance and commitment enriched with compassion and control ($P$= 0.001). Also, there was a significant difference between social adjustment in the post-test stage of the mentioned groups and the group of acceptance and commitment enriched with compassion showed more difference.

**Conclusion:** Therapies based on acceptance and commitment and focused on compassion and therapy based on acceptance and commitment enriched with compassion, are effective on social adjustment and the effect of therapy based on acceptance and commitment enriched with compassion is greater on social adjustment.

**Keywords:** Acceptance and Commitment Therapy, Compassion, Depression, Marital conflicts, Social adjustment

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## Introduction

Conflict is an inevitable component of human communication. People are different from each other and not always in harmony. As couples get closer to each other, these differences will inevitably lead to some disagreement (1). Marital conflicts may lead to personality disorders, mental disorders, physical disorders,

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irritating personality habits and traits, unhealthy communication patterns, spousal abuse, infidelity, irrational thoughts and beliefs of couples, problems with spending time with each other, problems with leading families and their harmful interference (2). With the increase of conflict in marital relations, incompatibility increases, more dissatisfaction is obtained. In addition, these problems are considered preconditions for divorce (3). Johanson considers marital discord a critical risk factor for depression, anxiety, bipolar disorder, alcohol dependence, and malignancies (4). Studies have shown that women are more prone to major depressive disorder (MDD) than men (5). Recent research shows that couples' conflicts are associated with increased depressive symptoms (6).

Lurent et al. examined the longitudinal relationship between marital conflict and depression and found that couples' engagement with each other during the physical conflict was associated only with depression in women (7), and marital conflicts lead to psychological conditions in couples (8).

In the bilateral study, Proulx et al. found that husbands 'violent behavior during marital interactions would increase depression in women three years later and that female violence was associated with husbands' depression (9). We all experience the greatest sense of security and sometimes the most significant vulnerability in our marital and family relationships, our deepest and most intimate relationships (10). Being in a satisfying romantic relationship is one of the strongest predictors of life satisfaction and well-being (11). A depressed person has trouble accepting him/her-self and many of his life events. Continuing the process causes later behavioral change and commitment. This means that when a person is not able to accept his inner experiences, which are the verbal-mental representation of events and happenings that have arisen as a result of interaction with the world around him and other human beings, and does not spend his energy in vain to change them, naturally and logically Will not be able to adapt to the situation and show flexibility (psychological flexibility) (12).

It is evident that every person faces various individual and social limitations in her daily life and during her life, and it is in dealing with these obstacles, she experiences conflict and failure and loses her balance. If someone can recognize and accept his limitations, find ways to deal with and use them, and control desires and aspirations, he is called an adaptive person (13).

Adaptability is comparative, and human beings achieve it to varying degrees. People with low Social adjustment have many problems in verbal communication with others, planning in life, taking care of themselves, doing daily affairs, etc. (14). Socialization is a bilateral communication process, and Social adjustment is a continuous process in which a person's social learning experiences create psychological needs and enable the acquisition of abilities and skills through needs can be met (15). In addition, social adjustment is the process of intercourse, compromise, adaptation, cooperation, and coping with oneself, the environment, and others (16). Therefore, due to the difficulty of adaptation, it is felt necessary to improve adaptation with an appropriate treatment method. One of the effective methods in improving adaptation is acceptance and commitment therapy (17). From the acceptance and commitment therapy (ACT) perspective, human suffering is rooted in psychological inflexibility created by cognitive fusion and avoidance of experiences (18). Acceptance and commitment therapy aims to create psychological flexibility, meaning the ability to choose an appropriate action between the available solutions, not a behavior to avoid stressful emotions and thoughts (19). In this method, to create psychological flexibility, the person is trained to increase the acceptance of his psychological experiences, understand the ineffectiveness of avoidant actions and behaviors against psychological experiences, and accept these experiences without any internal or external reactions, respectively. In the next stage, the person learns to be aware of all the moments of her life and to be able to determine her action and values independently of experiences, and finally, she is motivated to perform a committed action (20). In other words, acceptance and commitment through the combination of vitality and clear seeing of experiences and their acceptance can make positive changes in adaptation and well-being (21). One of the treatments that can facilitate the flow of psychotherapy for the ACT and develop its technical and functional aspects is the techniques of compassion-focused therapy. Compassion-focused therapy and other new

therapeutic approaches in third-wave psychology have been developed to reduce pain, suffering, anxiety, and depression (22). Compassion-focused therapy believes that human traits are rooted in states of mind that are important physiological systems motivating and simultaneously play a role in attachment, altruism, and caring behaviors (23). Compassion therapy, with the awareness of the inevitability of suffering and stress and adopting a soothing and compassionate view of oneself during stressful events, causes a person to treat kindly and receptive with himself (24). Our brain contains at least three major emotion regulation systems (25).

Brain systems that produce a sense of calm and security are similar to systems that produce relaxation feelings related to satisfaction and fulfillment of desires by releasing endorphins. The oxytocin hormone is also associated with a sense of social security, and along with endorphins, it gives us a sense of well-being. Feeling social security means feeling loved, desirable, and safe in the presence of others (26,27). This system focuses on educating compassion because it is vital for well-being (25). The main focus of CFT is to cultivate a compassionate mind.

The therapist does it gradually by explaining the skills and characteristics of compassion to the client (23). In addition, in the treatment by CFT, people learn not to avoid or suppress their painful feelings so that they can, in the first step, recognize their experience and feel compassion for it (28).Compassion-based treatment concentrates on acquiring six characteristics (sensitivity, sympathy, human motivation, disaster tolerance, lack of judgment, and empathy) (29).On the other hand, Nef and Bratos illustrated that people who have a higher rank in terms of their compassion also show more positive behaviors in their relationships (30). Hemmatafza et al. found in their research that acceptance and commitment-based therapy is effective in Social adjustment, psychosis, and self-discrepancy in patients with the transsexual disorder (31).The results of Ghasemzadeh et al.'s research also demonstrated that compassion-focused therapy effectively improves social adjustment and forgiveness in divorced women (32). In their study, Saadati et al. compared the effectiveness of acceptance and commitment therapy and compassion-focused therapy in boosting women's self-esteem and post-divorce adaptability. The results showed that both approaches in the post-test phase improved post-divorce adaptability and self-esteem. The effect of both treatment approaches in the follow-up phase was stable (33). Research by Annunziata, Green, and Marx demonstrated that acceptance and commitment therapy effectively influenced depression and anxiety (34).

In their research, Aghayi and Yavari depicted that acceptance and commitment therapy training has increased Social adjustment and self-compassion in the experimental group compared to the control group (35). Golan also acquired a high correlation between couples' low marital satisfaction and depression. The researcher said that women are tripled depressed in low satisfaction marriages (46 percent vs. 15 percent), and almost half of women with low marital satisfaction are depressed (36).

Accordingly, due to the increase in marital conflict and the prevalence of the depressive disorder in women necessity of effective interventions to reduce conflict and increase marital adaptability and analyzing the efficiency of therapeutic interventions in the field of marital conflict has become more visible to open new ways into resolving marital conflict and its sidelong problems.

Therefore, this study was conducted to compare the effectiveness of acceptance and commitment therapy and compassion-focused therapy and acceptance and commitment therapy enriched with compassion on Social adjustment.

## Materials and Methods

This study was a randomized controlled clinical trial with a pretest-posttest design and a control group. The statistical population of this study consisted of all depressed women with marital conflicts who were referred to counseling centers and psychological services of Mashhad.

This study was a randomized controlled clinical trial with a pretest-posttest design and a control group. The statistical population of this study consisted of all depressed women with marital conflicts who were referred to counseling centers and psychological services in Mashhad (2020-2021). After screening with the Marital Conflict Questionnaire (Barati and Sanai), 60 people received a higher score of 105 from the cut-off point and were also given a

moderate level of depression based on the DSM-V structured interview and Beck test were selected by purposive sampling method. Then, using random allocation, they were assigned to three experimental and control groups (15 people in each group).How to determine the sample size for studies whose statistical analysis is the main consequences using analysis of variance. The formula is used when you have more than two groups, and one of them is a placebo, to determine the volume of groups (37). Therefore, we consider 15 people in each group, 60 people. Inclusion criteria included existence of marital conflicts (individuals who obtained a minimum score of 105 or higher in the Marital Conflict Questionnaire), diagnosis of moderate depression based on structured interview based on DSM-V and Beck test (20 and above), duration of marriage between 5-25 years, aged 25-45 years, minimum diploma education, personal consent to participate in the research, the subject should not be treated with medication to reduce anxiety and depression.

Exclusion criteria for research included initiate or continue attending other psychological therapies, except treatment based on acceptance, commitment, and compassion from three months before participating in the study, diagnosis of borderline personality disorder - bipolar disorder - psychosis or mental retardation based on a structured interview, addiction to any substance, psychiatric hospitalization history, absence of more than two sessions in training sessions, failure to complete the questionnaires in different stages of the research.

Research instruments

*A) Adult from of Bell Assessment Questionnaire:* Professor Bell developed the Adaptation Questionnaire in 1961. He has developed two questionnaires on adaptation, one for students and the other for adults. This questionnaire has 160 items and five subscales (home adaptability, job adaptability, health adaptability, emotional adaptability, and Social adjustment). Each subscale has 32 questions. Answering the questions is three yes, no, and I do not know (38). The Bell questionnaire was standardized by Simon in 1986 in Iran and reduced by 160 to 45 questions for veterans in 1993 by Dr. Delavar. The validity of each of the five dimensions of the questionnaire and its total scores by the Spearman-Brown correlation method include: Home adaptability is 0.91, health adaptability is 0.81, Social adjustment is 0.88, emotional adaptability is 0.91, job adaptability is 0.85, and total: 0.94. Several researchers have used it in Iran and have often reported satisfactory reliability and validity. The reliability coefficient of Cronbach's alpha has been reported 0.87 (38). After translation and editing, this questionnaire was randomly implemented by Bahrami in 1992 on 200 people. The reliability of this test was calculated by Cronbach's alpha method and was equal to 0.89 (39). Only yes or no answers are scored in this test and based on the normalized table. The selected option is assigned several zero or one. The individual adaptation score equals the sum of the scores obtained from all questions. In addition to the total score, the individual adaptation scores can be calculated in each adjustment dimension, indicating the degree of individual adaptation. The social adaptation subscale, which has 32 questions, is used in this study. A higher score in this questionnaire indicates a higher Social adjustment (40).

*B) Beck Depression Inventory version 2 (BDI-II):* The questionnaire was first introduced in 1961 by Beck, Ward, Mendelssohn, Mook, and Abaq and revised in 1971 (41). The questionnaire is a 21-item self-report questionnaire to assess the severity of depression in adolescents and adults, revised in 1996 to better align with the DSM-VI criteria for depression. In this questionnaire, the answers are scored between 0-3. Cut points are such that the score is 0 to 13 non-depressed; 14 to 19 mild to moderate depression; 20 to 28 moderate to severe depression; and 29 to 63 indicates severe depression. Higher scores indicate more severe depressive symptoms. BDI-II has a positive correlation with Hamilton Depression Rating Scale (HRSD), r= 0.71 and its one-week retest reliability is 0.93 (42).

The meta-analysis results to determine the internal consistency have reported the range of this coefficient between 0.73 to 0.92 and the correlation between the two revised and primary forms equal to 0.89 (43). Fetti, Birshak, Atef Vahid, and Dobson (43) reported Cronbach's alpha of 0.91, a one-week retest coefficient of 0.81, and a Beck Anxiety Inventory correlation coefficient of 0.61. Also, in a study with a sample of 354 people diagnosed with major depression and were in recovery, the internal validity was 0.91 (44).

*C) Marital Conflict Questionnaire (MCQ):* The measuring tool was the Marital Conflict Questionnaire (Barati and Sanai). This questionnaire has 42 questions and is used to measure marital conflicts and measures seven dimensions of marital conflicts, which include: Cooperation, sexuality, emotional reactions, support for children, personal relationship with family, relationship with spouse relatives and finances, and for each option there are five answers (never, to Rare, sometimes, mostly, always) Which gives 1 to 5 points for each option. A high score indicates marital conflict, and a low score indicates a normal marital relationship. The minimum score is 42, and the maximum is 210. The reliability of the questionnaire was reported through the alpha coefficient of 0.53 and had good content validity. Raw scores in the range of 70 to 104 have normal marital relationships, and in the range of 105 to 134 have abnormal conflict and in the range of 135 and above, show abnormal and severe conflict (45,46).

The validity of Cronbach's alpha test for the whole questionnaire on a group of 32 people equal to 0.53 for its seven subscales is as follows: Reduction of cooperation, 0.30; Decrease in sex by 0.50; Increased emotional reactions 0.73; Increase child support 0.60; Increase personal relationship with relatives 0.64; Decrease in a family relationship with spouse relatives and friends 0.64; Separation of financial affairs from each other 0.51 (47).

Dehghan (2001) reported the total validity of the test as 0.52 and the subscales between 0.30 and 0.82. In the present study, the total validity of the test was estimated to be 0.675 by Cronbach's alpha method and between 0.48 and 0.645 for subscales (48).

*Intervention program*

To perform the Acceptance and Commitment Therapy (ACT) intervention, an educational package taken from the book of " Act made simple " (49) as well as the principles and metaphors presented in the book ACT with Love: Stop Struggling, Reconcile Differences, and Strengthen Your Relationship with Acceptance and Commitment Therapy (50) and Acceptance and Commitment Therapy for Couples (51) A description of 8 training sessions was prepared.

To perform the Compassion-Based Therapy (CFT) intervention, an educational package was prepared based on the compassion-focused therapy Book (52) and The ACT practitioner's guide to the science of compassion: tools for fostering psychological flexibility (53), which summarized eight training sessions. In addition, the content of the treatment intervention based on Acceptance and Commitment enriched with compassion was prepared based on a combination of content sessions of two approaches.

*Summary of Acceptance and Commitment Therapy (ACT) Intervention Sessions*

Session 1: Introduction and acquaintance- Pre-test.

Session 2: Analyzing members' issues and relationships- Examining their willingness to stay in the relationship and the amount of effort to improve the relationship - Discussion about experiences and ways of response (avoidance responses) - Difference in emotional pain and suffering - making creative frustration - Introducing the inevitable schema pain control as an issue - Identifying ineffective control strategies and its consequences.

Session 3: Introducing acceptance and praying for peace- Performing (NAME) exercises.

Session 4: Introducing layers of psychological fog and cognitive barriers and filling in the table of getting hooks into the mind outside the session.

Session 5: Introducing the change of perspective of oneself as content towards oneself as context.

Session 6: Introducing the application of mindfulness technique in psychological flexibility - Performing conscious breathing exercise.

Session 7: Explaining the clarification of individual values in the field of marriage as a compass of life-Filling in the table of values the field of marriage and examining and measuring appropriate behaviors to values.

Session 8: Creating readiness for committed action and filling out the commitment form in the path of a worthwhile life- Post-test - Coordinating the date of fulfillment the questionnaire to follow up with clients

*Summary of Compassion Focused Therapy (CFT) Intervention Sessions*

Session 1: Introduction and acquaintance - Pre-test. Session 2: Definition and explanation of the mind and types of mind products - Identification of different shovels (ineffective methods of dealing with problems) of life.

Session 3: Definition and interpretation of three emotional regulation systems (defense, motivation, security) and the characteristics of

each system and the role of security system in psychological well-being.

Session 4: Explain the concepts of pure and impure suffering and its relationship with emotion regulation systems and introduction three brains (old, analytical and conscious).

Session 5: Explaining the characteristics of a compassionate person- Encouraging self-knowledge and examining one's personality as a compassionate person and cultivating and understanding that others also have flaws and problems (cultivating a sense of human commonalities) in the face of self-destructive feelings and shame - Performing mindful breathing practice.

Session 6: Introducing the six skills of cultivating a compassionate mind.

Session 7: Introducing kind behaviors that include 4 behaviors (1- caressing, 2- giving opportunities, 3- structuring and 4- creating challenges) -Performing exercises of sensitivity to suffering and empathy and empathy with oneself and others - Compassionate notes for oneself and others and daily recording of real situations based on compassion and their performance in that situation.

Session 8: Reviewing the issues raised in the previous sessions- Summarizing the sessions- Post-test- Coordinating the date of the questionnaire to follow up with clients.Summary of treatment intervention sessions based on acceptance and commitment enriched with compassion: The content of treatment sessions based on Acceptance and Commitment Therapy enriched with compassion was prepared by combining the content sessions of two approaches.

The ethical considerations considered in this study were that the process was discussed with the subjects about the process and goals of the training sessions, and they expressed their informed consent to participate in this study and then in the initial evaluation session of this written consent. Subjects were also told that this training program is a research project. Also, if the results were effective, the control group was promised to hold training sessions after the end of the research program. Subjects were also assured that the data obtained from each individual would be kept confidential, and it was noted that the subject could be excluded from the program whenever the subject wished not to attend the sessions. The present study has the code of ethics IR.IAU.BOJNOURD.REC. 1399.035 from the ethics committee of Islamic Azad University, Bojnourd branch.

## Results

Describing the data collected in this study, in addition to the demographic characteristics of the experimental group (Table 1), descriptive indicators related to the total score of social adjustment, depression, and marital conflict in three stages of pre-test, post-test and follow-up are presented in Table 2.

The table results indicate that in the post-test and follow-up stages, the difference between the means in the experimental group is noticeable, showing that the interventions have affected women's social adjustment, depression, and marital conflict. Also, follow-up scores did not change significantly, indicating that treatment was sustained.

**Table 1.** Demographic characteristics of the participants

| Demographic profile | | Number | Percent |
|---|---|---|---|
| Education | Diploma | 11 | 18.3 |
| | Above diploma | 9 | 15.0 |
| | Bachelor degree | 21 | 35.0 |
| | M.A | 16 | 26.6 |
| | Ph.D | 3 | 5.0 |
| Duration of marriage | 5-10 years | 10 | 16.6 |
| | 11-15 years | 17 | 28.3 |
| | 16-20 years | 12 | 20.0 |
| | 21-25 years | 21 | 35.0 |
| Age | 25-30 years | 12 | 20.0 |
| | 31-35 years | 15 | 25.0 |
| | 36-40 years | 14 | 23.3 |
| | 41-45 years | 19 | 31.6 |

**Table 2.** Mean and standard deviation and normality of variable scores in the pre-test, post-test, and follow-up

| Scale | Phase | Compassion-focused | | ACT | | ACT enriched with compassion | | Control | | Result | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Average | SD | Average | SD | Average | SD | Average | SD | F | P |
| Social adjustment | Pre-test | 17.27 | 2.96 | 17.00 | 2.00 | 18.60 | 2.32 | 18.67 | 1.80 | 2.13 | 0.10 |
| | Post-test | 18.13 | 3.34 | 14.07 | 2.19 | 13.60 | 2.32 | 19.67 | 1.80 | 21.96 | 0.001 |
| | Follow-up | 17.00 | 3.42 | 13.07 | 2.19 | 11.20 | 1.97 | 20.67 | 1.80 | 45.17 | 0.001 |
| Depression | Pre-test | 44-80 | 8.41 | 42.27 | 10.05 | 45.40 | 7.14 | 45.20 | 9.02 | 0.41 | 0.74 |
| | Post-test | 31.67 | 7.15 | 28.80 | 8.71 | 24.60 | 6.45 | 46.67 | 8.77 | 25.54 | 0.001 |
| | Follow-up | 30.20 | 7.32 | 27.33 | 8.89 | 20.07 | 6.47 | 48.40 | 8.32 | 35.70 | 0.001 |
| Marital conflict | Pre-test | 131.53 | 7.65 | 125.93 | 13.39 | 130.53 | 7.43 | 130.20 | 9.48 | 0.96 | 0.41 |
| | Post-test | 106.53 | 7.65 | 100.93 | 10.58 | 94.07 | 10.76 | 140.20 | 9.48 | 66.93 | 0.001 |
| | Follow-up | 98.07 | 6.94 | 94.13 | 10.04 | 84.07 | 10.73 | 145.20 | 9.48 | 125.41 | 0.001 |

Then, to know whether these changes in post-test and follow-up are statistically significant or not, repeated measures analysis of variance was used. The use of this test requires compliance with a few basic assumptions. These assumptions include the normality of the distribution of scores and the homogeneity of variances, which were first examined. Kolmogorov-Smirnov test was used to assume the normality of data distribution, in which the significance level of the variable is greater than $P< 0.05$, and it means that the variable in question has a normal distribution. To check the assumption of the equality of variances within the subjects: the Mauchly sphericity test was used. Examination of the Mauchly sphericity test results showed that this test was not significant for social adjustment, and therefore the assumption of the equality of variances within the subjects was observed. Finally, the Levene test was used to evaluate the default homogeneity of variances.

The homogeneity test results of the variances of the experimental and control groups are not significant for social adjustment, so the variances of the experimental and control groups are the same. Given that the assumptions of using analysis of variance have been observed with repeated measurements, this statistical test can be used.

**Table 3.** Results of analysis of variance with repeated measures on the mean scores

| Variable | Total squares | Degrees of freedom | Average squares | F | P | Impact rate | Test power |
|---|---|---|---|---|---|---|---|
| Level | 176.81 | 2 | 88.41 | 55.89 | 0.00 | 050 | 1 |
| Stage * Group | 416.70 | 6 | 69.45 | 43.91 | 0.00 | 0.70 | 1 |
| Group | 822.27 | 3 | 274.09 | 19.26 | 0.00 | 0.51 | 1 |
| Error | 796.98 | 56 | 14.23 | | | | |

Table 3 shows a significant difference between the mean of pre-test, post-test, and follow-up the total score of Social adjustment in the three experimental and control groups. In other words, there is a significant difference between the scores of stages (pre-test, post-test, and follow-up) in these groups ($P< 0.01$, f= 55.89). Also, the significance of the interaction

between the stages with all three experimental groups in Social adjustment indicates that in the post-test and follow-up stages, the mean of the experimental groups is significantly higher than the control group ($P$<0.01, f = 43.91). Therefore, there is a significant difference between the level of social adjustment of the subjects in the three experimental and control groups (f=19.26, $P$< 0.01). These results indicate the effectiveness of Compassion Focused Therapy, Acceptance, and Commitment Therapy, and Acceptance and Commitment therapy enriched compassion on Social adjustment. For more detailed study and determination of groups that are different, the Bonferroni test is used (Table 4).

**Table 4.** Results of Bonferroni post hoc test for post-test of social adjustment

| | | Mean difference | P | Mean difference | P |
|---|---|---|---|---|---|
| Acceptance and commitment therapy | Compassion-focused treatment | 4.07 | 0.00 | 3.93* | 0.00 |
| | Acceptance and commitment enriched with compassion | 4.53* | 0.00 | 5.80* | 0.00 |
| | Control | -1.53* | 0.57 | -3.67* | 0.00 |
| Compassion-focused treatment | Acceptance and commitment therapy | -4.07* | 0.00 | -3.93* | 0.00 |
| | Acceptance and commitment enriched with compassion | 0.47 | 1 | 1.87* | 0.24 |
| | Control | -5.60* | 0.00 | -7.60* | 0.00 |
| Acceptance and commitment enriched with compassion | Acceptance and commitment therapy | -4.53* | 0.00 | -5.80* | 0.00 |
| | Compassion-focused treatment | -0.47* | 1 | -1.87* | 0.24 |
| | Control | -6.07* | 0.00 | -9.47* | 0.00 |

Table 4 shows that acceptance and commitment-based therapy training and compassion-based therapy, and compassion-enriched acceptance-commitment therapy have a significant effect on social adjustment in both post-test and follow-up stages ($P$< 0.05). As a result, there is a significant difference between social adjustment in the post-test stage and follow-up of the mentioned groups, and this difference is greater for acceptance and commitment enriched with compassion in the post-test (6.07) and follow-up (9.47). This indicates that teaching treatment based on acceptance and commitment enriched with compassion is more effective on social adjustment in the post-test phase and includes continuing this effect in the follow-up phase.

## Discussion

The research results showed that by using these two treatment methods and combining the two, the rate of Social adjustment in women with depression and marital conflicts could be significantly reduced. The results of this study in the follow-up phase also showed the continuation of the effect of therapeutic intervention after training. The findings of this study are consistent with a study conducted by Saadati et al. (54) comparing the effectiveness of Acceptance and Commitment (ACT) and Compassion-Based Therapy (CFT) in boosting self-esteem and post-divorce adjustment in women. A total of 36 divorced women participated in this study and were assigned to three experimental groups: ACT (n= 12), CFT (n= 12), and control. The ACT group received acceptance and commitment therapy, and the CFT group received compassion-focused therapy for eight sessions of 90 minutes each. Subjects were assessed using the Cooper-Smith Self-Esteem Scale (SEI) and Post-Divorce Adjustment Scale (FADS). Findings showed that both treatments and improving post-divorce adjustment levels in women also improved self-esteem. Also, the results of this study are in line with the research of Ashrafzadeh et al. (55) on the effectiveness of treatment based on acceptance and commitment on social anxiety and social adjustment of high school boys in Kerman. The sample consisted

of 30 high school students selected by the convenient sampling method and divided into two experimental groups (n= 15) and a control group (n= 15). Both groups responded to Connor et al. and the California Social Adjustment Scale = on the Social Anxiety Questionnaire before and after the training process. The number of training sessions for the experimental group was eight sessions and one session per week, and each session was 90 minutes, and the control group did not receive any training. The results showed that commitment-based education and acceptance affect high school boys' social anxiety and social adjustment in Kerman. Findings from Brennan, George, Efert, and Sarah (56) suggest that ACT may effectively increase marital adjustment and satisfaction and reduce interpersonal and psychological distress in couples. Future studies with larger samples and more controlled designs are needed to create a single case based on the results of this study. Two married couples participated in this study. Also, the findings of Idrisi's study (57) on the effectiveness of treatment based on Acceptance and Commitment on individual-social adjustment and mental health of dissatisfied couples referring to counseling centers in Tehran in 2019 are consistent with the findings of the present study. The results showed that group psychotherapy of Acceptance and Commitment was effective on "anxiety and insomnia", "social dysfunction," and "depression" of dissatisfied couples, while there was no difference between the groups in terms of "physical symptoms". The results of Beilby, Byrnes, and Yaruss's (58) study on the effectiveness of Acceptance and Commitment Therapy for adults who stutter: Psychological adjustment and fluency of speech are also consistent with the present study results (n=20). The program consisted of 2-hour treatment sessions conducted each week for eight consecutive weeks. These findings raise awareness of the impact of stuttering on psychological well-being and offer a new perspective on what might be successful in treating stuttering. In addition, clinical research demonstrates the acceptance and commitment treatment offered in a group as a promising and new intervention for adults with stuttering. Also, among the findings of Kazemi's research (59) entitled The effectiveness of treatment based on Acceptance and Commitment on anxiety and social adjustment of breast cancer patients, performed on 30 women with breast cancer referred to Shohada Tajrish Hospital in Tehran with research There is now alignment. The experimental group received eight sessions of 90 minutes based on Acceptance and Commitment, and the control group waited for treatment. Data were collected using the Zang Anxiety Scale and the Bell Social Adjustment Subscale. The results showed that the experimental and control groups were significantly different in terms of both anxiety and social adjustment. Thus, acceptance and commitment-based therapy reduced anxiety and increased social adjustment in patients with breast cancer. The results of the study of Nouri et al. (60), based on the effectiveness of group therapy based on acceptance and commitment on social and health adjustment of nursing students, was conducted on 40 nurses and evaluated with the subscale of health and social adjustment of Bell questionnaire, It also showed that there is a significant difference between experimental and control groups in social and health adjustment. In other words, group therapy based on acceptance and commitment significantly improved nursing students' social and health adjustment. The findings of this study are also consistent with the study of Esman et al. on the effect of the act on reducing the avoidance of adult avoidance situations with an average age of 42 years (with social phobia) (61). Explaining the effect of Acceptance and Commitment therapy on social adjustment, we can say that today we live in a world that needs flexibility and individual and social adjustment more than ever. In such situations, without a doubt, having adaptability and flexibility can play an important role in improving the health of people's lives (62). Acceptance and Commitment Therapy improves adaptation by creating acceptance, experiential avoidance, increasing mindfulness, reducing judgment, and evaluative thinking that emphasized in the treatment protocol. Also, in explaining the effectiveness of this treatment method, it can be said that according to the relevant theories, changes in the field of adaptation occur when people react to their private internal events, which reduce their involvement with negative thoughts and increase their acceptance. Reducing negative thoughts and increasing acceptance improves interpersonal relationships and helps people observe negative relationship reactions, and eliminate the pattern of avoidance and

conflicting behaviors. These factors can play an effective role in improving adjustment (63). In the effectiveness of acceptance and commitment therapy (ACT), it seems that ACT therapy allows clients to change relationships with their internal experiences in the first place, reduce empirical avoidance, increase flexibility, and ultimately adopt. Moreover, secondly, it teaches the authorities to increase invaluable action ways (64). Hutcherson, Seppala, and Gross (65) Also in his research entitled Kind Meditation increases social bonding. They showed that short-term meditation based on compassion increases the feeling of social connection and acceptance towards strangers. This finding is consistent with Ghasemzadeh's (32) study, which aimed at the effectiveness of compassion-focused treatment on improving social adjustment and forgiveness in divorced women, performed on 30 divorced women in Isfahan. In order to collect data, a social adjustment questionnaire and forgiveness questionnaire were used. The results showed that compassion-focused treatment is effective on social adjustment and forgiveness of divorced women. Also, the results of this research are in line with Nef and Carpathric's research (66) entitled self-compassion and adaptive psychological functioning, which is presented in the form of two studies. They found that self-compassion (unlike self-esteem) helps buffer against anxiety when faced with an ego threat in a laboratory setting. Self-compassion was also linked to using different languages when writing about weaknesses. found that increases in self-compassion occurring over a one-month interval were associated with increased psychological well-being and that therapist rating of self-compassion was significantly correlated with self-reports of self-compassion.

Studies by Nef et al. (67) examined the relationship between self-compassion, academic achievement goals, and coping with undergraduate academic failure. Study 1 (n= 222) found that self-compassion was positively associated with mastery goals and negatively associated with performance goals, a relationship mediated by the lesser fear of failure and greater perceived competence of self-compassionate individuals. Study 2 confirmed these findings among students who perceived their recent midterm grade as a failure (n= 110), with results also indicating that self-compassion was positively associated with emotion-focused coping strategies and negatively associated with avoidance-oriented strategies. Pak Tintan et al. (68) examined 32 patients with depressive disorder. Acceptance and commitment group therapy was performed for experimental groups with a view to compassion therapy. Research instruments included Garnfsky et al. Cognitive Emotion Regulation Questionnaire and Sohrabi and Samani's Adjustment Questionnaire. Furthermore, it showed that acceptance and commitment group therapy with a view to compassion had improved personal adjustment, social adjustment, academic adjustment, job adjustment, and family adjustment in the experimental group subjects in the post-test phase, which is consistent with the findings of the present study. In explaining the effectiveness of compassion-focused therapy, it can be said that compassion in CFT includes the development of various characteristics that facilitate an oriented and skilled approach to pain, conflict, and suffering. In all of these features, the focus is on helping clients build compassionate courage to approach and work on difficult tasks, especially challenging emotions that they may avoid (69). Self-compassion helps activate one's relief system (which is physiologically related to the parental care system) and thus reduces feelings of fear and withdrawal (70). Oxytocin is released in the body when people treat others with compassion or others treat them with compassion (71). Increasing oxytocin levels enhances feelings of trust, security, and social connection (72). People with high compassion resolve their interpersonal conflicts by considering their own needs and those of others (73). People with higher self-compassion report more emotional coping skills and can differentiate between their emotions and mood-regenerate negative emotional states (74).

Compassion-focused therapy aims to facilitate emotional change to provide more care and support, which weakens the attack, increases self-acceptance, and reduces emotional turmoil.

It thus enables the individual to relieve and control her/ himself more (64). Having a compassionate attitude in people helps them feel the bond between themselves and others and, through this feeling, overcome the fear of rejection and incompatibility with existing conditions (75). Numerous studies show that the kind of self we want to become affects our

well-being and social relationships, and compassionate identity has better results than self-centered identity (76). Comparing the effectiveness of acceptance commitment treatments and compassion-focused treatment are in line with the study by Reza Khani (77). It is based on comparing the effectiveness of compassion-based treatment and acceptance-based therapy on reducing the symptoms of people with depressive disorder, which was performed on 36 eligible people referred to Shiraz clinics. Experimental groups, I and II underwent acceptance and commitment therapy and compassion-based therapy during 8 group training sessions once a week that lasted about 2 hours.

The results showed that both treatments effectively reduced depression in people with depressive disorder. In another study, Ghaibi et al. (78) compared the effectiveness of Acceptance, Commitment, and Compassion-Focus Therapy on the psychological well-being of 45 male patients with multiple sclerosis. The experimental groups were trained in 8 sessions of 75 minutes (one session per week) with the methods of treatment based on acceptance, commitment, and compassion, respectively. The results showed that both therapies based on acceptance, commitment, and compassion increased psychological well-being compared to the control group, and the treatment results were maintained in the follow-up phase. Rezaei et al. (79) also evaluated the effectiveness of acceptance-based and compassion-based therapy on depression, anxiety, and quality of life of 80 patients with systemic lupus treated in Shiraz hospitals. They showed that this treatment has a significant effect on systemic lupus in the post-test and follow-up stages, which is consistent with the findings of the present study.

Due to limitations such as use of self-assessment tools, limited period of 1 month follow-up period Also, the sample of this study was women suffering from depression and marital conflicts, so in generalizing the results of this study to other sections of society, precautionary aspects should be observed. Therefore, it is suggested that the principles of this type of treatment in cultural and family centers to prevent the occurrence and aggravation of individual and family problems and conflicts during short training courses to women and participants in the training courses of these centers should be taught. In addition to being preventative, this will make women more aware of their need for timely referral when experiencing marital conflict and depressive symptoms.

## Conclusion

A summary of the results of this study shows that both Compassion Focus Therapy (CFT) and Acceptance and Commitment Therapy (ACT) are effective mechanisms to reduce depressive symptoms and marital conflicts in women.

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